LIFESAVING DISCRIMINATION

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Racial minorities in the United States, and Black people in particular, experience worse health outcomes and lower-quality medical care than White people do. Mounting empirical evidence indicates that for Black Americans, and perhaps other racial minorities, this gap can be narrowed if they are given the choice to receive care from physicians of their same race. Given the significant benefits of patient-physician racial concordance for people of color, this Article argues that medical providers who do not have enough physicians of color on staff to meet their patients' needs should be permitted in some cases to make race-conscious physician-hiring decisions. Despite its broad proscriptions against employment discrimination, Title VII of the Civil Rights Act of 1964 recognizes there are certain situations in which employment discrimination is justified. The statute permits employers to discriminate if sex, religion, or national origin is a bona fide occupational qualification ("BFOQ") reasonably necessary to the normal operation of the business. Congress excluded race from the BFOQ provision based on its judgment that race should never be a legitimate qualification for employment. This may have made good sense in 1964, but it is less defensible today in light of the now known benefits of patient-physician racial concordance for people of color. Consequently, Congress should amend Title VII to permit race-based BFOQs under the same narrow terms that courts have dictated for BFOQs based on sex, religion, and national origin. This would enable medical providers in certain cases to make race-conscious hiring decisions that would allow them to deliver more effective care to patients who prioritize racial congruence and cultural competency. If increasing access to physicians of color can lead to better health outcomes for some minorities—literally saving lives—then a race BFOQ for certain physician positions is at

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least as justifiable as other circumstances in which courts permit employers to legally discriminate.

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INTRODUCTION

In December 2020, Susan Moore, a Black woman from Indianapolis, posted a video of herself as she lay in a hospital bed battling Covid-19.[1] In the video, which quickly went viral, Moore—a doctor herself—described how a White physician had dismissed her pain and concerns about her treatment.[2] "You're not even short of breath," the physician told her.[3] "Yes, I am," she insisted.[4] Despite Moore's pain, the White physician considered sending her home and told her he did not feel comfortable giving her more narcotics.[5] "He made me feel like I was a drug addict [and] he knew I was a physician," Moore recounted.[6] "I put forth and I maintain if I was White, I wouldn't have to go through that . . . . This is how [B]lack people get killed."[7] Sadly, Moore's warning proved prescient: she died from the coronavirus two weeks later.[8]

During the pandemic, much was made of the fact that in the United States, racial minorities, and Black people in particular, died from Covid-19 at much higher rates than White people did.[9] National media outlets published hard-hitting exposés;[10] politicians, policymakers, and

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1. *See* Dakin Andone, *A Black Doctor Died of Covid-19 Weeks After Accusing Hospital Staff of Racist Treatment*, CNN (Dec. 25, 2020, 7:33 AM), https://www.cnn.com/2020/12/24/us/black-doctor-susan-moore-covid-19/index.html [https://perma.cc/TT9G-67CD].

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. *Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/Covid-data/investigationsdiscovery/hospitalization-death-by-race-ethnicity.html [https://perma.cc/TVA6-KTPL] (reporting that Black or African American, Non-Hispanic persons are 1.7 times more likely, Hispanic or Latino persons are 1.8 times more likely, American Indian or Alaska native, Non-Hispanic persons are 2.1 times more likely, and Asian, Non-Hispanic persons are 0.8 times more likely than White people to die of Covid-19).

10. *See, e.g.*, Dan Keating, Ariana Eunjung Cha & Gabriel Florit, *'I Just Pray God Will Help Me': Racial, Ethnic Minorities Reel from Higher Covid-19 Death Rates*, WASH. POST (Nov. 20, 2020), https://www.washingtonpost.com/graphics/2020/health/covid-race-mortality-rate [https://perma.cc/6GPH-TRP3]; Linda Villarosa, *'A Terrible Price': The Deadly Racial Disparities of Covid-19 in America*, N.Y. TIMES MAG. (Nov. 18, 2020), https://www.nytimes.com/2020/04/29/magazine/racial-disparities-covid-19.html [https://perma.cc/V2DU-ZU7A].

academics conducted hearings,[11] summits,[12] and conferences;[13] and leading health organizations issued high-profile reports urging greater equity in the treatment of Covid-19 patients.[14] Then-Presidential candidate Joe Biden made the racial disparity in Covid-19 deaths a key talking point during his campaign. In a tense exchange with President Trump during one of the presidential debates, Biden accused the president of doing nothing to remedy the situation: "You talk about helping African Americans—1 in 1,000 African Americans has been killed because of the coronavirus . . . . And if he doesn't do something quickly, by the end of the year, 1 in 500 will have been killed. 1 in 500 African Americans."[15] He continued, "This man is the savior of African Americans? This man cares at all? This man's done virtually nothing."[16]

Racial disparities in Covid-19 death rates, while unconscionable, should not have come as a surprise. Americans of color have long experienced worse health outcomes than their White counterparts; the pandemic merely shined a light on this dark and persistent truth. This inequity is particularly pronounced among Black people, who "continue to have higher rates of morbidity and mortality than [White

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11. *See, e.g.*, Press Release, U.S. Senate Special Comm. on Aging, Senators Collins, Casey Lead Hearing on COVID-19's Disparate Health Impacts on Seniors from Racial and Ethnic Minority Communities (July 21, 2020), https://www.aging.senate.gov/press-releases/senators-collins-casey-lead-hearing-on-Covid-19s-disparate-health-impacts-on-seniors-from-racial-and-ethnic-minority-communities [https://perma.cc/X8Z2-WJ8M].

12. *See, e.g.*, Claire Jarvis, *Addressing Health Disparities and Patient Access to Care in the Time of COVID-19*, SAPORTAREPORT (Sept. 21, 2020, 5:03 PM), https://saportareport.com/first-ever-summit-brings-patients-legislators-and-biopharmas-together-to-work-towards-the-common-goal-of-treatments-and-cures/ [https://perma.cc/J5AV-DT75] (reporting on a summit where speakers argued that racial disparities in Covid-19 treatment must be addressed through commitment to social justice and meaningful engagement).

13. *See, e.g.*, *Report of the 2020 Virtual Race, Ethnicity, and Place Conference, October 21-23, 2020*, RACE, ETHNICITY, & PLACE, https://repconference.org/rep-mad-aag-2020-virtual-conference-summary [https://perma.cc/FYU6-8BY7] (reporting that the organization's conference "had as an organizing theme the coronavirus and vulnerable populations").

14. *See What is Health Equity?*, CDC, https://www.cdc.gov/healthequity/whatis/index.html [https://perma.cc/PT4K-T4D3].

15. Dylan Scott, *It's True: 1 in 1,000 Black Americans Have Died in the Covid-19 Pandemic*, VOX (Sept. 29, 2020, 11:30 PM), https://www.vox.com/2020/9/29/21494803/presidential-debate-2020-joe-biden-us-covid-deaths [https://perma.cc/L5EZ-BXVR].

16. *Id.*

people] for most indicators of physical health."[17] Black Americans can expect to live an astounding 3.4 years less than White Americans[18] and are more likely to die from heart disease,[19] stroke,[20] cancer,[21] HIV/AIDS,[22] diabetes,[23] and pregnancy-related conditions.[24] The reasons for these disparities are complex and multifaceted, to be sure, but they stem at least in part from the lower quality of medical care

17. David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 HEALTH CARE FIN. REV. 75, 75 (2000).

18. CDC, HEALTH, UNITED STATES, 2020–2021, Table LExpMort, Life expectancy at birth, age 65, and age 75, by sex, race, and Hispanic origin: United States, selected years 1900–2019, https://www.cdc.gov/nchs/data/hus/2020-2021/LExpMort.pdf [https://perma.cc/J7TF-JRV8].

19. *Number of Heart Disease Deaths per 100,000 Population by Race/Ethnicity*, KAISER FAMILY FOUND. (2020), https://www.kff.org/other/state-indicator/number-of-heart-disease-deaths-per-100000-population-by-raceethnicity-2/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/6739-QH2P] (reporting a heart disease death rate of 228.6 per 100,000 for Black people, compared to 170.1 for White people in 2020).

20. Salim S. Virani, Alvaro Alonso, Emelia J. Benjamin, Marcio S. Bittencourt, Clifton W. Callaway, April P. Carson et al., *Heart Disease and Stroke Statistics—2020 Update: A Report from the American Heart Association*, 141 CIRCULATION e139, e356, e380 (2020) (reporting that the risk of a first stroke is nearly twice as high for Black people as for White people).

21. *Number of Cancer Deaths per 100,000 Population by Race/Ethnicity*, KAISER FAMILY FOUND. (2020), https://www.kff.org/other/state-indicator/cancer-death-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/49PZ-A64K] (reporting a cancer death rate of 166.7 per 100,000 for Black people, compared to 149.9 for White people).

22. *Estimated Death Rates (per 100,000) of Adults and Adolescents with an HIV Diagnoses, by Race/Ethnicity*, KAISER FAMILY FOUND. (2020), https://www.kff.org/hivaids/state-indicator/estimated-death-rates-per-100000-of-adults-and-adolescents-with-an-hiv-diagnosis-by raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/4J6L-2YY2] (reporting an HIV death rate of 19.5 per 1000,000 for Black people, compared to 2.9 for White people).

23. *Number of Diabetes Deaths per 100,000 Population by Race/Ethnicity*, KAISER FAMILY FOUND. (2020), https://www.kff.org/other/state-indicator/diabetes-death-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/63QM-MKTK] (reporting a diabetes death rate of 46.8 per 100,000 for Black people, compared to 21.1 for White people).

24. Emily E. Peterson, Nicole L. Davis, David Goodman, Shanna Cox, Carla Syverson, Kristi Seed et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007-2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, 763 tbl.1 (2019) (reporting a pregnancy-related death rate of 41 per 100,000 for Black people, compared to 13 for White people from 2007–2016).

Black people receive compared to White people.[25] In 2002, the Institute of Medicine issued a landmark report showing that minority patients, and especially Black people, were more likely than White people to receive substandard medical care, leading to poorer health outcomes.[26] The report found that racial minorities were considerably less likely to receive medical care when needed and that the care they did receive was usually inferior.[27] Follow-up studies indicate this gap not only persists but, in some ways, has widened.[28]

Efforts to reduce racial disparities in medical care tend to focus on improving access to health services.[29] This is obviously a crucial part of the solution, but it is hardly sufficient; studies indicate that racial minorities still receive worse medical care even when controlling for access-related factors such as insurance status and income.[30] Researchers attribute this residual inequality, in part, to discrimination patients of color experience from their treating physicians and medical institutions.[31] This results not only in minorities receiving inferior care but also in deep-seated distrust in the medical system that causes many

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25. *See* Williams & Rucker, *supra* note 17, at 75 (asserting that "racial and ethnic differentials in the . . . quality of care are a likely contributor to racial disparities in health status").

26. INST. OF MED., UNEQUAL TREATMENT: WHAT HEALTHCARE PROVIDERS NEED TO KNOW ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 2 (2002).

27. *Id.* at 2, 4.

28. *See, e.g.*, Robert S. Levine, Nathaniel C. Briggs, Barbara S. Kilbourne, William D. King, Yvonne Fry-Johnson, Peter T. Baltrus et al., *Black-White Mortality from HIV in the United States Before and After Introduction of Highly Active Antiretroviral Therapy in 1996*, 97 AM. J. PUB. HEALTH 1884, 1884, 1888 (2007) (finding that the Black-White disparity in AIDS diagnoses and mortality has grown substantially over time). *See generally* Kevin Fiscella & Mechelle R. Sanders, *Racial and Ethnic Disparities in the Quality of Health Care*, 37 ANN. REV. PUB. HEALTH 375 (2016) (arguing that progress towards health care equality for all racial and ethnic disparities has been historically slow, but hope remains that the issue will be addressed effectively).

29. *See, e.g.*, David R. Williams & Lisa A. Cooper, Commentary, *Reducing Racial Inequities in Health: Using What We Already Know to Take Action*, INT'L J. ENV'T RSCH. & PUB. HEALTH, Feb. 2019, at 1, 8 (arguing that the healthcare system needs new emphasis on ensuring access to high quality care for all).

30. INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 42 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003).

31. *See* William J. Hall, Mimi V. Chapman, Kent M. Lee, Yesenia M. Merino, Tainayah W. Thomas, Keith Payne et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH 60, 61, 72 (2015).

patients of color either to withhold critical health information from their physicians or to avoid seeking treatment altogether.[32]

It is becoming increasingly apparent that reducing racial disparities in healthcare not only requires improving minorities' access to health services but also their access to physicians of their same race. Mounting empirical evidence indicates that for Black people in particular, patient-physician racial concordance can result in better medical care. When Black patients receive care from Black physicians, they are more likely to utilize health services;[33] they report better communication,[34] higher satisfaction with their visit,[35] and increased adherence to medical regimen;[36] and they experience less bias in their medical treatment.[37] Two studies even found a direct link between patient-physician racial concordance and health outcomes. One found that Black infants are half as likely to die when cared for by a Black physician,[38] and in the other, Black patients not only reported—but actually *experienced*—less pain when a physician of their same race administered heat stimulations.[39] For other minority groups, the benefits of patient-physician racial concordance are not as well understood. Few studies have examined the effects of concordance on Latinos, Asian Americans, Native Americans, or other people of color, and the handful that do exist yielded mixed results.[40] Significantly, patient-physician racial concordance does not seem to be nearly as impactful for White people as it is for Black people.[41] In fact, several studies have found that White patients derive no benefit whatsoever

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32. *See* Elizabeth A. Jacobs, Italia Rolle, Carol Estwing Ferrans, Eric E. Whitaker & Richard B. Warnecke, *Understanding African Americans' Views of the Trustworthiness of Physicians*, 21 J. GEN. INTERNAL MED. 642, 645 (2006); Donald Musa, Richard Schulz, Roderick Harris, Myrna Silverman & Stephen B. Thomas, *Trust in the Health Care System and the Use of Preventive Health Services by Older Black and White Adults*, 99 AM. J. PUB. HEALTH 1293, 1293, 1297 (2009).

33. *See infra* Section II.A.1.

34. *See infra* Section II.A.2.

35. *See infra* Section II.A.3.

36. *See infra* Section II.A.4.

37. *See infra* Section II.A.5.

38. Brad N. Greenwood, Rachel R. Hardeman, Laura Huang & Aaron Sojourner, *Physician-Patient Racial Concordance and Disparities in Birthing Mortality for Newborns*, 117 PROC. NAT'L ACAD. SCI. 21194, 21194 (2020).

39. Steven R. Anderson, Morgan Gianola, Jenna M. Perry & Elizabeth A. Reynolds Losin, *Clinician-Patient Racial/Ethnic Concordance Influences Racial/Ethnic Minority Pain: Evidence from Simulated Clinical Interactions*, 21 PAIN MED. 3,109, 3,117, 3,121 (2020).

40. *See infra* Section II.A.

41. *See infra* notes 277–280 and accompanying text.

from seeing a White physician.[42] As discussed later, this discrepancy may stem from the fact that Black people are more likely than White people to approach medical interactions from a place of distrust.[43]

To increase opportunities for patient-physician racial concordance for Black people and other racial minorities (if empirically justified), this Article argues that medical providers that do not have enough physicians of color on staff to meet their patients' needs should be allowed to make race-conscious physician-hiring decisions. Despite its broad proscription against employment discrimination, Title VII of the Civil Rights Act of 1964[44] permits employers to discriminate in instances where sex, religion, or national origin is a bona fide occupational qualification ("BFOQ") reasonably necessary to the normal operation of the business.[45] Employers have successfully invoked Title VII's BFOQ provision to justify a range of discriminatory employment decisions, from a men's prison hiring only male guards[46] to a Jesuit-affiliated university hiring only members of the religious order for certain faculty positions.[47] Medical providers and other caregiving enterprises have relied on the BFOQ defense to make sex-based staffing assignments designed to enhance the care they provide to their clients.[48] The BFOQ exception does not apply to race, a reflection of congressional judgment that race should not factor into employment decisions.[49] This Article challenges that notion, arguing that in light of the now proven benefits of patient-physician racial concordance, Congress should amend Title VII to add race alongside sex, religion, and national origin as a basis for a BFOQ. This would enable medical providers to factor race into personnel decisions where

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42. *See infra* notes 179, 206, 219, 221, 252 and accompanying text.

43. *See infra* notes 263–272 and accompanying text.

44. 42 U.S.C. §§ 2000e-2000e-17.

45. *Id.* § 2000e-2(e).

46. Dothard v. Rawlinson, 433 U.S. 321, 336–37 (1977).

47. Pime v. Loyola Univ. of Chi., 803 F.2d 351, 354 (7th Cir. 1986).

48. *See, e.g.*, Healey v. Southwood Psychiatric Hosp., 78 F.3d 128, 133 (3d Cir. 1996) (upholding the hospital's use of sex-based staffing assignments "because children who have been sexually abused will disclose their problems more easily to a member of a certain sex, depending on their sex and the sex of the abuser"); Backus v. Baptist Med. Ctr., 510 F. Supp. 1191, 1195–96 (E.D. Ark. 1981) (concluding that hiring a male nurse would invade the privacy of obstetrical patients in a hospital where nurses performed sensitive or intimate tasks), *vacated on other grounds*, 671 F.2d 1100 (8th Cir. 1982).

49. *See, e.g.*, Swint v. Pullman-Standard, 624 F.2d 525, 535 (5th Cir. 1980) ("Our interpretation of the legislative history of [the BFOQ provision] is that Congress did not view race as a qualification which could, conceptually, be reasonably necessary to the efficient operation of any business."), *rev'd on other grounds*, 456 U.S. 273 (1982).

necessary to improve minority patients' access to a racially concordant physician, should they desire it, thus creating greater equity in healthcare by giving patients of color more autonomy to select a doctor of their same race—a freedom White patients have long enjoyed.[50] To be sure, patient-physician racial concordance has limitations, given the vast differences within minority groups[51] and the fact that some patients of color may not want a racially congruent physician. However, these limitations do not eclipse the benefit that many patients of color can derive from having the ability to choose same-race medical care.

This Article proceeds as follows. Part I provides background on the BFOQ exception, including why it was added to Title VII and how the courts have construed it over time. Part II examines why a race BFOQ for physicians is factually justified. It reviews empirical research on the benefits of patient-physician racial concordance and considers various theoretical explanations for why Black people, in particular, fare better when treated by a physician of their same race. Part III considers the legal justifications for a race-based BFOQ. It explains how each of the third-party interests that courts have recognized as legitimate reasons for a BFOQ—therapy, safety, and privacy—are implicated in patient-physician exchanges. Part IV explores the moral justifications for a race BFOQ. Although race discrimination is never ideal, in this case, the ends justify the means. If increasing minority patients' autonomy to choose a racially concordant physician can lead to better health outcomes—literally saving lives, then a race BFOQ for physicians is at least as justifiable as other circumstances in which courts have allowed employers to legally discriminate, if not more so.

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50. In theory, a race BFOQ could also result in a healthcare employer hiring a White physician over a more qualified minority candidate to treat White patients. This scenario seems unlikely, however, given that White people do not appear to benefit nearly as much as Black people do from patient-physician racial concordance. *See infra* Section II.B. Moreover, given the abundance of White doctors, the vast majority of White patients are likely already able to access a White physician if they so choose.

51. *See* Alexis Hoag, *Black on Black Representation*, 96 N.Y.U. L. REV. 1493, 1525–26 (2021) (explaining that "[d]ifferences in class, gender, country of origin, and other coexistent identities can have varying degrees of impact on the way Black people experience their race and ethnicity in this country . . . . [N]evertheless, there is a unifying Black experience in this country given the institution of slavery and the hierarchy that resulted").

I. THE BFOQ EXCEPTION

This Part provides background on the BFOQ exception. It begins by examining the operative statutory language and the legislative history surrounding it. The legislative history reveals that Congress considered adding race to Title VII's BFOQ provision but ultimately declined out of concern that White people might use the race BFOQ to justify discrimination against Black people. This Part then turns to how the judiciary has construed the BFOQ exception. Courts are most willing to accept BFOQ defenses where third-party privacy, safety, or therapeutic interests are implicated, whereas they almost always reject BFOQs based on stereotypes or customer preference. This Part concludes by reviewing Equal Employment Opportunity Commission (EEOC) guidance and enforcement action pertaining to the BFOQ exception.

A. Statutory Text and Legislative History

Title VII prohibits employers from discriminating against any employee or applicant "because of such individual's race, color, religion, sex, or national origin."[52] Congress designed the statute to remove "artificial, arbitrary, and unnecessary barriers to employment . . . [that] discriminate on the basis of racial or other impermissible classification[s]."[53] Despite this broad proscription, Title VII's ban on employment discrimination is not absolute. Congress recognized that in limited situations, employers should be permitted to discriminate[54] and thus included in the statute a provision allowing employers to "hire and employ employees . . . on the basis of . . . religion, sex, or national origin in those certain instances where religion, sex, or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise."[55] The BFOQ provision applies only to hiring, firing, and promotion decisions, not to harassment or discriminatory pay scales or benefits,[56] and is an affirmative defense

52. 42 U.S.C. § 2000e-2(a).

53. Griggs v. Duke Power Co., 401 U.S. 424, 431 (1971).

54. *See* Michael J. Frank, *Justifiable Discrimination in the News and Entertainment Industries: Does Title VII Need a Race or Color BFOQ?*, 35 U.S.F. L. REV. 473, 476 (2001) (explaining that "Congress also recognized that sometimes discrimination on these bases was not only morally acceptable, but also made sound economic sense").

55. § 2000e-2(e).

56. *See* EEOC v. Fremont Christian Sch., 781 F.2d 1362, 1366–67 (9th Cir. 1986).

that must be proven on a case-by-case basis through a "fact-intensive inquiry."[57]

Conspicuously absent from this provision is any allowance for a race-based BFOQ. The omission of race (and color) was not an oversight; Congress considered an amendment that would have added race to the BFOQ provision but ultimately rejected it.[58] Representative Williams of Mississippi proposed adding race as a BFOQ, at least ostensibly to protect Black-operated businesses that catered exclusively to Black clientele.[59] Other representatives, mainly from southern states, voiced similar concerns about how the absence of a race BFOQ might adversely affect the Harlem Globetrotters, the Birmingham Black Barons (a former professional Negro League baseball team), radio stations with exclusively Black audiences, theatrical groups, and other enterprises.[60] Opponents countered that a race BFOQ would undermine Title VII's very purpose. Representative Celler of New York explained, "[w]e did not include the word 'race' because we felt that race or color would not be a bona fide qualification."[61] He later added, "[y]ou must remember that the basic purpose of title VII is to prohibit discrimination in employment on the basis of race or color. Now the substitute amendment, I fear would destroy this principle . . . . It would establish a loophole, that could well gut this title."[62] Representative Roosevelt of California voiced a similar concern, noting, "[w]e are against [a race BFOQ] because it would open up the wrong kind of emphasis in respect to the problem of discrimination. We are trying to get rid of discrimination in our national life."[63] Representative Corman, also of California, worried that a race BFOQ could lead to

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57. Gately v. Massachusetts, 2 F.3d 1221, 1227 (1st Cir. 1993).

58. 110 CONG. REC. 2,550–63, 13,825 (1964) (documenting debate and votes on two proposed amendments).

59. *Id.* at 2,550 ("If the amendment I have offered is not accepted as part of the bill many of those business will be destroyed."). A more cynical take on this proposal is that Representative Williams and other representatives from Southern states advocated for a race BFOQ so that their state judges could use the race BFOQ to protect White businesses that refused to hire Black employees. This may help explain why the amendment was defeated and why the courts have adhered so closely to the technical racial exclusion even when, in practice, they have recognized some exceptions. *See infra* notes 77–79 and accompanying text.

60. 110 CONG. REC. 2,550.

61. *Id.*

62. *Id.* at 2,556.

63. *Id.* at 2,563.

White employers hiring only White employees.[64] "When we hire people to work we want it to be based on their individual qualifications, not on the color of their skin. I can see a big hole in this substitute amendment."[65] In the end, the House rejected the amendment by a vote of 108 to 70.[66]

The Senate considered an even broader amendment that would have allowed an employer to hire an employee based on race if the employer "believes, on the basis of substantial evidence, that the hiring of such an individual . . . will be more beneficial to the normal operation of the particular business or enterprise involved or to the good will thereof than the hiring of an individual without consideration of his race."[67] Senator McClellan of Arkansas, the architect of the proposed amendment, argued that without it, Title VII would "constitute an infringement on personal liberty, denying to the employer the right to exercise his judgment in his own business affairs as to whom he might employ to help him carry on his business and . . . make the business more prosperous."[68] Senator Case of New Jersey disagreed, warning the amendment would "destroy the bill."[69] The Senate ultimately voted down the amendment 61 to 30.[70]

Congress's aversion to a race BFOQ in 1964 was understandable, given the historical context in which Title VII and the Civil Rights Act more broadly were enacted. Although the statute prohibits employment discrimination based on several traits, Congress's focus was on eradicating race discrimination.[71] The Supreme Court explained that "Congress' primary concern . . . was with 'the plight of the Negro in our economy,'" as the relative position of Black workers

64. *Id.* at 2,559 ("[I]f it is a bona fide reason to permit Negro insurance companies to hire only Negro salesmen because they are the only ones that want to deal with people in a Negro community, why would it not follow that a [W]hite insurance company, and a lot of other businesses, could hire only [W]hite people to deal with people in a [W]hite community?").

65. *Id.*

66. *Id.* at 2,563.

67. *Id.* at 13,825.

68. *Id.*

69. *Id.*

70. *Id.* at 13,826.

71. *See* Parham v. Sw. Bell Tel. Co., 433 F.2d 421, 425 (8th Cir. 1970) (explaining that Congress's purpose in enacting Title VII was "to eliminate the inconvenience, unfairness and humiliation of racial discrimination").

had been steadily worsening.[72] According to the Court, "Congress considered this a serious social problem" and "feared that the goals of the Civil Rights Act—the integration of [B]lacks into the mainstream of American society—could not be achieved unless this trend were reversed. And Congress recognized that that would not be possible unless [B]lacks were able to secure jobs 'which have a future.'"[73] If Congress had added race to the BFOQ provision, it risked sending mixed messages to the country at a time when its rejection of race discrimination needed to be unequivocal.

B. Judicial Interpretation

The courts have taken Congress's exclusion of race from the BFOQ provision as a clear sign that race cannot constitute a BFOQ.[74] They have likewise rejected employers' calls to recognize a "judicial BFOQ" for race.[75] Nevertheless, a number of courts have acknowledged, at least in dicta, situations in which racial discrimination in employment might be justifiable. In *Wygant v. Jackson Board of Education*,[76] Justice John Paul Stevens identified two such examples:

> [I]n law enforcement, if an undercover agent is needed to infiltrate a group suspected of ongoing criminal behavior—and if the members of the group are all of the same race—it would seem perfectly rational to employ an agent of that race rather than a member of a different racial class. Similarly, in a city with a recent history of racial unrest, the superintendent of police might reasonably conclude that an integrated police force could develop a better relationship with the community and thereby do a more effective job of maintaining law and order than a force composed only of [W]hite officers.[77]

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72. United Steelworkers of Am., AFL-CIO-CLC v. Weber, 443 U.S. 193, 202 (1979) (quoting 110 CONG. REC. 6,548).

73. *Id.* at 202–03 (quoting 110 CONG. REC. 7,204).

74. *See, e.g.*, Ferrill v. Parker Grp., Inc., 168 F.3d 468, 473 (11th Cir. 1999) (collecting cases); Burwell v. E. Air Lines, Inc., 633 F.2d 361, 370 n. 13 (4th Cir. 1980) (per curiam) (explaining that a statutory BFOQ defense is not available for facial race discrimination in employment).

75. *See, e.g.*, Chaney v. Plainfield Healthcare Ctr., 612 F.3d 908, 913 (7th Cir. 2010) (noting that "Title VII forbids employers from using race as a BFOQ"); *Ferrill*, 168 F.3d at 473 (noting that the BFOQ defense "is an extremely narrow exception . . . and is *not* available for racial discrimination"); Patrolmen's Benevolent Ass'n of the City of N.Y., Inc. v. City of New York, 74 F. Supp. 2d 321, 337–38 (S.D.N.Y. 1999) (declining to create a race BFOQ exception).

76. 476 U.S. 267 (1986).

77. *Id.* at 314 (Stevens, J., dissenting).

The Fifth Circuit similarly suggested that a police department could consider race for "the undercover infiltration of an all-Negro criminal organization," "plainclothes work in an area where a [W]hite man could not pass without notice," and for "[s]pecial assignments . . . during brief periods of unusually high racial tension."[78] In a later case, the Fifth Circuit again acknowledged the potential validity of a race-based employment decision, reasoning that "[a] business necessity exception may also be appropriate in the selection of actors to play certain roles. For example, it is likely that a [B]lack actor could not appropriately portray George Wallace, and a [W]hite actor could not appropriately portray Martin Luther King, Jr."[79]

Outside the Title VII context, there is an intriguing decision from the Seventh Circuit where an employer successfully asserted what essentially amounted to a race BFOQ. In *Wittmer v. Peters*,[80] White prison guards claimed the Illinois Department of Corrections violated the Constitution's equal protection clause by passing them over for promotion to lieutenant in favor of a Black guard who scored lower than them on an occupational test.[81] The Department defended its decision as necessary for the success of its boot-camp prison program, arguing that Black inmates, who constituted more than two-thirds of the prisoners, were "unlikely to play the correctional game of brutal drill sergeant and brutalized recruit unless there [were] some [B]lacks in authority in the camp."[82] The Seventh Circuit held that the Department's racially discriminatory promotion practice survived strict scrutiny, as the Department had backed its assertion that a Black lieutenant was necessary with uncontroverted expert testimony that "the boot camp . . . would not succeed in its mission of pacification and reformation with as [W]hite a staff as it would have had if a [B]lack male had not been appointed to one of the lieutenant slots."[83] Although *Wittmer* is an equal protection case and thus is not directly applicable to Title VII, it is nonetheless significant in its recognition that a racially discriminatory employment practice may be constitutionally justifiable.

Despite the courts' rejection of a race BFOQ, understanding how the judiciary assesses other types of BFOQs is helpful in considering

78. Baker v. City of St. Petersburg, 400 F.2d 294, 301 n.10 (5th Cir. 1968).
79. Miller v. Tex. State Bd. of Barber Exam'rs, 615 F.2d 650, 654 (5th Cir. 1980).
80. 87 F.3d 916 (7th Cir. 1996).
81. *Id.* at 917.
82. *Id.* at 920.
83. *Id.* at 920–21.

how judges would likely analyze a race BFOQ in the healthcare context. The Supreme Court has decided three cases involving BFOQs. On the first occasion it had to consider the BFOQ provision, the 1977 case of *Dothard v. Rawlinson*,[84] the Court opined that "the bfoq exception was in fact meant to be an extremely narrow exception to the general prohibition of discrimination."[85] At issue was an Alabama Board of Corrections regulation that prohibited female correctional counselors from working in "contact positions" requiring close physical proximity to male inmates at maximum-security institutions.[86] The Court agreed with the Board's assertion that being male was a BFOQ for the position, reasoning that "[t]he essence of a correctional counselor's job is to maintain prison security" and that "[a] woman's relative ability to maintain order in a male, maximum-security, unclassified penitentiary . . . could be directly reduced by her womanhood."[87] The Court found "a basis in fact" for expecting that inmates would sexually assault women guards because they were women,[88] though it did not cite any evidence to support this position.[89] The Court reasoned that this "would pose a real threat not only to the victim of the assault but also to the basic control of the penitentiary and protection of its inmates and the other security personnel."[90] In the Court's view, "[t]he employee's very womanhood would thus directly undermine her capacity to provide the security that is the essence of a correctional counselor's responsibility."[91] Thus, the penitentiary could lawfully discriminate against women in hiring correctional counselors for contact positions.[92]

Eight years later, the Supreme Court refined its BFOQ analysis in *Western Air Lines, Inc. v. Criswell*.[93] The case involved a challenge under

84. 433 U.S. 321 (1977).
85. *Id.* at 334.
86. *Id.* at 324–25.
87. *Id.* at 335.
88. *Id.* at 335–36.
89. In his blistering dissent, Justice Marshall called into question the Court's factual basis for claiming female prison guards were more susceptible to assault. *Id.* at 342 (Marshall, J., dissenting). He pointed out that the record before the Court "shows that the presence of women guards has not led to a single incident amounting to a serious breach of security in any Alabama institution." *Id.* at 344.
90. *Id.* at 336 (majority opinion).
91. *Id.*
92. *Id.* at 336–37.
93. 472 U.S. 400 (1985).

the Age Discrimination in Employment Act[94] ("ADEA") to Western Air Lines' mandatory retirement policy for flight engineers who reached age sixty.[95] Similar to Title VII, the ADEA permits employers to discriminate "where age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business."[96] The airline defended its policy, in part, on the theory that being younger than sixty was a BFOQ reasonably necessary to the safe operation of an aircraft.[97] The Court cautioned that "like its Title VII counterpart, the [ADEA's] BFOQ exception [is] . . . 'extremely narrow.'"[98] It explained that in cases involving a BFOQ based on safety considerations, age qualifications must be more than convenient or reasonable; they must be "reasonably necessary . . . to the particular business."[99] An employer can make this showing by establishing that either (1) it had "a factual basis for believing, that all or substantially all [persons over the age qualification] would be unable to safely and efficiently perform the duties of the job," or (2) "age was a legitimate proxy for the safety-related job qualifications" due to the impossibility or impracticality of dealing with older employees on an individualized basis.[100] The Court upheld the jury's verdict rejecting the airline's BFOQ defense.[101]

The Supreme Court's most recent interpretation of the BFOQ exception came in 1991 in *UAW v. Johnson Controls, Inc.*[102] The case involved the legality of a battery manufacturer's policy that prohibited women capable of bearing children from working in jobs involving exposure to lead.[103] Johnson Controls claimed the discriminatory policy was justified by its desire to protect potential fetuses from health risks related to lead exposure.[104] In rejecting this argument, the Court reiterated the narrowness of the BFOQ exception:

> The wording of the BFOQ defense contains several terms of restriction that indicate that the exception reaches only special situations. The statute thus limits the situations in which

94. 29 U.S.C. §§ 621–634.
95. *Criswell*, 472 U.S. at 402–03.
96. 29 U.S.C. § 623(f)(1).
97. *Criswell*, 472 U.S. at 406.
98. *Id.* at 412 (quoting Dothard v. Rawlinson, 433 U.S. 321, 334 (1977)).
99. *Id.* at 414–16 (alteration in original) (citation omitted).
100. *Id.* at 414–15 (alteration in original) (citations omitted).
101. *Id.* at 423.
102. 499 U.S. 187 (1991).
103. *Id.* at 190–91.
104. *Id.* at 191–92.

> discrimination is permissible to 'certain instances' where sex discrimination is 'reasonably necessary' to the 'normal operation' of the 'particular' business. Each one of these terms—certain, normal, particular—prevents the use of general subjective standards and favors an objective, verifiable requirement. But the most telling term is 'occupational'; this indicates that these objective, verifiable requirements must concern job-related skills and aptitudes.[105]

The Court concluded that the policy, no matter how well-meaning, was an invalid basis for a sex-based BFOQ because "[f]ertile women . . . participate in the manufacture of batteries as efficiently as anyone else."[106] Furthermore, the "essence" of Johnson Controls' business was making batteries—not "concerns about the welfare of the next generation."[107] The Court explained that, unlike *Dothard*, where inmate safety considerations "went to the core of the employee's job performance" and "involved the central purpose of the enterprise," the unconceived fetuses of employees were not third parties whose safety was essential to Johnson Controls' business of battery manufacturing.[108]

The lower courts have followed the Supreme Court's lead in construing the BFOQ provision narrowly. Employers have asserted the BFOQ defense in an attempt to justify a variety of interests, but their success has been mainly limited to situations where third-party privacy, safety, or therapeutic interests are at stake. Courts are most accepting of BFOQ defenses tied to the bodily privacy interests of third parties such as unclothed patients or customers.[109] The Ninth Circuit explained, "We cannot conceive of a more basic subject of privacy than the naked body. The desire to shield one's unclothed figure from view of strangers, and particularly strangers of the opposite sex, is impelled

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105. *Id.* at 201.
106. *Id.* at 206.
107. *Id.*
108. *Id.* at 203–04.
109. *See* Emily Gold Waldman, *The Case of the Male OB-GYN: A Proposal for Expansion of the Privacy BFOQ in the Healthcare Context*, 6 U. PA. J. LAB. & EMP. L. 357, 372 (2004) ("In contrast to the general presumption against allowing customer preferences to create a BFOQ, courts have been quite willing to recognize a BFOQ when a customer's privacy interests are implicated."); *see also Johnson Controls*, 499 U.S. at 206 n.4 (cautioning that nothing in the Court's decision should be interpreted as suggesting "sex could not constitute a BFOQ when privacy interests are implicated").

by elementary self-respect and personal dignity."[110] Courts have accepted sex-based BFOQs based on bodily privacy concerns in cases involving correctional officers,[111] hospital orderlies,[112] janitors,[113] washroom and bathhouse attendants,[114] nursing home assistants,[115] nurses,[116] and other healthcare workers.[117] Importantly, courts do not accept BFOQ defenses based on privacy concerns where the concern lies with the employee rather than a third party. In *EEOC v. New Prime, Inc.*,[118] the district court rejected a trucking company's BFOQ defense to its policy that applicants must receive over-the-road training from a

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110. York v. Story, 324 F.2d 450, 455 (9th Cir. 1963). Although courts widely accept the privacy rationale, the Seventh Circuit once questioned its validity: "Is it significant that preferences for privacy from members of the opposite sex may be entirely culturally created, and that by recognizing such preferences the courts may encourage sex differences at the expense of equality in employment?" Torres v. Wis. Dep't of Health & Soc. Servs., 838 F.2d 944, 950 (7th Cir. 1988), *vacated upon rehearing en banc*, 859 F.2d 1523 (7th Cir. 1988).

111. *See, e.g.*, Everson v. Mich. Dep't of Corr., 391 F.3d 737, 753 (6th Cir. 2004) (holding that being female was a BFOQ for correctional officers who worked in the housing units at a female prison because it would "advance a constellation of interests related to the 'essence' of the [Department's] business," including "the privacy rights of inmates").

112. *See, e.g.*, Jones v. Hinds Gen. Hosp., 666 F. Supp. 933, 935–37 (S.D. Miss. 1987) (holding that being male was a BFOQ that justified a hospital's decision to lay off only female nursing assistants due to a shortage of male orderlies needed to care for male patients).

113. *See, e.g.*, Hernandez v. Univ. of St. Thomas, 793 F. Supp. 214, 218 (D. Minn. 1992) (denying janitor's motion for summary judgment because there was a fact issue as to whether being female was a BFOQ for janitors serving female bathrooms in university dorms).

114. *See, e.g.*, Norwood v. Dale Maint. Sys., Inc., 590 F. Supp. 1410, 1416–17 (N.D. Ill. 1984) (holding that sex was a BFOQ for a day-shift position as a male washroom attendant); Brooks v. ACF Indus., Inc., 537 F. Supp. 1122, 1133–34 (S.D. W. Va. 1982) (holding that being male was a BFOQ for attendants in bathhouse used exclusively by men).

115. *See, e.g.*, Fesel v. Masonic Home of Del., Inc., 447 F. Supp. 1346, 1352–54 (D. Del. 1978) (holding that a retirement home could justify its female-only hiring policy for nurses based on the privacy interests of the guests because two-thirds of the retirees were female and objected to male treatment), *aff'd*, 591 F.2d 1334 (3d Cir. 1979).

116. *See, e.g.*, Backus v. Baptist Med. Ctr., 510 F. Supp. 1191, 1195–96 (E.D. Ark. 1981) (concluding that hiring a male nurse would invade the privacy of obstetrical patients in a hospital where nurses performed sensitive or intimate tasks), *vacated on other grounds*, 671 F.2d 1100 (8th Cir. 1982).

117. *See, e.g.*, Local 567 AFSCME v. Mich. Council 25, 635 F. Supp. 1010, 1012–14 (E.D. Mich. 1986) (holding that the privacy rights of mental health patients justified a BFOQ to provide for same-sex personal hygiene care).

118. 42 F. Supp. 3d 1201 (W.D. Mo. 2014).

same-sex instructor.[119] The company claimed its policy was motivated by safety and privacy concerns for women.[120] The court questioned whether a BFOQ defense could apply to an employee's own privacy concerns and ultimately struck down the policy because it "removed a female applicant's ability to make her own decision with regard to any alleged safety or privacy concerns she may or may not encounter with the potential job."[121]

Courts likewise accept BFOQs where third-party safety is at stake—but only if the safety is "indispensable to the particular business at issue" and goes "to the core of the employee's job performance."[122] BFOQs based on safety are somewhat rare because there are few situations in which an employer could prove that excluding members of a protected class from employment is necessary for the safety of customers and other third parties.[123] Most BFOQs based on safety tend to involve pregnancy-related restrictions. Airlines have found some success in defending policies that prohibit pregnant flight attendants from flying based on concerns that passenger safety would be jeopardized if pregnant flight attendants were unable to perform their roles in emergencies.[124] By contrast, in *Everts v. Sushi Brokers LLC*,[125] the district court rejected a restaurant's claim that non-pregnancy was a BFOQ for sushi servers because they must be able to carry heavy plates in close proximity to sharp sushi knives in a crowded area where they might get bumped or fall.[126] The court determined that a server's pregnancy created no safety risk to customers, that protecting a server's unborn fetus did not go to the essence of the business, and that concerns over conditions the employer deemed inappropriate for

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119. *Id.* at 1214.

120. *Id.*

121. *Id.*

122. *See* UAW v. Johnson Controls, Inc., 499 U.S. 187, 203 (1991).

123. BFOQs related to third-party safety are typically tied to age. *See generally* Robert L. Fischman, Note, *The BFOQ Defense in ADEA Suits: The Scope of "Duties of the Job"*, 85 MICH. L. REV. 330, 333, 346 (1986). Employers with mandatory retirement policies often invoke the age BFOQ based on third-party safety concerns. *Compare* Iervolino v. Delta Air Lines, Inc., 796 F.2d 1408, 1417 (11th Cir. 1986) (affirming that a sixty-year age limit for flight engineers was a BFOQ reasonably necessary to ensure passenger safety), *with* W. Air Lines, Inc. v. Criswell, 472 U.S. 400, 423 (1985) (affirming jury verdict rejecting airline's similar age-related BFOQ for flight engineers).

124. *See, e.g.*, Levin v. Delta Air Lines, Inc., 730 F.2d 994, 997–98 (5th Cir. 1984); Burwell v. E. Air Lines, Inc., 633 F.2d 361, 366, 372–73 (4th Cir. 1980) (per curiam).

125. 247 F. Supp. 3d 1075 (D. Ariz. 2017).

126. *Id.* at 1082.

a pregnant server were based on "arbitrary stereotypes about the physical capabilities of pregnant women."[127]

Perhaps most relevant for this Article's purposes, courts have also accepted BFOQs tied to third-party therapeutic or rehabilitative interests. In *Healey v. Southwood Psychiatric Hospital*,[128] the Third Circuit considered a challenge to a psychiatric hospital's practice of making sex-based staffing assignments.[129] The hospital claimed its policy was necessary to meet the therapeutic needs and privacy concerns of its mixed-sex patient population.[130] Noting that the essence of the hospital's business was to treat emotionally disturbed and sexually abused minors, the court accepted the BFOQ defense, reasoning:

> A balanced staff is . . . necessary because children who have been sexually abused will disclose their problems more easily to a member of a certain sex, depending on their sex and the sex of the abuser. If members of both sexes are not on a shift, Southwood's inability to provide basic therapeutic care would hinder the "normal operation" of its "particular business."[131]

Similarly, in *City of Philadelphia v. Pennsylvania Human Relations Commission*,[132] a Pennsylvania appellate court upheld Philadelphia's practice of restricting supervision of juvenile detainees at its youth study center to employees of their same sex.[133] Noting that the supervisor's job was to "gain the confidence and the respect of the [emotionally-troubled] children in order to aid them in regaining a proper perspective," the court found sex to be a BFOQ because it is

> common sense that a young girl with a sexual or emotional problem will usually approach someone of her own sex . . . seeking comfort and answers. . . . To expect a female or a male supervisor to gain the confidence of troubled youths of the opposite sex in order to be able to alleviate emotional and sexual problems is to expect the impossible.[134]

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127. *Id.* at 1083.
128. 78 F.3d 128 (3d Cir. 1996).
129. *Id.* at 130.
130. *Id.*
131. *Id.* at 133.
132. 300 A.2d 97 (Pa. Commw. Ct. 1973).
133. *Id.* at 102–04. Although this case involved a discrimination claim under state law, the court interpreted the law using federal precedent.
134. *Id.* at 103.

In *Torres v. Wisconsin Department of Health and Social Services*,[135] the Seventh Circuit was open to a sex-based BFOQ in the prison context.[136] The court recognized that a prison superintendent's testimony that provided female inmates with a living environment free from the presence of males in a position of authority was necessary to foster the foal of rehabilitation. The court noted that inmate rehabilitation went to the essence of the prison system's business.[137] The court concluded, "[t]here can be no question that the proposed BFOQ is directly related to the 'essence' of the 'business.'" It remanded the case for further consideration of whether there was a sufficient factual basis for the Department to believe all or substantially all men would be unable to effectively perform the job duties.[138]

While third-party privacy, safety, and therapeutic interests are by far the most common justifications for BFOQs, courts have allowed BFOQs in a handful of other circumstances. In *Chambers v. Omaha Girls Club, Inc.*,[139] the Eighth Circuit upheld an after-school club's decision to terminate an unmarried instructor who became pregnant.[140] The club's mission was to help adolescent girls maximize their life opportunities, and it directed many of its activities at pregnancy prevention.[141] The court found that the club's "role model rule," which banned single-parent pregnancies among its employees, was "reasonably necessary to the Club's operations" because the club trained and expected staff members to act as role models for the girls, with the intent that the girls would seek to emulate their behavior.[142] In *Garcia v. Rush-Presbyterian-St. Luke's Medical Center*,[143] the Seventh Circuit held that the ability to speak English constituted a BFOQ that justified the Hospital in not hiring Latinos who could not speak English.[144] The court reasoned that "[t]he ability to speak and read some English is a necessary, job-related requirement for virtually every job in this highly sophisticated medical care institution."[145] Finally,

135. 859 F.2d 1523 (7th Cir. 1988) (en banc).
136. *Id.* at 1527–33.
137. *Id.* at 1530.
138. *Id.* at 1530, 1532.
139. 834 F.2d 697 (8th Cir. 1987).
140. *Id.* at 704–05.
141. *Id.* at 698–99.
142. *Id.* at 704–05.
143. 660 F.2d 1217 (7th Cir. 1981).
144. *Id.* at 1222.
145. *Id.*

there is at least the potential for an employer to prevail where a BFOQ is necessary to preserve authenticity. Although there are no federal cases where courts have accepted a BFOQ defense based on authenticity concerns,[146] several courts, the EEOC, and members of Congress have acknowledged hypothetical situations in which such a BFOQ might be justified, such as a restaurant hiring Chinese servers in order to maintain the authentic atmosphere of an ethnic Chinese restaurant,[147] a theater company hiring female actors to portray female characters,[148] or a French restaurant employing a native French cook.[149]

Courts can and do uphold BFOQs in a variety of contexts, but in general, they remain highly skeptical of the defense. They are especially intolerant of BFOQs derived from stereotypes, as Title VII's very purpose is "to eliminate subjective assumptions and traditional stereotyped conceptions" about an individual's ability to perform work.[150] In *Breiner v. Nevada Department of Corrections*,[151] the Ninth Circuit rejected the Department's claim that being female was a BFOQ for correctional lieutenants at a women's prison.[152] The Department justified its policy by claiming male lieutenants would be more likely to sexually abuse female inmates and could also be more easily manipulated by female inmates.[153] The court found the sexual-abuse rationale to be based on "entirely specious gender stereotypes that have no place in a workplace governed by Title VII."[154] It dismissed the Department's manipulation justification as an "unsupported generalization that . . . would violate 'the Congressional purpose to eliminate subjective assumptions and traditional stereotyped

146. *See, e.g.*, EEOC v. Joe's Stone Crab, Inc., 220 F.3d 1263, 1281–85 (11th Cir. 2000) (rejecting the restaurant's claim that being male was a BFOQ for servers based on the restaurant's desire to create an authentic "Old World" ambience "in which tuxedo-clad men served its distinctive menu") (citation omitted).

147. Local 246, Util. Workers Union v. S. Cal. Edison, Co., 320 F. Supp. 1262, 1265 (C.D. Cal. 1970).

148. 29 C.F.R. § 1604.2(a)(2) (2018) (explaining that a sex BFOQ is lawful "[w]here it is necessary for the purpose of authenticity or genuineness . . . e.g., an actor or actress").

149. 110 CONG. REC. 7,212–13 (1964) (prepared statement of Sen. Clark and Sen. Case) (explaining that a BFOQ could properly be asserted where a French restaurant has a preference for a French cook).

150. *See* Rosenfeld v. S. Pac. Co., 444 F.2d 1219, 1225 (9th Cir. 1971).

151. 610 F.3d 1202 (9th Cir. 2010).

152. *Id.* at 1211–15.

153. *Id.* at 1211.

154. *Id.* at 1215.

conceptions regarding the . . . ability of women to do particular work.'"[155]

Courts likewise tend to reject BFOQs that are based solely on customer preference. In *Diaz v. Pan American World Airways, Inc.*,[156] the Fifth Circuit was unmoved by the airline's claim that being a female was a BFOQ for flight attendants because its passengers overwhelmingly preferred to be served by female stewardesses.[157] The Court explained:

> While we recognize that the public's expectation of finding one sex in a particular role may cause some initial difficulty, it would be totally anomalous if we were to allow the preferences and prejudices of the customers to determine whether the sex discrimination was valid. Indeed, it was, to a large extent, these very prejudices [Title VII] was meant to overcome.[158]

Despite what some courts may claim,[159] the prohibition against customer-preference-based BFOQs is not absolute. BFOQs based on privacy can easily be recast as a matter of preference: a female patient prefers to be treated by a female doctor because she feels uncomfortable with a male doctor viewing her unclothed body. Moreover, it may be possible to establish a customer-preference-based BFOQ if the preference goes to the essence of the employer's business. In *Wilson v. Southwest Airlines Co.*,[160] the district court acknowledged that a sex-based BFOQ would be permitted where "sex or vicarious sexual recreation is the primary service provided" and "female sexuality [is] reasonably necessary to perform the dominant purpose of the job which is forthrightly to titillate and entice male customers."[161]

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155. *Id.* (second alteration in original) (quoting Rosenfeld v. S. Pac. Co. 444 F.2d 1219, 1224 (9th Cir. 1971)).

156. 442 F.2d 385 (5th Cir. 1971).

157. *Id.* at 387–88.

158. *Id.* at 389.

159. *See, e.g.*, Olsen v. Marriott Int'l, Inc., 75 F. Supp. 2d 1052, 1065 (D. Ariz. 1999) (noting that "[c]ourts have consistently rejected requests for a BFOQ based on customer preference"); Vigars v. Valley Christian Ctr. of Dublin, Cal., 805 F. Supp. 802, 808 n.4 (N.D. Cal. 1992) (reasoning that "it is clear that fellow employees' and customers' 'preferences' do not constitute BFOQs for sex discrimination any more than they constitute BFOQs for race discrimination").

160. 517 F. Supp. 292 (N.D. Tex. 1981).

161. *Id.* at 301. In this case, the court rejected Southwest's claim that being female was a BFOQ for its flight attendant and ticketing agent positions. *Id.* at 302–05. The

C. EEOC Guidance

Though not binding on the courts, the EEOC's guidance on BFOQs is useful insofar as courts often defer to the Commission on matters of Title VII interpretation.[162] The EEOC rejects the possibility of a race BFOQ, explaining in its Compliance Manual that "[t]he protected class of race is not included in the statutory exception and clearly cannot, under any circumstances, be considered a BFOQ for any job."[163] As for race, sex, and national origin BFOQs, the Commission is in agreement with the courts that the exception is narrow. In its guidance on sex discrimination published in the federal regulations, the EEOC cautions that sex-based BFOQs "should be interpreted narrowly" and are not warranted by assumptions about the comparative employment characteristics of women, stereotyped characterizations, or employer, coworker, or client preferences.[164] The regulations identify just one situation where a sex-based BFOQ may be permissible: "[w]here it is necessary for the purposes of authenticity or genuineness . . . , e.g., an actor or actress."[165] The EEOC also references the BFOQ exception in its federal regulations on national origin discrimination, simply noting that national-origin-based BFOQs "shall be strictly construed."[166] The Commission has issued more detailed BFOQ guidance in its Compliance Manual. This guidance, which focuses mainly on sex-based BFOQs, closely tracks judicial decisions where courts have rejected the defense when based on stereotypes, customer preference, or other unjustified interests.[167]

In addition to this formal guidance, the EEOC has issued informal discussion letters on the BFOQ exception. Particularly relevant is a

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company maintained that its attractive female employees "personif[ied] the airline's sexy image and fulfill[ed] its public promise to take passengers skyward with 'love.'" *Id.* at 293. The court was unconvinced, finding that selling love or sex appeal did not go to the essence of Southwest's business. *Id.* at 302. "[S]ex does not become a BFOQ merely because an employer chooses to exploit female sexuality as a marketing tool, or to better ensure profitability." *Id.* at 303.

162. *See* EEOC v. Arabian Am. Oil Co., 499 U.S. 244, 257 (1991) (explaining that because Congress "did not confer upon the EEOC authority to promulgate rules or regulations," EEOC guidelines are only entitled to Skidmore deference (quoting Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 141, 142 (1976))).

163. EEOC, EEOC COMPLIANCE MANUAL § 625.1 (1982) [hereinafter COMPLIANCE MANUAL].

164. 29 C.F.R. § 1604.2(a)(1) (2018).

165. § 1604.2(a)(2).

166. § 1606.4.

167. COMPLIANCE MANUAL, *supra* note 163, §§ 625.5–625.7.

2005 letter in which the EEOC addressed whether a medical provider could make sex-based staffing assignments in accordance with a psychiatrist's recommendation.[168] The Commission concluded that if there was evidence that assigning a male staff member "would hinder patient treatment and the essence of the employer's business was to provide effective patient care, Title VII likely would not prohibit assignment of a female worker to that patient."[169]

Finally, the EEOC regularly brings suit against employers in cases where it believes a BFOQ defense is unwarranted. In recent years, it has settled suits in which a cleaning service fired a Latina housekeeper because she was not fluent in English,[170] a lingerie store refused to hire male salespeople,[171] a private school fired a male softball coach,[172] a restaurant refused to hire more than one male bartender,[173] and a nonprofit organization rejected a male applicant for its maternity-home program based on the perceived inability of men to change diapers and work with pregnant women.[174]

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168. *EEOC Informal Discussion Letter: Title VII – BFOQ Psychotherapy*, EEOC (Aug. 22, 2005), https://www.eeoc.gov/foia/eeoc-informal-discussion-letter-138 [https://perma.cc/J2J7-6CLR].

169. *Id.*

170. Press Release, EEOC, Blackstone Consulting, Inc., Will Pay $37,500 to Settle EEOC National Origin Discrimination Suit (Nov. 3, 2020), https://www.eeoc.gov/newsroom/blackstone-consulting-inc-will-pay-37500-settle-eeoc-national-origin-discrimination-suit [https://perma.cc/M74D-VLU9].

171. Press Release, EEOC, Sactacular Holdings to Pay $35,000 to Settle EEOC Sex Discrimination Lawsuit (Aug. 13, 2020), https://www.eeoc.gov/newsroom/sactacular-holdings-pay-35000-settle-eeoc-sex-discrimination-lawsuit [https://perma.cc/U5UR-23LR].

172. Press Release, EEOC, Park School of Baltimore Will Pay $41,000 to Settle EEOC Sex Discrimination Suit (Feb. 12, 2019), https://www.eeoc.gov/newsroom/park-school-baltimore-will-pay-41000-settle-eeoc-sex-discrimination-suit [https://perma.cc/5SKS-LJA2].

173. Press Release, EEOC, R Wings R Wild / Buffalo Wild Wings Settles Sex Discrimination Suit with EEOC for $30,000 (Jan. 29. 2019), https://www.eeoc.gov/newsroom/r-wings-r-wild-buffalo-wild-wings-settles-sex-discrimination-suit-eeoc-30000 [https://perma.cc/D32Q-2ARZ].

174. Press Release, EEOC, EEOC Sues the Children's Home, Inc., for Sex Discrimination and Retaliation (Oct. 3, 2017), https://www.eeoc.gov/newsroom/eeoc-sues-childrens-home-inc-sex-discrimination-and-retaliation [https://perma.cc/LU85-TDST]; Press Release, EEOC, The Children's Home Settles EEOC Sex Discrimination Lawsuit (May 2, 2018), https://www.eeoc.gov/newsroom/childrens-home-settles-eeoc-sex-discrimination-lawsuit [https://perma.cc/47S6-XNUY].

II. FACTUAL JUSTIFICATIONS

An employer that asserts a BFOQ defense must demonstrate the discriminatory practice in question is factually justified. This requirement derives from *Dothard*, where the Supreme Court determined there was a "basis in fact for expecting that sex offenders who have criminally assaulted women in the past would be moved to do so again if access to women were established within the prison."[175] This Part examines the factual basis for invoking a race BFOQ for certain physician positions. Section (a) reviews the empirical research, which shows that, at least for Black people, patient-physician racial concordance improves several dimensions of medical care. Section (b) considers various theoretical explanations for why this is the case.

A. Benefits of Patient-Physician Racial Concordance

Research in the area of patient-physician racial concordance is relatively new. But in the two decades since researchers began studying this phenomenon, a clear relationship has emerged between racial concordance and improved medical care, at least for Black patients.[176] More research is necessary to determine whether this pattern holds true for other races.[177] As detailed below, numerous studies, employing an impressive array of designs and methodologies, have found that patient-physician race concordance improves several dimensions of healthcare. Black patients who receive care from Black physicians are more likely to utilize health services; they report better communication with their doctors, more satisfaction with their treatment, and greater adherence to medical regimens; and they are less likely to experience bias in their treatment.

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175. Dothard v. Rawlinson, 433 U.S. 321, 335 (1977).

176. To be sure, not all studies have found an association between race concordance and medical care, and certainly more research is needed to fully understand this phenomenon. *See, e.g.*, Megan Johnson Shen, Emily B. Peterson, Rosario Costas-Muñiz, Migda Hunter Hernandez, Sarah T. Jewell, Konstantina Matsoukas et al., *The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature*, 5 J. RACIAL & ETHNIC HEALTH DISPARITIES 117, 117–40 (2018) (reviewing studies). But the lack of uniform scientific consensus does not mean there is an insufficient factual basis to justify a race BFOQ. The Seventh Circuit made clear in *Torres* that unanimity of opinion is not required. Torres v. Wis. Dept. of Health & Soc. Servs., 859 F.2d 1523, 1532 (7th Cir. 1988) (en banc) ("Certainly, the court ought not require unanimity of opinion and ought not to substitute completely its own judgment for that of the [penal] administration.").

177. *See infra* notes 278–281 and accompanying text.

1. Utilization of Health Services

Health services utilization is a key predictor of health outcomes.[178] Racial minorities are more likely to experience barriers to accessing health services and, consequently, have lower healthcare utilization rates than White people do.[179] Lower rates of health insurance, lower socioeconomic status, and lack of regular sources of care only partially explain lower utilization rates among minorities.[180] Nonfinancial barriers, including the inability of patients of color to be treated by same-race physicians, also play a role. In a field experiment that has garnered widespread attention, Marcella Alsan and colleagues recruited Black men in Oakland, California, to participate in a free health screening.[181] The researchers randomly matched the participants with a White or a Black physician and asked them to select which preventive services (e.g., body mass index, blood pressure, diabetes, and cholesterol screening) they wanted to receive.[182] Participants selected the services before meeting with their physician and then were given the option to revise their selections afterward.[183] Those participants paired with Black physicians increased their selections by 18% relative to participants paired with non-Black physicians.[184] In considering why this was the case, the researchers found evidence that communication and trust played an important role. Subjects were ten percentage points more likely to talk with Black physicians about other health problems, nine percentage points more likely to discuss personal matters or health issues unrelated to the

178. *See* Terri Fowler, David Garr, Natalie Di Pietro Mager & Joan Stanley, *Enhancing Primary Care and Preventive Services Through Interprofessional Practice and Education*, 9 ISR. J. HEALTH POL'Y RSCH., 2020, at 1, 1 ("Receipt of preventive services is associated with a reduction in morbidity and mortality, most notably in the areas of cancer, chronic disease, infectious disease (immunizations), mental health, substance abuse, vision, and oral health.").

179. *See* Thomas A. LaVeist, Amani Nuru-Jeter & Kiesha E. Jones, *The Association of Doctor-Patient Race Concordance with Health Services Utilization*, 24 J. PUB. HEALTH POL'Y 312, 312 (2003) ("It is well established that racial and ethnic minorities experience barriers to accessing health services and, as a result, have lower health care utilization rates than [W]hites.").

180. *Id.* ("Although lower utilization rates are partially explained by lower rates of health insurance, lower socio-economic status, and lack of a regular source of care, those factors do not fully explain health care utilization disparities.").

181. Marcella Alsan, Owen Garrick & Grant Graziani, *Does Diversity Matter for Health? Experimental Evidence from Oakland*, 109 AM. ECON. REV. 4071, 4073 (2019).

182. *Id.* at 4073–74.

183. *Id.* at 4074.

184. *Id.* at 4074–75.

screening, and the Black physicians were eleven percentage points more likely to write notes about their patients than were the non-Black physicians.[185] The researchers calculated that by increasing Black patients' access to Black physicians, cardiovascular mortality among Black men could be reduced by 16 deaths per 100,000, leading to a 19% reduction in the Black-White male gap in cardiovascular mortality.[186]

Other studies employing different methodologies have reached similar results. Thomas LaVeist and colleagues' analysis of 1994 Commonwealth Fund Minority Health Survey data revealed that patients with same-race physicians were more likely to utilize needed health services, were less likely to delay seeking care, and had much greater odds of having made at least one doctor visit in the past year compared to patients with racially discordant physicians.[187] Adjusting for health status and a variety of other known predictors of healthcare utilization did not substantially affect the relationship.[188] Analysis within race-specific sub-samples found this pattern to be most consistent among Black patients and White patients and less prevalent among Hispanic patients and Asian-American patients.[189] Based on these findings, the researchers expressed concern that demographic trends will make it increasingly difficult for patients of color to access physicians of their same race, and that "[t]he tendency to underutilize health services in the absence of doctor-patient concordance might therefore exacerbate racial/ethnic disparities in health."[190]

Somnath Saha and Mary Beach conducted a study in which participants whose records indicated a diagnosis of heart disease or heart disease risk factors viewed a video vignette depicting a physician reviewing cardiac catheterization results and recommending coronary artery bypass graft surgery to a patient.[191] The race of the physician depicted in each video varied, but the recommendation was identical and was communicated in the same way.[192] Participants rated the

185. *Id.* at 4092–93.
186. *Id.* at 4077–78.
187. LaVeist et al., *supra* note 179, at 314–20.
188. *Id.* at 319.
189. *Id.* at 319–20.
190. *Id.* at 320.
191. Somnath Saha & Mary Catherine Beach, *Impact of Physician Race on Patient Decision-Making and Ratings of Physicians: A Randomized Experiment Using Video Vignettes*, 35 J. GEN. INTERNAL MED. 1084, 1085 (2020).
192. *Id.*

physician's communication, interpersonal style, competence, trustworthiness, likability, and overall performance.[193] Black participants viewing a video of a Black physician gave higher ratings on all physician attributes, were more likely to perceive the surgery as necessary, and were more likely to say they would undergo the surgery if they were the video patient compared to Black participants viewing a video of a White physician.[194] Physician race was not associated with any outcomes among White respondents.[195]

These studies indicate that Black patients are more willing to utilize health services when they have access to a Black physician. The significance of this finding is difficult to overstate, as health services utilization is at once a major predictor of health outcomes but also a dimension of healthcare in which the gap between White people and racial minorities is most pronounced.

2. Communication

Patient-physician communication is one of the most critical aspects of healthcare because it is the "primary process by which medical decision-making occurs."[196] Quality communication "may increase the accuracy of shared information and the quality of care, which could lead to more appropriate diagnoses and treatments which may in turn improve outcomes for minority individuals."[197] As with so many other aspects of healthcare, Black people and other minorities tend to experience lower quality patient-physician communication than White people do.[198] On the other hand, numerous studies show that racial concordance can improve several dimensions of patient-physician

193. *Id.* at 1085–86.

194. *Id.* at 1086–88.

195. *Id.* at 1087.

196. Howard S. Gordon, Richard L. Street Jr., Barbara F. Sharf & Julianne Souchek, *Racial Difference in Doctors' Information-Giving and Patients' Participation*, 107 CANCER 1313, 1314 (2006).

197. Tunay Oguz, *Is Patient-Provider Racial Concordance Associated with Hispanics' Satisfaction with Health Care?*, 16 INT'L J. ENV'T RSCH. & PUB. HEALTH, Jan. 2019, at 1, 2.

198. *See* Kimberly D. Martin, Debra L. Roter, Mary C. Beach, Kathryn A. Carson & Lisa A. Cooper, *Physician Communication Behaviors and Trust Among Black and White Patients with Hypertension*, 51 MED. CARE 151, 151 (2013) (citing studies in support of assertion that "African American and other ethnic minority patients have been found to receive poorer interpersonal communication, including lower levels of affective behaviors such as rapport building and overall affective tone, and greater physician verbal dominance, less patient centeredness, and shorter visits, compared with [W]hite patients").

communication, including information-giving, partnership building and participatory decision-making, and affect.

a. Information-Giving

Information-giving "is a fundamental feature of medical consultations and, importantly, the foundation upon which medical decision-making occurs."[199] In an analysis of physician-patient consultations, Gordon and colleagues found that Black patients and their companions received significantly less information from physicians and produced significantly fewer active participation utterances than White patients did.[200] Patients in racially concordant visits received substantially more information from their physician (99.4 versus 62.1 mean utterances) and were significantly more active participants (41.7 versus 27.2 mean utterances) when compared to patients in racially discordant visits.[201] The lack of information-giving (both by physicians and patients) in racially discordant visits can negatively impact patients' comprehension of their treatment options. Persky and colleagues conducted a controlled experiment to assess whether perceived physician race influenced Black patients' risk-perception accuracy following the provision of objective lung cancer risk information.[202] They found that participants who interacted with a racially discordant virtual physician were less accurate in their risk perceptions than those who interacted with a racially concordant virtual physician.[203] Significantly, neither trust in the provider, engagement with the healthcare system, nor attention during the encounter mediated these effects.[204]

b. Partnership Building and Participatory Decision-Making

Patient participation in healthcare decision-making empowers patients and improves both services and health outcomes.[205] In an

199. Gordon et al., *supra* note 196, at 1314.
200. *Id.* at 1315–16.
201. *Id.* at 1316.
202. Susan Persky, Kimberly A. Kaphingst, Vincent C. Allen Jr. & Ibrahim Senay, *Effects of Patient-Provider Race Concordance and Smoking Status on Lung Cancer Risk Perception Accuracy Among African Americans*, 45 ANNALS BEHAV. MED. 308, 309 (2013).
203. *Id.* at 312–13.
204. *Id.*
205. *See* Lisa Cooper-Patrick, Joseph J. Gallo, Junius J. Gonzales, Hong Thi Vu, Neil R. Powe, Christine Nelson et al., *Race, Gender, and Partnership in the Patient-Physician*

analysis of telephone survey data from over 1,800 adults who had recently visited a primary care practice, Cooper-Patrick and colleagues found that Black respondents rated their visits as significantly less participatory than White respondents did.[206] Asian, Latino, and other minority patients likewise rated their visits as less participatory, but the results were not statistically significant.[207] The study found that respondents who visited physicians of their same race rated their interactions as significantly more participatory than patients whose visits were racially discordant.[208] Gender concordance was not significantly related to participatory decision-making, but respondents who were both race and gender concordant with their physician reported the highest levels of participatory decision-making.[209] Gordon and colleagues found similar results in their study of lung cancer patients at a Veterans Affairs hospital.[210] Their data showed that overall, Black patients perceived that their physicians shared less information, engaged in less partnership building, and were less supportive compared with White patients' perceptions.[211] These findings were more pronounced in racially discordant patient-physician pairings than in racially concordant pairings.[212]

c. Affect

Positive affect, as manifested by both patients and physicians, is a crucial component of communication. Affect may reflect a mutual liking and respect, enhanced trustworthiness, and positive expectations, which in turn influence both the communication process and patient judgment of the medical visit.[213] Cooper and colleagues examined the relationship between patient-physician racial

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Relationship, 282 J. AM. MED. ASS'N 583, 584 (1999) ("Studies have shown that increasing patient involvement in care via negotiation and consensus-seeking improves patient satisfaction and outcomes.").

206. *Id.* at 584, 586.

207. *Id.* at 586.

208. *Id.* at 587.

209. *Id.*

210. Howard S. Gordon, Richard L. Street Jr, Barbara F. Sharf, P. Adam Kelly & Julianne Souchek, *Racial Differences in Trust and Lung Cancer Patients' Perceptions of Physician Communication*, 24 J. CLINICAL ONCOLOGY 904, 908 (2006).

211. *Id.* at 907.

212. *Id.*

213. Lisa A. Cooper, Debra L. Roter, Rachel L. Johnson, Daniel E. Ford, Donald M. Steinwachs & Neil R. Powe, *Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race*, 139 ANNALS INTERNAL MED. 907, 912 (2003).

concordance and affect in a study of 252 adults receiving care from thirty-one physicians.[214] They analyzed data from audiotaped recordings of the medical visits and from post-visit patient surveys.[215] Coders rated the global affect of the dialogue on each audiotape across several dimensions, including the patient's engagement, interest, friendliness, and responsiveness, as well as the physician's interest, friendliness, responsiveness, sympathy, and level of hurriedness.[216] Compared with race-discordant visits, race-concordant visits lasted approximately 2.2 minutes longer and had slower speech speed in the dialogue of both the patient and the physician.[217] The researchers suggested that visit duration may have particular salience within the context of race, given the many studies in which Black patients report shorter physician visits and lower satisfaction with time spent in the visit.[218] In this study, race-concordant visits had higher mean ratings of positive affect among patients.[219] Ratings of positive affect for physicians were also higher but did not achieve statistical significance.[220] Stepanikova and colleagues similarly found in their study of nonverbal communication that Black physicians used more open-body position, smile, and touch with Black patients than with patients of other races.[221] There were no differences between White physicians' behavior toward Black versus White patients.[222]

3. Patient Satisfaction

Patient satisfaction is an important determinant of numerous health-related outcomes, including health services utilization, the decision to switch to another health plan, compliance with medical regimens, and

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214. *Id.* at 908–09.
215. *Id.* at 908.
216. *Id.* at 909.
217. *Id.* at 910.
218. *Id.* at 911; *cf.* M. Norman Oliver, Meredith A. Goodwin, Robin S. Gotler, Patrice M. Gregory & Kurt C. Strange, *Time Use in Clinical Encounters: Are African-American Patients Treated Differently?*, 93 J. NAT'L MED. ASS'N 380, 382–83 (2001) (questioning the statistical significance of findings that physicians spent slightly more time with Black patients but a lower proportion of that time in informal small talk, general health discussion, and preventive screening).
219. Cooper et al., *supra* note 213, at 910.
220. *Id.*
221. Irena Stepanikova, Qian Zhang, Darryl Wieland, Paul Eleazer & Thomas Stewart, *Non-Verbal Communication Between Primary Care Physicians and Older Patients: How Does Race Matter?*, 27 J. GEN. INTERNAL MED. 576, 578–79 (2011).
222. *Id.* at 579.

the decision to initiate a malpractice suit.[223] In general, Black people are less satisfied than White people with their medical care.[224] But a number of studies have found that Black patients' satisfaction with their care improves when Black physicians treat them. Saha and colleagues' analysis of 1994 Commonwealth Fund Minority Health Survey data found that Black respondents with Black physicians were more likely than Black respondents with non-Black physicians to rate their physicians as excellent and to report receiving preventive care and all needed medical care during the previous year.[225] Malat's analysis of patient survey data from Detroit revealed that White respondents were nearly twice as likely as Black respondents to report that their physician had treated them with dignity and respect, and that patients with racially concordant physicians were 1.4 times more likely than patients with racially discordant physicians to rate their visit as excellent.[226] In the aforementioned Cooper study, the researchers similarly found that patients with racially concordant physicians expressed more satisfaction with their visit and were more likely to recommend their physician to a friend.[227] More recently, a cross-sectional analysis of nearly 120,000 responses to the Press Ganey Outpatient Medical Practice Survey found that both Black and White patients were more satisfied with their healthcare experience (as measured by their likelihood of recommending their physician to others) when treated by a physician of their same race.[228] The researchers interpreted these results as "a call to action to vigorously support the training of underrepresented minority medical students

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223. *See* Thomas A. LaVeist & Amani Nuru-Jeter, *Is Doctor-Patient Race Concordance Associated with Greater Satisfaction with Care?*, 43 J. HEALTH & SOC. BEHAV. 296, 297–98 (2002) (collecting studies).

224. *Cf.* Kelly A. Hunt, Ayorkor Gaba & Risa Lavizzo-Mourey, *Racial and Ethnic Disparities and Perceptions of Health Care: Does Health Plan Type Matter?*, 40 HEALTH SERVS. RSCH. 551, 552 (2005) (citing studies in support of the assertion that "racial and ethnic minorities have lower levels of trust and satisfaction with their providers—physicians, hospitals, health plans, and the health care system in general").

225. Somnath Saha, Miriam Komaromy, Thomas D. Koepsell & Andrew B. Blindman, *Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care*, 159 ARCHIVES INTERNAL MED. 997, 998 (1999).

226. Jennifer Malat, *Social Distance and Patients' Rating of Healthcare Providers*, 42 J. HEALTH & SOC. BEHAV. 360, 366, 368–69 (2001).

227. Cooper et al., *supra* note 213, at 910–11.

228. Junko Takeshita, Shiyu Wang, Alison W. Loren, Nandita Mitra, Justine Shults, Daniel B. Shin et al., *Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians with Patient Experience Ratings*, 3 J. AM. MED. ASS'N NETWORK OPEN, Nov. 2020, at 1, 4.

and residents while also ensuring the promotion and retention of underrepresented minority physicians."[229]

4. Adherence to Medical Regimens

Patient adherence to medical regimens, such as taking medication, attending follow-up appointments, and participating in physical therapy, is a crucial aspect of healthcare.[230] Nonadherence is associated with poorer patient outcomes and increased healthcare costs.[231] Three studies have found a positive association between patient-physician racial concordance and medical regimen adherence. Adamson and colleagues examined how patient-physician race and sex concordance affects the likelihood of a patient filling and picking up a dermatology prescription.[232] Overall, patients failed to pick up 31.6% of the 4,307 prescriptions analyzed.[233] For Black patients who were treated by a Black physician, the nonadherence rate was lower (24.4%), and the risk of nonadherence fell by 11%.[234] There was no association between racial concordance and nonadherence for White or Hispanic patients, nor was there any relationship between sex concordance and nonadherence.[235] In a study of over 130,000 diabetes patients, Traylor and colleagues found that although Black patients were significantly less likely than White patients to be in good adherence to all of their medications, racial concordance reduced the rate of nonadherence from 53% to 50%.[236] Racial concordance was not significantly associated with adherence for White, Asian, or Hispanic patients,

229. *Id.* at 10.

230. *See* SHAMONDA BRAITHWAITE, ILNAZ SHIRKHORSHIDIAN, KELSEY JONES & MICHEAL JOHNSRUD, AVALERE, THE ROLE OF MEDICATION ADHERENCE IN THE U.S. HEALTHCARE SYSTEM 2 (2013) ("When patients struggle to obtain and use medication appropriately, they may limit a drug's effectiveness, experience poor health outcomes as a result, and raise the overall cost of care in the United States.").

231. Aurel O. Iuga & Maura J. McGuire, *Adherence and Health Care Costs*, 7 RISK MGMT. & HEALTHCARE POL'Y 35, 37–39 (2014) (describing the magnitude of the medication nonadherence problem and related costs).

232. Adewole S. Adamson, Donald A. Glass & Elizabeth A. Suarez, Research Letter, *Patient-Provider Race and Sex Concordance and the Risk for Medication Primary Nonadherence*, 76 J. AM. ACAD. DERMATOLOGY 1193, 1193 (2017).

233. *Id.* at 1194.

234. *Id.*

235. *Id.*

236. Ana H. Traylor, Julie A. Schimttdiel, Connie S. Uratsu, Carol M. Mangione & Usha Subramanian, *Adherence to Cardiovascular Disease Medications: Does Patient-Provider Race/Ethnicity and Language Concordance Matter?*, 25 J. GEN. INTERNAL MED. 1172, 1172, 1175 (2010).

although language concordance did reduce the rate of nonadherence for Hispanic patients from 51% to 45%.[237] Lasser and colleagues analyzed data on nearly 75,000 follow-up visits by approximately 14,000 patients.[238] They found that race and language concordance between patients and their primary care providers lowered the odds of missing an appointment.[239]

5. Reduced Physician Bias

It is well established that patient sociodemographic characteristics, including race, have an impact on both physician behavior during medical encounters and on the diagnoses and treatments patients receive.[240] Van Ryn and Burke's study of post-angiogram patient-physician encounters revealed that physicians tended to perceive Black patients more negatively than they did White patients on a number of dimensions, including their assessment of patient intelligence, feelings of affiliation toward the patient, and beliefs about the patient's likelihood of risk behavior and adherence to medical advice.[241] Physician biases in turn affect the care that patients receive. Schulman and colleagues found a link between patient race and physicians' recommendations for cardiac catheterization.[242] As part of the study, 720 physicians viewed a recorded interview of an actor portraying a patient and describing chest pain symptoms.[243] The interview only varied in terms of the patient's race, age, and sex.[244] The physicians were then asked to make recommendations about the patient's care.[245] Logistic-regression analysis indicated that Black patients were less

237. *Id.*

238. Karen E. Lasser, Ira L. Mintzer, Astrid Lambert, Howard Cabral & David H. Bor, *Missed Appointment Rates in Primary Care: The Importance of Site of Care*, 16 J. HEALTH CARE FOR POOR & UNDERSERVED 475, 479 (2005).

239. *Id.* at 478–79.

240. *See* Michell van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients*, 50 SOC. SCI. & MED. 813, 813–14 (2000) (citing studies in support of assertion that "[t]here is considerable evidence that patient sociodemographic characteristics have an impact on both physician behavior during medical encounters and on the diagnoses and treatments patients receive").

241. *Id.* at 814, 821.

242. Kevin A. Schulman, Jesse A. Berlin, William Harless, Jon F. Kerner, Shyrl Sistrunk, Bernard J. Gersh et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 623 (1999).

243. *Id.* at 618.

244. *Id.* at 619.

245. *Id.*

likely than White patients to be referred for cardiac catheterization.[246] In considering why this was the case, the researchers suggested that overt bias on the part of physicians was a possibility but found it more plausible that the physicians' subconscious biases had affected their judgment.[247]

King and colleagues conducted a study of whether patient-physician racial concordance impacted the timing of receipt of protease inhibitors, an antiretroviral drug used to treat HIV.[248] Adjusting for patient characteristics, the researchers found that Black patients with White physicians received protease inhibitors significantly later than did Black patients with Black physicians (median 461 days versus 342 days).[249] No statistically significant difference was found between Black patients with Black physicians and White patients with White physicians (median 342 days versus 353 days).[250] Although the study did not test physician bias, the researchers suggested their findings may be attributable to differences in physician prescribing behavior, which could be unintentional or possibly represent overt racial discrimination.[251]

Physician racial bias not only affects diagnosis and treatment but also communication with patients. Hagiwara and colleagues investigated how physician bias influences non-Black physicians' word use in racially discordant medical interactions with Black patients.[252] Analyzing 117 video-recorded racially discordant medical interactions, the researchers found that physicians with higher levels of implicit racial bias used anxiety-related words and first-person plural pronouns more frequently than physicians with lower levels of implicit bias.[253] The latter is significant because social psychology research on linguistic patterns indicates that social dominance and status are strongly associated with the use of first-person pronouns; higher status

246. *Id.* at 622–23.

247. *Id.* at 624–25.

248. William D. King, Mitchell D. Wong, Martin F. Shapiro, Bruce E. Landon & William E. Cunningham, *Does Racial Concordance Between HIV-Positive Patients and Their Physicians Affect the Time to Receipt of Protease Inhibitors?*, 19 J. GEN. INTERNAL MED. 1146, 1146 (2004).

249. *Id.* at 1150–51.

250. *Id.* at 1150.

251. *Id.* at 1151.

252. Nao Hagiwara, Richard B. Slatcher, Susan Eggly & Louis A. Penner, *Physician Racial Bias and Word Use During Racially Discordant Medical Interactions*, 32 HEALTH COMMC'N 401, 401 (2017).

253. *Id.* at 403–05.

speakers tend to use more first-person plural pronouns and fewer first-person singular pronouns.[254]

Penner and colleagues examined the effects of oncologists' implicit racial bias in racially discordant oncology interactions.[255] Analyzing survey data from patients and physicians, as well as video recordings of their medical interactions, the researchers found that non-Black oncologists with higher levels of implicit bias had shorter interactions with Black patients and that their communication was less patient-centered and supportive.[256] Higher physician implicit bias was also associated with more patient difficulty remembering the contents of the interaction, less patient confidence in recommended treatments, and greater perceived difficulty completing them.[257]

6. Health Outcomes

Although patient-physician racial concordance is thought to affect health outcomes indirectly through the channels of care discussed above, two studies have found a direct association between concordance and health outcomes. In a study that has sent shockwaves through the medical world, Greenwood and colleagues found that while Black newborns die at three times the rate of White newborns in the United States, newborn-physician racial concordance is associated with a significant improvement in mortality for Black infants.[258] The study, which examined 1.8 million hospital births in Florida between 1992 and 2015, found that clinical penalties for Black newborns treated by Black physicians are halved compared with the penalties Black newborns experience when cared for by White physicians.[259] These benefits accrue more sharply in more medically complicated cases and are more pronounced in hospitals that deliver more Black newborns.[260] Race concordance between a birthing mother and her physician did not have a statistically significant impact on mortality for birthing mothers.[261]

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254. *Id.* at 402.

255. Louis A. Penner, John F. Dovidio, Richard Gonzalez, Terrance L. Albrecht, Robert Chapman, Tanina Foster et al., *The Effects of Oncologist Implicit Racial Bias in Racially Discordant Oncology Interactions*, 34 J. CLINICAL ONCOLOGY 2874, 2874 (2016).

256. *Id.* at 2876–77.

257. *Id.* at 2877.

258. Greenwood et al., *supra* note 38, at 21194–21200.

259. *Id.* at 21194–95.

260. *Id.* at 21195.

261. *Id.*

A second study by Anderson and colleagues examined the relationship between patient-physician racial concordance and pain.[262] The study stemmed from research showing Black patients report more intense and disabling pain in clinical and experimental settings but are less likely to receive adequate pain treatment compared to White patients.[263] In this study, Black, White, and Hispanic patients participated in a simulated doctor's appointment where they were given a mildly painful series of heat stimulations on their arm by a medical trainee playing the role of a doctor.[264] Participants indicated the intensity of their pain, and researchers also measured their physiological responses to the heat stimulations.[265] Some patients were paired with a racially concordant doctor, whereas others were not.[266] Not only did Black patients paired with Black doctors report experiencing less pain than Black patients paired with White or Hispanic doctors, but their actual physical responses to pain were also lower when they were paired with a racially concordant doctor.[267] The study found no association between racial concordance and pain for White or Hispanic patients.[268] According to the researchers, what most differentiated Black respondents from those of other races was that they were much more likely to say they had experienced racial discrimination or were currently concerned about it.[269] Black patients who reported experiencing and worrying more about discrimination showed the greatest reductions in their bodily responses to pain when they had a racially concordant doctor.[270] The researchers suggested one reason for the link between race concordance and lower pain levels for Black respondents was because they were less anxious about the possibility of being discriminated against when they were treated by a physician of their same race.[271]

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262. Anderson et al., *supra* note 39, at 3109–10.
263. *Id.* at 3109.
264. *Id.* at 3110–12.
265. *Id.* at 3111–12.
266. *Id.* at 3113.
267. *Id.* at 3117–19.
268. *Id.* at 3119–20.
269. *Id.*
270. *Id.* at 3121.
271. *Id.*

B. Theoretical Explanations

Researchers have advanced at least three theories about why patient-physician racial concordance benefits Black patients. First, they posit that racial concordance can help alleviate the distrust many Black people feel toward the medical system.[272] This distrust stems from centuries of discriminatory treatment dating back to slavery, when Black people were not allowed to see physicians, so they instead relied on the folklore remedies they brought with them from Africa.[273] Particularly scarring for many Black people was the infamous Tuskegee Syphilis Study, in which federal health officials withheld treatment from Black men from the 1930s to the 1970s in order to study the progression of syphilis.[274] Jones argues that for many Black people, this study "became a symbol of their mistreatment by the medical establishment, a metaphor for deceit, conspiracy, malpractice, and neglect, if not outright racial genocide."[275] Glaring inequities in

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272. *See, e.g.*, Saha & Beach, *supra* note 191, at 1088 (suggesting that patient-physician racial concordance is beneficial to Black people because "Black Americans have endured systematic oppression that provides ample reason to trust members of their own community over others. . . . In this context, it is understandable that [B]lack patients might be more comfortable with [B]lack physicians, and more likely to trust their recommendations"); Traylor et al., *supra* note 236, at 1176 (suggesting that more so than other races, Black people benefit from patient-physician racial concordance because of "[a] long history of discrimination, legal and de facto segregation in the United States health care system, infamous medical trials . . . and under-representation of racial and ethnic minority groups in health care professions"); *see also* LIZ HAMEL, LUNNA LOPES, CAILEY MUÑANA, SAMANTHA ARTIGA & MOLLYANN BRODIE, KAISER FAM. FOUND., RACE, HEALTH, AND COVID-19: THE VIEWS AND EXPERIENCES OF BLACK AMERICANS 22–23 (2020) (finding that 59% of Black respondents were likely to trust doctors (compared to 78% of White respondents) and 44% of Black respondents trust the healthcare system to do what is right for them and their communities (compared to 55% of White respondents)).

273. *See* Bernice Roberts Kennedy, Christopher Clomus Mathis & Angela K. Woods, *African Americans and Their Distrust of the Health Care System: Healthcare for Diverse Populations*, 14 J. CULTURAL DIVERSITY 56, 57 (2007) ("As slaves, African Americans were not offered the opportunity to see physicians or nurses, so they relied on many of the folklore remedies that they brought with them from Africa for times of illness.").

274. *See* Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care*, 87 AM. J. PUB. HEALTH 1773, 1773–77 (1997) (detailing the various ways in which the Tuskegee experiment has affected how Black people view the healthcare system); *see also* Saha & Beach, *supra* note 191, at 1088 (arguing that "the Tuskegee syphilis study still pervades our society and its institutions, including our healthcare system," such that Black patients may be more likely to trust Black physicians than White physicians).

275. JAMES H. JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT 222–23 (2d ed. 1993).

modern-day care continue to drive Black people's distrust of the medical system. Kennedy and colleagues explain that "[i]n today's modern society, many African American people feel that the actual act of receiving health care is very often a degrading and humiliating experience."[276] Concern over Black people's distrust of the medical system resurfaced during the Covid-19 pandemic when surveys showed that half of Black respondents would refuse to get vaccinated—even as their racial group was being disproportionately ravaged by the virus.[277]

The distrust many Black people feel toward the medical system contributes to racial disparities in health outcomes.[278] Lack of patient trust has been associated with less doctor-patient interaction, poorer clinical relationships, reduced adherence to recommendations, worse self-reported health, and decreased utilization of health services.[279] Because Black people exhibit lower trust levels in the healthcare system than other racial groups, they are at greater risk of experiencing these negative outcomes.[280] But when Black patients are able to see Black physicians, their trust level increases, which can in turn lead to improved medical care. In the aforementioned Alsan study, where Black patients selected more preventive health services when they met with a Black physician, the researchers found that the benefits of race concordance were most pronounced in patients who reported higher

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276. Kennedy et al., *supra* note 273, at 57.

277. *See* HAMEL ET AL., *supra* note 272, at 4 (the survey found that even though Black respondents reported being especially hard-hit by the pandemic, both financially and emotionally, about half of Black respondents said they would not want to get a coronavirus vaccine even if deemed safe by scientists and freely available); *see also* Lola Fadulu, *Amid History of Mistreatment, Doctors Struggle to Sell Black Americans on Coronavirus Vaccine*, WASH. POST (Dec. 7, 2020, 5:15 PM), https://www.washingtonpost.com/local/social-issues/black-vaccine-trust/2020/12/07/9245e82e-34c2-11ebb59cadb7153d10c2_story.html [https://perma.cc/7Z6M-RDEZ] (reporting on the distrust that Black people lacks feel toward healthcare generally, and the coronavirus vaccine in particular, even as "Black people are nearly three times more likely than Whites to die of covid-19 . . . [,] Black children are losing more ground than their peers because of school shutdowns, and Black workers have been devastated by pandemic-related job losses").

278. *See* Musa et al., *supra* note 32, at 1293 (explaining how Black people's distrust in the medical system contributes to racial health disparities). Medical doctor Susan Dorr Goold argues that trust is a prerequisite to seeking care, and that without it, a physician can hardly expect a patient to share their full medical history, expose themselves during a physical exam, or accept recommendations for tests or treatments. Susan Dorr Goold, Editorial, *Trust, Distrust and Trustworthiness: Lessons from the Field*, 17 J. GEN. INTERNAL MED. 79, 79 (2002).

279. *See* Musa et al., *supra* note 32, at 1293 (collecting studies).

280. *Id.*

levels of distrust in the medical system.[281] Street and colleagues similarly found that patients in racially concordant interactions with physicians reported more personal and ethnic similarity, which in turn strongly predicted patients' trust in the physician, satisfaction with care, and intent to adhere to treatment recommendations.[282]

A second way that race concordance is beneficial to Black patients is by reducing the risk of physician bias. Although physicians are generally expected—and expect themselves—to be unaffected by a patient's social or demographic characteristics in forming judgments, studies indicate that such expectations are unrealistic.[283] Physicians are not immune from racial stereotypes and biases. A 2016 study found that half of White medical trainees believe such myths as Black people have thicker skin or less sensitive nerve endings than White people do.[284] Whereas physicians generally exhibit relatively low levels of explicit bias, they display substantial implicit bias toward Black patients at levels comparable to the general public.[285] Because implicit bias is automatically activated and operates at a nonconscious level, it can be extraordinarily difficult to control.[286] Van Ryn and Burke theorize that "[p]hysicians may be especially vulnerable to the use of stereotypes in forming impressions of patients since time pressure, brief encounters, and the need to manage very complex cognitive tasks are common characteristics of their work."[287] Although being treated by a Black physician is no guarantee that a Black patient will not experience discrimination, certainly the odds of being subjected to such bias are lower in racially concordant medical interactions.[288]

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281. Alsan et al., *supra* note 181, at 4095.

282. Richard L. Street, Kimberly J. O'Malley, Lisa A. Cooper & Paul Haidet, *Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity*, 6 ANNALS FAM. MED. 198, 202 (2008).

283. *See* van Ryn & Burke, *supra* note 240, at 814.

284. Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Normal Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCIS. 4296, 4297–98 (2016).

285. *See* Penner et al., *supra* note 255, at 2874–75 (collecting studies).

286. *See* van Ryn & Burke, *supra* note 240, at 814.

287. *Id.*

288. *See* Erin C. Strumpf, *Racial/Ethnic Disparities in Primary Care: The Role of Physician-Patient Concordance*, 49 MED. CARE 496, 496 (2011) (explaining that "[p]atient-provider concordance (matching) may lessen racial/ethnic disparities by fostering favorable prejudice, modifying negative stereotypes, and increasing clinical certainty, trust, and compliance").

A final way that patient-physician racial concordance is thought to benefit Black patients is through greater cultural competency by Black physicians. Aside from the fact that Black physicians are less likely to be biased toward Black patients, by virtue of having a shared race, they are also more likely to possess the knowledge, skills, and awareness necessary to provide effective treatment to Black patients.[289] Much has been written concerning the need for cultural competence in the care of Black and other patients of color.[290] This requires more than simply refraining from discrimination. Eiser and Ellis argue that in caring for Black patients, a culturally competent practitioner must understand certain aspects of the Black cultural historical experience that are unique to that particular group, including the legacy of discrimination, both within the healthcare system and more broadly; how religion and spirituality affect Black people's attitude toward healthcare; the role of home or natural remedies in treating illness; and Black people's deep-seated distrust of the medical system.[291] While non-Black physicians may obtain some level of cultural competence through coursework and training, no amount of study is likely to match the competency that comes by virtue of the shared lived experiences of Black physicians and Black patients.[292]

The theoretical explanations for why Black people benefit from racial concordance may also help explain why concordance is less important for White people. Whereas Black people generally distrust the medical system, White people do not.[293] Therefore, White patients may not derive the same benefits by seeing a racially concordant

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289. *See* Joseph P. Williams, *Why America Needs More Black Doctors*, U.S. NEWS & WORLD REP. (Aug. 31, 2018, 6:30 AM), https://www.usnews.com/news/healthiest-communities/articles/2018-08-31/why-america-needs-more-black-doctors (discussing the mistrust experienced between both doctors and patients).

290. *See, e.g.*, Josepha Campinha-Bacote, *A Culturally Competent Model of Care for African Americans*, 29 UROLOGICAL NURSING 49, 49 (2009); Timothy D. Noe, Carol E. Kaufman, L. Jeanne Kaufmann, Elizabeth Brooks & Jay H. Shore, *Providing Culturally Competent Services for American Indian and Alaska Native Veterans to Reduce Health Care Disparities*, 104 AM. J. PUB. HEALTH S548, S548 (2014).

291. Arnold R. Eiser & Glenn Ellis, *Cultural Competence and the African American Experience with Health Care: The Case for Specific Content in Cross-Cultural Education*, 82 ACAD. MED. 176, 176–81 (2007).

292. *See* Stephane M. Shepherd, *Cultural Awareness Workshops: Limitations and Practical Consequences*, 19 BMC MED. EDUC., Jan. 2019, at 1, 8 (2019) (arguing that cultural awareness training for health professionals tends to be "over-generalizing, simplistic and impractical," and may even induce unintended negative consequences).

293. *See* HAMEL ET AL., *supra* note 272, at 23 (finding that 59% of Black respondents were likely to trust doctors (compared to 78% of White respondents)).

physician as Black patients do because White patients generally do not approach medical interactions from a place of distrust. In the aforementioned Traylor study, the researchers posited that the reason race concordance benefited Black respondents but not White respondents was because "[W]hite patients are less likely to face cultural and language barriers in the medical system."[294] Saha and Beach, who similarly found in their own study that racial concordance benefitted Black patients but not White patients, reasoned that "[i]t should also be unsurprising that physician race did not influence [W]hite patients' perceptions and decision-making, as they have not been on the receiving end of the racial oppression that likely underlies the impact of physician race for [B]lack patients."[295] Latinos, Asians, and other people of color certainly have experienced discrimination within the healthcare system, but their experiences may be very different from that of Black people.[296] Likewise, whereas it is well known that White physicians discriminate against Black patients, it is less clear whether and how they discriminate against patients of other races. Finally, the meaning and importance of cultural competence differs from race to race. It may be very important to Black patients that their physician demonstrates cultural competence, but this may be less of a concern to White patients. More research is needed not only to understand how patient-physician racial concordance affects non-Black patients but also to more clearly identify the pathways through which such relationships operate.

III. LEGAL JUSTIFICATIONS

This Part considers the legal justifications for a race BFOQ for certain physician jobs. It first argues that Congress's exclusion of race from Title VII's BFOQ provision does not necessarily mean it disapproved of all race-based employment discrimination. In reality, Congress acknowledged employers could justifiably discriminate on the basis of race in some situations. Next, it demonstrates how the third-party therapeutic, safety, and privacy rationales that courts have deemed sufficient for sex-based BFOQs apply with equal force to a

294. Traylor et al., *supra* note 236, at 1175.

295. Saha & Beach, *supra* note 191, at 1088.

296. *See* Traylor et al., *supra* note 236, at 1175 (suggesting the reason concordance did not benefit Asians or Hispanics in their study was because of how much diversity exists within those populations: "Primary language spoken, dialect, level of acculturation and cultural differences among patients from different national backgrounds within each racial and ethnic group may mask concordance effects").

race-based BFOQ for physicians. It then argues that a race BFOQ for physicians is consistent with both congressional and judicial recognition that BFOQs may be especially justifiable in the healthcare context, where patient-physician interactions can be deeply intimate and affect an individual's overall well-being. This Part concludes by demonstrating how a healthcare employer could successfully assert a race BFOQ defense, if Congress were to allow it.

A. Congress's View on Race Discrimination

Congress's inclusion of the BFOQ provision in Title VII is an unequivocal acknowledgment that some employment discrimination is justified. Although courts have construed the provision narrowly, Congress likely intended it to have a broader effect, as evidenced by the provision's requirement that the BFOQ need only be "reasonably"—not "vitally" or "substantially"—necessary to a business's "normal operation."[297] But regardless of how broadly Congress intended the BFOQ provision to apply, it is clear that Congress did not want it to be used to justify race discrimination. Some courts and commentators have taken Congress's rejection of a race BFOQ to mean it believed race discrimination was never ever justifiable,[298] but this may be an overstatement. Even the chief opponents of the race BFOQ amendment conceded that race discrimination is sometimes acceptable—the Harlem Globetrotters could hire Black players, and a movie director could cast Black actors to play characters in a movie about Africa.[299] Perhaps more accurately, Congress rejected a race BFOQ not because race discrimination is never justifiable but because the instances in which it is defensible are too few to warrant a statutory exception that would have run counter to the Civil Rights Act's broader purpose.

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297. *See* Waldman, *supra* note 109, at 368.

298. *See, e.g.*, Rhonda M. Reaves, *One of These Things is Not Like the Other: Analogizing Ageism to Racism in Employment Discrimination Cases*, 38 U. RICH. L. REV. 839, 868–69 (2004) (asserting that "Congress made a legislative determination that race is never a [BFOQ] for employment").

299. Senators Clark and Case argued that even without a race BFOQ, the Harlem Globetrotters could discriminate in favor of Black players because it probably did not have enough employees to be a covered employer under Title VII. 110 CONG. REC. 7217 (1964). In response to a question about whether "a movie company making an extravaganza on Africa" could hire Black actors, the senators explained that the director "could specify that he wished to hire someone with the physical appearance of a Negro." *Id.*

If Congress could have foreseen how narrowly courts construe the BFOQ provision, perhaps lawmakers would have felt more inclined to include race in the BFOQ provision. Indeed, if Congress were to now amend Title VII to allow race BFOQs, there would be very few situations in which courts would allow an employer to assert the defense.[300] This is because, with few exceptions, courts are only willing to uphold BFOQ defenses where third-party interests other than preference are at play.[301] Because the courts have limited such interests to safety, privacy, and therapy, it is difficult to imagine scenarios outside the healthcare context where an employer could successfully assert a race BFOQ under the current judicial framework.[302]

B. How Physician Race Implicates Third-Party Interests

Patient-physician racial concordance invokes not just one but all three of the third-party interests that courts recognize as legitimate bases for sex-based BFOQs. Healthcare most directly implicates the therapeutic interest, as its obvious goal is to improve a patient's health. Although the cases in which courts have accepted BFOQ defenses based on therapeutic interests have involved psychological health, certainly the interest is broad enough to encompass physical health as well. Although the importance of one's health is self-evident, the courts have shed some light on why therapeutic interests may justify discrimination. In *City of Philadelphia*, the court explained that Philadelphia's policy of assigning same-sex supervisors to troubled youth was justified by the City's "ultimate goal of . . . restor[ing] these children to society with a mental attitude which will allow them to function in a way beneficial to themselves and society. The right of these children to proper supervision is paramount."[303] In cases involving therapeutic interests, courts have allowed sex-based BFOQs precisely because a person's chances of rehabilitation improve when an employee of their same sex cares for them.[304] Based on the empirical research,[305] this rationale applies with equal force to patient-physician racial concordance: If a medical practice can make sex-based staffing assignments because it could improve a patient's health, it

300. *See infra* Section IV.D.
301. *See supra* Section I.B.
302. *See infra* Section IV.D.
303. City of Philadelphia v. Pa. Hum. Rels. Comm'n, 300 A.2d 97, 103 (Pa. Commw. Ct. 1973).
304. *See supra* notes 128–138 and accompanying text.
305. *See supra* Section II.A.

should likewise be permitted to make race-based staffing assignments in light of the known therapeutic benefits of patient-physician racial concordance.

A physician's race can also impact a patient's safety interest. A physician does not protect a patient in the same way a prison guard protects an inmate[306] or a flight attendant protects a passenger.[307] Yet, at bottom, healthcare's entire purpose is to make patients safe, not from prison riots or plane crashes but from injury and disease. The courts have shown greater willingness to uphold BFOQs where third-party safety concerns are at stake. The Fifth Circuit explained that the "greater the safety factor, measured by the likelihood of harm and the probable severity of that harm . . . , the more stringent may be the [employer's] job qualifications designed to [prevent such harm]."[308] The Sixth Circuit similarly observed that the "presence of an overriding safety factor might well lead a court to conclude as a matter of policy that the level of proof required to establish the reasonable necessity of a BFOQ is relatively low."[309] In the Supreme Court's view, if an employer "establishes that a job qualification has been carefully formulated to respond to documented concerns for public safety, it will not be overly burdensome to persuade a trier of fact that the qualification is 'reasonably necessary' to safe operation of the business."[310] In medical interactions, the safety factor overrides all else. Just as a prison guard who fails to maintain order endangers the safety of inmates, a physician who fails to provide adequate treatment jeopardizes the safety of patients. A White physician who misdiagnoses a Black patient (either because of the physician's own biases or because the patient does not trust the physician enough to disclose sensitive information)[311] may not only prevent the patient from getting better but could cause the patient to feel worse. For Black patients, racial concordance with their physicians is known to improve their medical care—and thus their safety.[312] Accordingly, a race BFOQ that can make patients safer is legally consistent with a sex BFOQ that can make inmates safer.[313]

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306. *See supra* notes 80–83 and accompanying text.
307. *See supra* note 124 and accompanying text.
308. Usery v. Tamiami Trail Tours, Inc., 531 F.2d 224, 236 (5th Cir. 1976).
309. Tuohy v. Ford Motor Co., 675 F.2d 842, 845 (6th Cir. 1982).
310. W. Air Lines, Inc. v. Criswell, 472 U.S. 400, 419 (1985).
311. *See supra* Section II.A.
312. *See supra* Section II.A.
313. *See, e.g.*, Dothard v. Rawlinson, 433 U.S. 321, 336–37 (1977).

A physician's race can likewise implicate a patient's privacy interests. As previously discussed, courts often have little difficulty upholding BFOQs that protect a third party's bodily privacy interest in not being seen nude by a worker of the opposite sex.[314] Some patients may feel just as strongly about not being seen nude, or more invasive yet, physically examined by a physician of a different race. For instance, a Black patient may feel uncomfortable being seen naked or touched by a White physician based on centuries of White objectification and commodification of Black bodies. Cooper explains that "[t]he horror of the institution of slavery . . . was not that it displaced millions of African people . . ., but rather that it laid the foundation for the commodification and dehumanization of the [B]lack body that was culturally, socially, and politically maintained for hundreds of years to come."[315] Of course, the bodily privacy interests at stake in medical interactions extend beyond nudity. Few relationships are as intimate as the patient-physician relationship, where it is often necessary for a patient to disclose sensitive and deeply personal information—often to a complete stranger. For some patients, disclosing such personal details to a physician of a different race could feel as intrusive as being naked in front of a physician of the opposite sex.

C. BFOQs in the Healthcare Context

A race BFOQ is further justified by congressional and judicial recognition that healthcare is an industry in which BFOQs may be particularly appropriate. During Congress's deliberations over whether to include sex in Title VII's BFOQ provision, Representative Goodell of New York used healthcare to illustrate why a sex BFOQ was necessary:

> There are so many instances where the matter of sex is a bona fide occupational qualification. For instance, I think of an elderly woman who wants a female nurse. There are many things of this nature which are bona fide occupational qualifications, and it seems to me they would be properly considered here as an exception.[316]

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314. *See supra* notes 104–112 and accompanying text.

315. Iman Cooper, *Commodification of the Black Body, Sexual Objectification and Social Hierarchies During Slavery*, 7 EARLHAM HIST. J. 21, 21 (2015). *See generally* Cecil J. Hunt, II, *Feeding the Machine: The Commodification of Black Bodies from Slavery to Mass Incarceration*, 49 U. BALT. L. REV. 313 (2020) (discussing the historical and ongoing commodification and exploitation of Black people).

316. 110 CONG. REC. 2718 (1964).

Representative Green of Oregon affirmed the reasonableness of a sex-based BFOQ in healthcare with this hypothetical:

> In a large hospital an elderly woman needs special round-the-clock nursing. Her family is seeking to find a fully qualified registered nurse. It does not make any difference to this family if the nurse is a white or a Negro or a Chinese or a Japanese if she is fully qualified. But it does make a great deal of difference to this elderly woman and her family as to whether this qualified nurse is a man or a woman.[317]

These statements demonstrate that healthcare was at the forefront of Congress's mind in considering the necessity of the BFOQ provision.[318] Representative Green's hypothetical is also noteworthy for its assumption that the patient and her family would care a "great deal" about a nurse's sex but would be indifferent to the nurse's race or ethnicity so long as the nurse is fully qualified.[319] Her claim about the relative unimportance of race may have been more aspirational than realistic, given the racial tensions of the time. At any rate, Representative Green made this statement without the benefit of today's racial concordance research, which establishes that many patients do—and should—care about the race of their provider.[320]

Like Congress, the courts have recognized that BFOQs may be more justifiable in the healthcare setting than in other employment contexts. Two cases illustrate this point. In *Fesel v. Masonic Home of Delaware, Inc.*,[321] the district court directed a verdict for a nursing home that claimed being female was a BFOQ for the position of nurse's aide.[322] The nursing home supported its argument with evidence that many of its female patients and their families objected to having a male nurse's aide assist them with activities involving intimate personal care.[323] The court concluded that "[s]ince it is clear that a substantial portion of the female guests will not consent to such care, it follows that the sex of the nurse's aides at the Home is crucial to successful job

317. *Id.* at 2720.

318. *See* Waldman, *supra* note 109, at 365 (explaining that "Title VII's legislative history reveals that Congress recognized the heightened importance of the BFOQ defense in the healthcare setting").

319. 110 CONG. REC. 2720 (1964).

320. *See supra* Section II.A.

321. 447 F. Supp. 1346 (D. Del. 1978), *aff'd*, 591 F.2d 1334 (3d Cir. 1979).

322. *Id.* at 1354.

323. *Id.* at 1352.

performance."[324] By contrast, in *Olsen v. Marriott International, Inc.*,[325] the court granted summary judgment for a male massage therapist who was denied employment at a hotel spa.[326] The court rejected Marriott's claim that being female was a BFOQ for the percentage of massage therapists needed to satisfy customer requests for female therapists.[327] The court dismissed Marriott's claim that the BFOQ implicated privacy interests, reasoning that because clients were allowed to choose between male and female therapists, it was unnecessary that the client and the massage therapist be of the same sex; the issue was merely one of customer preference.[328] In both *Fesel* and *Olsen*, bodily privacy interests were at stake. A major difference, of course, was that *Fesel* involved medical patients, whereas *Olsen* involved spa customers.

Courts may be more accepting of BFOQs in the healthcare setting because the stakes are higher when an individual's health is on the line. Medical care is unlike going to a spa, not just because it may involve more invasive touching or examination but also due to the broader interests at stake. Because nothing is more important than a person's health, it is critical that patients are granted as much autonomy as possible over their medical decisions.[329] Indeed, "current codes of medical ethics and the laws of informed patient consent grant patients the right to make medical decisions consistent with their own values and preferences," even though they may run contrary to

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324. *Id.* at 1353. Other courts have shown similar deference to medical providers. *See, e.g.*, EEOC v. Mercy Health Ctr., No. Civ. 80-1374-W, 1982 WL 3108, at *2–3 (W.D. Okla. Feb. 2, 1982) (upholding a sex BFOQ for labor and delivery nurses because their duties required "not only substantial contact with the mother's genitalia but also substantial invasion of the mother's body," and a substantial number of patients had expressed discomfort with the use of male nurses); Backus v. Baptist Med. Ctr., 510 F. Supp. 1191, 1193 (E.D. Ark. 1981) (upholding a sex-based BFOQ for labor and delivery nurses, whose jobs required intimate tasks such as "checking the cervix for dilation, shaving the perineum, giving an enema, assisting in the expulsion of the enema and sterilizing the vaginal area"), *vacated on other grounds*, 671 F.2d 1100 (8th Cir. 1982).

325. 75 F. Supp. 2d 1052 (D. Ariz. 1999).

326. *Id.* at 1056, 1074.

327. *Id.* at 1068.

328. *Id.* at 1065. Similarly, in *EEOC v. Sedita*, the district court determined there was a fact issue as to whether a women's health club could refuse to hire men for certain positions, even though the positions involved performing duties that involved exposure to partial or complete nudity in showers, locker rooms, and exercise rooms, as well as touching clients' breasts, inner thighs, buttocks, and crotch area while taking measurements and providing instructions on exercise equipment. 816 F. Supp. 1291, 1296 (N.D. Ill. 1993).

329. *See infra* Section IV.A.

physicians' recommendations.[330] Courts' willingness to recognize BFOQs in the healthcare setting is consistent with the notion that patients should have greater autonomy over their healthcare, including who administers it to them.

D. The Potential Applicability of a Race BFOQ to Physicians

Ultimately, legal justification for a race BFOQ is dependent upon whether a healthcare employer could successfully invoke it as a defense to discriminatory personnel decisions under the extant legal framework. To prevail on a BFOQ defense, courts generally require an employer to prove the essence of its business would be undermined if it were unable to engage in the discrimination and that there is a factual basis for believing that all or substantially all persons in the excluded class would be unable to perform safely and efficiently the duties of the job involved.[331] The latter requirement can alternatively be met if the employer demonstrates that the exclusionary trait is a legitimate proxy for the job qualification at issue by proving it is impossible or highly impractical to deal with members of the excluded class on an individualized basis.[332]

1. Essence of the Business

For a healthcare employer to successfully assert a race BFOQ defense, it would first have to establish that "the essence of the business operation would be undermined" if it were unable to discriminate based on race.[333] The essence of a healthcare employer's business is clearly to provide competent and effective care to patients seeking medical treatment.[334] The empirical research summarized in Part II shows that, at least for Black patients, this is better accomplished when

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330. Jessica Mantel, *Refusing to Treat Noncompliant Patients is Bad Medicine*, 39 CARDOZO L. REV. 127, 161 (2017).

331. *See* Teamsters Local Union No. 117 v. Wash. Dep't of Corr., 789 F.3d 979, 987 (9th Cir. 2015) ("Under our precedent, the BFOQ defense 'may be invoked only when the *essence* of the business operation would be undermined by hiring individuals of both sexes.'" (citation omitted)).

332. *See* W. Air Lines, Inc. v. Criswell, 472 U.S. 400, 414–15 (1985). Although the test derived from an age BFOQ, courts also have applied it to Title VII BFOQs. *See, e.g.*, Everts v. Sushi Brokers LLC, 247 F. Supp. 3d 1075, 1081 (D. Ariz. 2017).

333. *See Teamsters*, 789 F.3d at 987.

334. *See, e.g.*, Healey v. Southwood Psychiatric Hosp., 78 F.3d 128, 132–33 (3d Cir. 1996) (finding that the essence of the hospital's business was "to treat emotionally disturbed and sexually abused adolescents and children").

they are treated by a same-race physician.[335] Patient-physician racial concordance increases utilization of health services; improves communication, satisfaction, and adherence to medical regimens; decreases physician bias; and in some cases directly improves health outcomes.[336] Thus, a physician's race relates to the essence of a healthcare employer's business—providing effective medical care—in precisely the same way a childcare specialist's sex relates to the essence of a psychiatric hospital's business of treating emotionally disturbed adolescents.[337]

The relationship between physician race and the essence of a healthcare employer's business stands in stark contrast to a case like *Diaz*, where Pan American Airlines insisted that employing only female flight attendants went to the essence of its business.[338] The Fifth Circuit rejected this argument, explaining that the essence of an airline's business is to transport passengers safely from one point to another, and that while female flight attendants may enhance the environment and perform the non-mechanical functions of the job more effectively than most men, these benefits were "tangential to the essence of the business involved."[339] Employing male flight attendants would not "so seriously affect the operation of an airline as to jeopardize or even minimize its ability to provide safe transportation."[340] By contrast, employing a non-Black physician to treat Black patients could undermine a healthcare employer's ability to provide effective medical care.[341]

2. Racially Discordant Physicians Provide Less Effective Care

To successfully assert a race BFOQ, a healthcare employer would also have to show it has a basis in fact for believing all or substantially all physicians not of a particular race would be unable to provide as effective medical care to patients of a different race.[342] Importantly, the

335. *See supra* Section II.A.
336. *See supra* Section II.A.
337. *See Healey*, 78 F.3d at 132.
338. Diaz v. Pan Am. World Airways, Inc., 442 F.2d 385, 387–88 (5th Cir. 1971).
339. *Id.* at 388.
340. *Id.*
341. *See supra* Section II.A.
342. This requirement, as first articulated by the Fifth Circuit and later endorsed by the Supreme Court, requires proof that members of the excluded class cannot "safely and efficiently" perform the job duties at issue. Weeks v. S. Bell Tel. & Tel. Co., 408 F.2d 228, 235 (5th Cir. 1969); W. Air Lines, Inc. v. Criswell, 472 U.S. 400, 414 (1985).

inability of physicians of one race to provide care that is effective to patients of another race does not necessarily stem from any specialized knowledge required to treat such patients. Although cultural competence can aid a physician in diagnosing and treating a condition,[343] how a physician treats congestive heart failure, for example, is the same regardless of the patient's race. The inability of physicians to care for racially discordant patients as effectively is attributable to the discordance itself. As the *City of Philadelphia* court explained, "[t]here is no question that a woman is equally qualified . . . to conduct a search for contraband as well as is a man. However, the vital factor that the Commission here disregards is 'who are the people being searched?'"[344]

Courts vary in how much evidence they require for an employer to make this showing. Some demand extensive factual evidence, whereas others seem content to defer to employers,[345] particularly in cases where therapeutic interests are at stake. In *City of Philadelphia*, the Commission alleged the City failed to empirically justify its policy of restricting supervision of juvenile detainees to employees of their same sex.[346] The Commission argued that a letter from the City explaining why same-sex assignments were necessary was "without factual basis and . . . contained multitudinous preconceptions, subjective evaluations, and commonly held assumptions."[347] The court disagreed, observing that "the zeal of the Commission to eliminate all

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Because those cases involved BFOQs based solely on safety concerns, the "safely and efficiently" requirement makes sense. In the context of medical care, safety remains a top concern, but privacy and therapeutic concerns are also at play. *See supra* Section III.B. Thus, I have replaced "safely and efficiently" with a more general (but substantively comparable) requirement of "effectiveness" to better reflect the unique features of medical exchanges.

343. *See supra* Section II.A.

344. City of Philadelphia v. Pa. Hum. Rels. Comm'n 300 A.2d 97, 102 (Pa. Commw. Ct. 1973).

345. *See, e.g.*, Chambers v. Omaha Girls Club, Inc., 834 F.2d 697, 702 (8th Cir. 1987) (upholding the club's BFOQ defense over the plaintiff's objection that the club's policy of firing employees who became pregnant out of wedlock was "based only on speculation by the Club and ha[d] not been validated by any studies showing that it prevents pregnancy among the Club's members"); Pime v. Loyola Univ. of Chi., 803 F.2d 351, 354 (7th Cir. 1986) (holding that a Jesuit university could discriminate in favor of Jesuit instructors even though it had "not been shown that Jesuit training is a superior academic qualification, applying objective criteria, to teach the particular courses").

346. *City of Philadelphia*, 300 A.2d at 101.

347. *Id.*

discrimination has caused it in this case to lose sight of common-sense principles and the potential consequences of the situation."[348] It further reasoned that "[t]he Commission cannot expect the City to produce cold, empirical facts to show that girls and boys at this age relate better to Supervisors of the same sex. It is common sense."[349]

It is not clear how much less effectively racially discordant physicians would have to care for patients to justify a race BFOQ. If a White physician is 90% as effective as a Black physician at treating Black patients, can it really be said that the White physician is unable to provide effective medical care? Maybe. Because medical care so directly impacts health, a 10% difference in effectiveness could quite literally be the difference between life and death. In the sex BFOQ cases involving therapeutic interests, the courts did not require the employers to prove that employees of one sex were a specific percentage less effective in providing care than employees of the other sex. To the contrary, the Third Circuit seemed to reject such a requirement outright, noting in *Healey* that "appraisals need not be based on objective, empirical evidence, and common sense and deference to experts in the field may be used."[350] The court accepted the hospital's BFOQ defense based on evidence that "a male is better able to serve as a male role model than a female and vice versa," and "children who have been sexually abused will disclose their problems more easily to a member of a certain sex, depending on their sex and the sex of the abuser."[351] Thus, in considering whether members of the excluded sex were unable to perform as effectively, it was enough that

348. *Id.*

349. *Id.* at 103. The Seventh Circuit showed similar deference to the employer in *Torres*, reversing the district court's determination that the Corrections Department failed to prove a basis in fact to justify its policy of staffing female prisons with female guards to further its rehabilitative interest. Torres v. Wis. Dep't of Health & Soc. Servs., 859 F.2d 1523, 1531–33 (7th Cir. 1988) (en banc). The lower court found the Department's justification deficient because it "offered no objective evidence, either from empirical studies or otherwise, displaying the validity of [its] theory." *Id.* at 1526 (citation omitted). The appellate court deemed this standard erroneous because "there is no general requirement that the necessity of a BFOQ be established by this type of evidence." *Id.* at 1531. In the court's view, the Department had been "required to meet an unrealistic, and therefore unfair, burden" and should instead be evaluated based on the "totality of the circumstances as contained in the entire record," which included the judgments of penal administrators, whose views are "entitled to substantial weight when they are the product of a reasoned decision-making process, based on available information and experience." *Id.* at 1532.

350. Healey v. Southwood Psychiatric Hosp., 78 F.3d 128, 132 (3d Cir. 1996).

351. *Id.* at 133.

the job could be performed "better" and "more easily" by members of the opposite sex.

Physicians are certainly capable of treating patients of all races. Caring for a Black patient is no different than caring for a White patient from a treatment standpoint; the medical regimen will almost certainly be the same regardless of a patient's race. The issue is not that Black patients require specialized care that only Black physicians can provide. Rather, it is that Black patients receive better, more culturally competent care from physicians of their same race. Part of this phenomenon is attributable to physician bias.[352] Although medical institutions attempt to mitigate bias through cultural competence and implicit bias training, there is mounting evidence that such measures are largely ineffective.[353] If Black patients receiving better care from Black physicians were solely attributable to physician bias, perhaps it would be an overstatement to claim all or substantially all non-Black physicians are incapable of treating Black patients effectively. Certainly, there are non-Black physicians who either have no bias or who are able to successfully suppress it. But no matter how unbiased a physician may be, the physician is still only one-half of the patient-physician relationship. Medical care is a two-way endeavor that requires trust, cooperation, and communication by both the patient and the physician.[354] Many Black patients are deeply distrustful of the medical system and, as such, are not as cooperative or communicative with non-Black physicians.[355] Just as it is often easier for male adolescents who have experienced trauma to confide in a male healthcare worker, it may be easier for a patient of color to confide in

352. *See supra* Section II.A.5.

353. *See* Shepherd, *supra* note 292, at 6, 8; Tiffany L. Green & Nao Hagiwara, *The Problem with Implicit Bias Training*, SCI. AM. (Aug. 28, 2020), https://www.scientificamerican.com/article/the-problem-with-implicit-bias-training [https://perma.cc/PE76-6FQV] (arguing that while implicit bias training is "well motivated," there is little evidence that it leads to meaningful behavioral changes).

354. *See supra* Section II.A.; *see also* Carlos A. Pellegrini, *Trust: The Keystone of the Physician-Patient Relationship*, BULLETIN AM. COLL. SURGEONS (Jan. 1, 2017), https://bulletin.facs.org/2017/01/trust-the-keystone-of-the-physician-patient-relationship [https://perma.cc/3D9P-4RJ7] ("Just as the patient must be able to trust the physician, the physician needs to have trust in the patient. Mutual trust is an important aspect of the patient-physician relationship with potential benefits for each party. Trust improves cooperation and reduces the need for monitoring. A physician's trust in the patient enhances the relationship and contributes significantly to the physician's sense of well-being and professional satisfaction.").

355. *See supra* Section II.A.

a same-race physician.[356] The law does not question whose fault this is or whether such bias should be tolerated; the mere existence of this phenomenon is enough to establish that all or substantially all physicians not of a patient's same race are unable to provide as effective care as compared to if they were of the same race.

3. Race as a Proxy for Effective Care

Even if a healthcare employer were unable to prove that all or substantially all physicians of one race could not as effectively care for patients of a different race, it could alternatively prevail on its BFOQ defense by demonstrating that physician race is a legitimate proxy for the job qualifications related to treating patients of a particular race due to the impossibility or impracticality of dealing with physicians on an individualized basis.[357] The argument is two-fold. First, determining which physicians are biased and which ones are not would be a logistical nightmare. No physician would willingly admit to bias, and even if unconscious bias (or the absence thereof) could be detected through implicit bias testing, a test result does not indicate whether a physician is affected by bias in treating patients. Detecting actual bias in medical exchanges requires a level of sophistication and instrumental sensitivity that few medical providers possess. Second, even if biased physicians could be identified, a physician's effectiveness in treating patients of a particular race further depends on the level of trust those patients have in the physician.[358] This is not something healthcare practices ordinarily inquire about, and even if they did, it would be unreasonable to expect them to be able to accurately discern when patient distrust stems from physician bias and not some other factor (e.g., the patient's education level, medical condition, or familiarity with the healthcare system). Given the impracticality—if not outright impossibility—of determining on an individual basis which physicians can effectively treat patients of a different race, patient-physician racial concordance is a legitimate proxy for this job qualification.

IV. MORAL JUSTIFICATIONS

Any allowance of race discrimination, whether in the employment context or otherwise, risks reversing the progress the United States has

356. Gordon et al., *supra* note 196, at 1316.
357. *See* W. Air Lines, Inc. v. Criswell, 472 U.S. 400, 414–16 (1985).
358. *See supra* Section II.D.3.

made in the fight for racial equality in the nearly six decades since the Civil Rights Act was enacted. Thus, an argument in favor of racial discrimination not only requires factual and legal support but moral justification as well. This Part considers the moral issues at play in arguing that certain healthcare employers should be allowed to make race-conscious hiring decisions. Although not without its drawbacks, a race BFOQ in this context is morally justified because it would grant patients of color greater autonomy over their medical treatment, help reduce racial disparities in healthcare, and increase minority representation in the medical profession. Additionally, this form of discrimination is relatively benign because it would only be permitted in the very limited situations where it is truly warranted.

A. Patient Autonomy

A race BFOQ for physicians is consistent with the notion that patients should be empowered to make their own medical choices. In recent decades, we have transitioned away from a healthcare system in which physicians made all of the decisions for their patients.[359] In today's more "enlightened era of care,"[360] the patient-physician relationship has become more collaborative, and respect for patient autonomy has shifted power to patients to make their own decisions about which healthcare interventions they will or will not receive.[361] Perhaps the most important aspect of patient autonomy is the ability to choose a physician with whom the patient feels comfortable. Whereas in the past, patients had little, if any, say over who treated

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359. *See* Mantel, *supra* note 330, at 160–61 ("The paternalism that characterized the past practice of medicine . . . has been replaced with respect for patient autonomy.").

360. Carolyn A. Bernstein, *Take Control of Your Health Care (Exert Your Patient Autonomy)*, HARV. HEALTH BLOG (May 7, 2018, 10:30 AM), https://www.health.harvard.edu/blog/take-control-of-your-health-care-exert-your-patient-autonomy-2018050713784 [https://perma.cc/R8M3-BQX7] ("In the past, physicians made all the decisions for their patients. They would plan the care, prescribe the treatment, and the patient would either comply or not . . . . We have moved into a much more enlightened era of care, and many physicians seek to involve patients, to help them understand treatment options, and to work collaboratively to achieve goals of wellness.").

361. *See* Madison K. Kilbride & Steven Joffe, Opinion, *The New Age of Patient Autonomy: Implications for the Patient-Physician Relationship*, 320 J. AM. MED. ASS'N 1973, 1973 (2018) ("The rejection of medical paternalism in favor of respect for patient autonomy transformed the patient-physician relationship . . . . The decades since the 1950s have seen an increasing emphasis on patients' rights to accept or decline recommended treatment.").

them, today they are actively encouraged to find a physician who is "right" for them.[362] In a post to Harvard Medical School's health blog with the attention-grabbing title, "Take control of your health care (exert your patient autonomy)," a physician encouraged readers to select a physician they are comfortable with by asking themselves questions such as, "What is my style about health care?," "Would I like someone who is more relational or more boundaried?," "How much do I want my doctor to know about me as a person?," and "What might happen if I disagree with my doctor?"[363] The author concluded:

> Figuring out how you want your physician to work with you lets you maintain your patient autonomy . . . . Receiving the kind of care that is comfortable for you is exercising your autonomy . . . . Make sure your doctor's style matches your own. How the treating relationship works is an essential part of the treatment. If it works, everything is enhanced. If your autonomy is not respected, your health care will suffer.[364]

The American Medical Association similarly emphasizes the importance of empowering patients to make their own healthcare decisions, asserting in its ethics code that "[r]espect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity."[365]

Patient autonomy in choosing a physician is critical because patient-physician compatibility can directly influence health outcomes.[366] The patient's choice should not be characterized as mere preference but as one in a potentially long line of decisions a patient must make about what course of treatment to pursue. Because racial concordance studies confirm that Black patients receive better care from physicians

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362. *See, e.g.*, *Find a Provider*, EMORY HEALTHCARE, https://www.emoryhealthcare.org/physician-finder/index.html [https://perma.cc/67UN-LMZB] (encouraging patients to "[c]hoose the right medical professional for you" and to "speak with a nurse who understands your needs and can help you choose the right provider").

363. Bernstein, *supra* note 360.

364. *Id.*

365. AM. MED. ASS'N, CODE OF MEDICAL ETHICS § 2.1.2, https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf [https://perma.cc/VS5L-GNWD].

366. *See, e.g.*, Alan J. Christensen, M. Bryant Howren, Stephen L. Hillis, Peter Kaboli, Barry L. Carter, Jamie A. Cvengros et al., *Patient and Physician Beliefs About Control over Health: Association of Symmetrical Beliefs with Medication Regimen Adherence*, 25 J. GEN. INTERNAL MED. 397, 398–402 (2010) (finding that patient-physician compatibility increased medication regimen adherence and lowered diastolic blood pressure).

of their same race,[367] a Black patient's request for a doctor who shares her race is a medical decision that could impact the outcome of her treatment. In some cases, this could be a life-or-death decision.[368]

Viewed in this light, a Black patient's ability to select a racially concordant physician is exponentially more justifiable than, for example, a restaurant-goer's ability to choose a racially concordant server. While it is possible that a restaurant-goer may feel more comfortable with a server of his same race, the relative importance of a restaurant-goer feeling at ease while dining pales in comparison to the necessity of a patient feeling comfortable with their physician. Moreover, a patient's interest in choosing a racially concordant physician is arguably of much greater import than the interests at stake in scenarios where BFOQ defenses are largely uncontroversial, such as a business hiring only male janitors to clean a men's restroom[369] or a French restaurant hiring a French cook.[370] As important as privacy and authenticity interests may be, being seen naked by a member of the opposite sex or eating crêpes prepared by a non-French chef is not a matter of life or death. From a moral standpoint, if those interests are important enough to justify sex and national-origin discrimination, allowing healthcare employers to make race-based personnel decisions that will provide patients of color with greater autonomy over their healthcare is even more justifiable.

B. Racial Inequality in Healthcare

Racial inequities in healthcare are well documented. On the presidential campaign trail, Biden called the racial disparities in Covid-19 cases and deaths "a national disgrace" and urged the government to "tackle racial disparities in health care and our economy head-

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367. *See supra* Section II.A.

368. *See, e.g.*, Alsan et al., *supra* note 181, at 4073 (finding that if Black patients had better access to Black physicians, cardiovascular mortality among Black men could be reduced by 16 deaths per 100,000); *see* Greenwood et al., *supra* note 38, at 21194 (finding that Black infants are half as likely to die when cared for by a Black physician).

369. *See, e.g.*, Norwood v. Dale Maint. Sys., Inc., 590 F. Supp. 1410, 1417 (N.D. Ill. 1984) (upholding a sex BFOQ where janitors could view men urinating in a restroom in a workplace where the restroom was in continuous use due to the size of the workforce).

370. *See* 110 CONG. REC. 7213 (1964) (prepared statement of Sen. Clark and Sen. Case) (explaining that a BFOQ could properly be asserted where a French restaurant has a preference for a French cook).

on."[371] Inequities manifest themselves not only in virtually all health outcomes but also in healthcare itself.[372] Perhaps most distressingly, the lower quality of medical care that minority patients receive is not solely a function of socioeconomic status or access to health insurance—racial discrimination also plays a role.[373] The fact that well into the twenty-first century Americans of color continue to receive worse medical care because of the color of their skin is more than a national disgrace; it is scandalous, unconscionable, and intolerable.

The racial inequities that persist in the American healthcare system provide moral justification for a race BFOQ. The Supreme Court explained in *Johnson Controls* that "in order to qualify as a BFOQ, a job qualification must relate to the 'essence' or to the 'central mission of the employer's business.'"[374] A race BFOQ for physicians certainly does this, but its reach is much deeper. In addition to empowering healthcare employers to provide better care for patients of color, and thus carry out the essence of their business, it has the added benefit of potentially helping close the longstanding gap between White and minority health outcomes by giving patients of color more options in choosing who treats them. As Paul-Emile persuasively argues, accommodating patients' racial preferences "is not only consistent with our normative commitments to racial equality but, in fact, constitutes an effective means of alleviating race-based health disparities, improving health outcomes, and quite possibly, saving patients' lives."[375] Unlike virtually any other BFOQ, the benefits of a race BFOQ extend beyond the customer-business relationship to society more broadly. When a strip club is allowed to hire only female dancers, the BFOQ benefits the club (by way of increased profits) and the patron (by way of sexual entertainment), but it does not provide any added benefit to society at large. By contrast, allowing a medical practice to hire a Black physician over a White physician would not

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371. Joe Biden (@JoeBiden), TWITTER (July 7, 2020, 9:00 PM) https://twitter.com/joebiden/status/1280667921916854273?lang=en [https://perma.cc/K6E7-RH93].

372. *See* Leonard E. Egede, Editorial, *Race, Ethnicity, Culture, and Disparities in Health Care*, 21 J. GEN. INTERNAL MED. 667, 667 (2006) ("[T]here is evidence that racial and ethnic minorities tend to receive lower quality of care than nonminorities . . . .").

373. *See* UNEQUAL TREATMENT, *supra* note 30, at 1.

374. UAW v. Johnson Controls, Inc., 499 U.S. 187, 203 (1991) (first quoting Dothard v. Rawlinson, 433 U.S. 321, 333 (1997); and then quoting W. Air Lines, Inc. v. Criswell, 472 U.S. 400, 413 (1985)).

375. Kimani Paul-Emile, *Patients' Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. REV. 462, 462 (2012).

only benefit the practice (by enabling it to provide more effective treatment to Black patients) and Black patients (by giving them the option to receive treatment from a physician of their same race), but also society at large by creating greater racial equality within the healthcare system. If sexual entertainment is important enough to justify sex discrimination, how much more justifiable is race discrimination that could potentially improve and even save lives?

The irony of fighting discrimination with more discrimination is not lost on this author. Perhaps the strongest argument against a race BFOQ for physicians is that catering to patients' racial preferences runs counter to the goal of racial equality. If Black patients primarily see Black physicians, how will they ever overcome their distrust of White doctors? Likewise, how will White physicians overcome their biases against Black patients if they have fewer opportunities to treat them? There is widespread consensus among social scientists that one of the most effective ways to combat prejudice is through intergroup interactions; positive experiences with members of a perceived out-group are known to help to counter negative perceptions or stereotypes associated with the group.[376] The argument, then, is that a race BFOQ would lead to less, not more, intergroup interaction, hindering progress toward the goal of creating a healthcare system in which a patient receives the same level of care regardless of the patient's or the physician's race.[377]

This argument is not without some merit. But it overlooks the reality that centuries of White physicians treating Black patients has not achieved the goal of healthcare equality. A chasm persists between White and minority healthcare and health outcomes, resulting in people of color living sicker and dying younger.[378] Closing this gap—saving lives—must be the top priority. While the solution is undoubtedly complex and multifaceted, research has proven that one way to narrow the gap, at least for Black patients, is to give them the option to be treated by physicians of their same race. So while a race BFOQ may undermine the ultimate goal of physicians treating patients

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376. *See* John F. Dovidio, Angelika Love, Fabian M. H. Schellhaas & Miles Hewstone, *Reducing Intergroup Bias Through Intergroup Contact: Twenty Years of Progress and Future Directions*, 20 GRP. PROCESSES & INTERGROUP RELS. 606, 609 (2017) (reviewing empirical studies on how intergroup contact helps reduce bias).

377. *See* Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701, 748 (2007) ("The way to stop discrimination on the basis of race is to stop discriminating on the basis of race.").

378. *See supra* notes 17–24 and accompanying text.

free of racial bias, from an anti-subordination perspective, giving patients of color the ability to choose to be treated by a physician of their same race—a power White patients have long wielded—promotes greater healthcare equality.[379] In a perfect world, a race BFOQ for physicians would be unnecessary. But that is not the world that patients of color presently inhabit. Minority patients' ability to select same-race physicians could be the difference between life and death. As the Supreme Court has acknowledged in the affirmative action context, sometimes discrimination is a necessary step in creating greater equality for all.[380]

C. Underrepresentation of Black Physicians

A race BFOQ is also morally justified because most minority groups are grossly underrepresented in the medical profession. Whereas Black, Hispanic or Latino, and American Indian/Alaska Native people make up approximately one-third of the total U.S. population, they comprise just 11.1% of physicians.[381] The dearth of Black male physicians, in particular, has received heightened attention[382] after a study revealed that fewer Black males applied to and

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379. *See* Paul-Emile, *supra* note 375, at 497 (arguing that accommodating patients' racial preferences should be conceptualized through an "antisubordination lens," meaning "we should address the negative impact that centuries of race discrimination have had on members of disadvantaged groups by allowing for the consideration of race in some circumstances rather than adopt a formalistic approach that would view any consideration of race as problematic.").

380. *See* Cleveland Fire Fighters For Fair Hiring Pracs. v. City of Cleveland, No. 1:00 CV 301, 2009 WL 2602366, at *12 (N.D. Ohio Aug. 20, 2009) (explaining that "the [United States Supreme Court has] determined that a limited and temporary imposition of 'reverse' discrimination or 'affirmative action' was a necessary step toward creating greater equality for all") (alteration in original) (citation omitted), *vacated on other grounds*, 669 F.3d 737 (6th Cir. 2012).

381. *See Quick Facts*, U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/fact/table/US/IPE120219 [https://perma.cc/LD58-RS5G] (indicating that Black, Latino or Hispanic, and American Indian and Alaska Native people make up 13.6%, 18.9%, and 1.3% of the United States' population, respectively); *Diversity in Medicine: Facts and Figures 2019*, ASS'N OF AM. MED. COLLS., https://www.aamc.org/data-reports/workforce/ interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018 [https://perma.cc/4MK2-8UBS].

382. *See, e.g.*, Torian Easterling, *America Can't Afford to Lose More Black Male Doctors*, TIME (June 18, 2020, 5:29 PM), https://time.com/5855636/black-male-doctors/ [https://perma.cc/3VPC-T8WA] (highlighting the impact of losing Black male doctors to COVID-19 when only 515 Black men graduated from U.S. medical schools in 2014).

enrolled in medical school in 2014 than in 1978.[383] The scarcity of physicians of color is not only problematic for minority patients who wish to receive care from a same-race physician, but it also disadvantages White physicians who are impeded in their ability to develop cultural competence because they do not have the benefit of working with physicians of color who can facilitate this process.

A race BFOQ could help increase the number of physicians from underrepresented racial groups. If students of color who are contemplating attending medical school know healthcare employers can legally discriminate in their favor in making hiring and other personnel decisions, this could provide them with added incentive to pursue a career in medicine. A race BFOQ would not only help medical graduates of color enter the professional workforce but would also serve to expand their presence in areas of medicine and practice settings where they are traditionally underrepresented. As more Black, Latino, and Native American physicians enter the medical profession and practice in a greater variety of fields and settings, more children of color will be able to look to minority physicians as role models for their own careers.

D. Benign Discrimination

A race BFOQ for some physicians is also morally justifiable because it permits a relatively benign form of discrimination. In arguing for an expansion of the sex BFOQ to female OB-GYNs, Waldman identified three conditions that make a BFOQ rooted in patient preference

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383. ASS'N OF AM. MED. COLLS., ALTERING THE COURSE: BLACK MALES IN MEDICINE 6–7 (2015) (finding that in 1978, 1410 Black men applied to medical school and 542 ended up enrolling, whereas in 2014, 1337 Black men applied and 515 enrolled). Efforts to increase minority representation in medicine have focused primarily on affirmative action programs in medical school admissions. *See* Gabriel Garcia, Cathryn L. Nation & Neil H. Parker, *Increasing Diversity in the Health Professions: A Look at Best Practices in Admissions*, *in* IN THE NATION'S COMPELLING INTEREST: ENSURING DIVERSITY IN THE HEALTH CARE WORKFORCE 233, 238–42 (Brian D. Smedley, Adrienne Stith Butler & Lonnie R. Bristow eds., 2004). Although these programs have enjoyed some success, *see generally* JAMES L. CURTIS, AFFIRMATIVE ACTION IN MEDICINE 145–46 (2003), they are becoming increasingly limited, and in any event, they do little to help students of color obtain employment or advance in their careers. *See* Liliana M. Graces & David Mickey-Pabello, *Racial Diversity in the Medical Profession: The Impact of Affirmative Action Bans on Underrepresented Student of Color Matriculation in Medical School*, 86 J. HIGHER EDUC. 264, 264–94 (2015) (describing limitations and bans on race-conscious admissions policies in medical schools and how such limitations have adversely affected minority enrollment).

justifiable in the eyes of the courts: (1) the patient's preference is for same-gender service as opposed to a general preference for a position to be filled by employees of only one gender, (2) the business at issue implicates privacy or therapeutic interests that are gender-related, and (3) the preference for same-gender service does not derive from malignant gender stereotypes.[384] Each of these conditions is satisfied in the context of a race BFOQ for physicians.

First, a patient's desire to be treated by a racially concordant physician implicates a preference for same-race medical service rather than a general view that only members of a particular race should be physicians. A finding that being a certain race is a BFOQ for physicians who primarily treat patients of that race would be unlikely to discourage members of other racial groups from pursuing a medical degree, and by no means would it shut them out from the general field of medicine. Second, the business of healthcare clearly implicates both privacy and therapeutic interests, and these interests are race related. As previously discussed, there is strong empirical evidence that Black patients receive better care from Black physicians, in part because they are more likely to trust Black physicians with their intimate and private information.[385] Third, while it is possible that some patients may request a same-race physician based on malignant stereotypes, this would seem to be the exception rather than the rule. Most racial minorities are accustomed to racially discordant service exchanges as part of their daily lives. For patients of color, the desire to see a same-race physician is unlikely to derive from racial contempt but rather from a desire to receive medical care—the most important service they will likely ever require—by a physician who is better able to understand them, communicate with them, and diagnose and treat them free from the racial bias that too often permeates medical exchanges. Moreover, the fact that most minority patients will have received treatment from White physicians in the past before switching to a same-race physician (when given the chance) underscores that this preference generally is not based on malignant or ignorant biases, but on a sincere desire to receive effective medical care.

There are other reasons to believe a race BFOQ would be relatively harmless. It would be unlikely to usher in an era of more segregated healthcare where White patients only see White physicians and Black patients only see Black physicians. By no means would a race BFOQ

384. Waldman, *supra* note 109, at 375–76.
385. *See supra* Section II.A.

mandate that patients see a physician of their same race; it would merely give them more freedom to do so if racial concordance is something they value. White patients have long enjoyed this ability; increasing access to minority physicians would merely grant patients of color this same ability. Although a race BFOQ would almost certainly result in more patients of color choosing a same-race physician, it probably would not result in more White patients choosing White physicians. Given the abundance of White doctors in most parts of the United States, White patients already have the ability to choose a White physician in most instances. Thus, White patients who prefer White physicians are likely already going to White physicians, so a race BFOQ would not increase their odds of doing so. If anything, the increased presence of minority physicians that would result from a race BFOQ would lead to more White patients being seen by non-White physicians than is currently the case.

In theory, a race BFOQ could be used to discriminate in favor of hiring a White physician who primarily treats White patients. However, the case for doing so would not be nearly as strong as the case for hiring minority physicians to treat patients of color. Patient-physician racial concordance does not seem nearly as important to White people as it is to Black people[386]—a phenomenon likely explained by the fact that White people generally do not exhibit the same levels of distrust toward the medical system[387] or encounter the same types of discrimination by healthcare providers as Black people do.[388] Moreover, when White patients are treated by physicians of color, it is likely by choice. If White patients do not feel comfortable with their physician's race, they may be able to switch to a White doctor, given the prevalence of White physicians. Thus, it is not as crucial that a medical practice hire White physicians to treat White patients as it is for a practice to hire minority physicians to treat minority patients.

A final reason a race BFOQ would be relatively benign is that the courts' restrictive interpretation of the BFOQ defense would ensure that a race BFOQ would only apply in very limited circumstances. Adding race to Title VII's BFOQ provision would theoretically open the door to race-based BFOQs in settings beyond medical care. But in

386. *See, e.g.*, Saha & Beach, *supra* note 191, at 1088; Traylor et al., *supra* note 236, at 1175.

387. *See* HAMEL ET AL., *supra* note 272, at 23 (finding that White respondents were 19% more likely than Black respondents to trust doctors).

388. *See supra* Section II.A.5.

reality, the number of job positions where race would qualify as a BFOQ under the current judicial parameters would likely be very small. It is hard to imagine a context other than healthcare where an employee's race would be necessary to protect privacy, safety, or therapeutic interests. Of course, if courts were to extend the BFOQ defense to other third-party interests, such as education or legal representation, perhaps educational institutions or law firms could rely on a race BFOQ to make race-conscious hiring decisions, if empirically justified.[389] One non-healthcare-related area where a race BFOQ could potentially be of use under the existing jurisprudence is in those limited situations where race is necessary to perform an occupational task, such as Justice Stevens' example of an undercover agent who infiltrates a criminal group where the members of the group are all the same race.[390] A race BFOQ could similarly apply to theatrical casting decisions, where even the EEOC has acknowledged the value of authenticity (albeit in the context of sex).[391] No longer would directors have to make casting decisions based on superficial "physical appearance" requirements;[392] instead, they could simply hire a Black actor to play the role of a Black character in a historically accurate production.[393]

In reality, racial discrimination of this nature is commonplace and, at least for now, largely uncontroversial. The absence of racial discrimination lawsuits by White actors who were denied roles in all-Latino theatrical productions or by Black agents who were not assigned to infiltrate the Ku Klux Klan demonstrates there is widespread consensus that there are some situations where allowing employers to engage in race discrimination in order to perform an occupational task

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389. *See, e.g.*, Hoag, *supra* note 51, at 1543–44 (arguing that indigent Black criminal defendants should be allowed to select a racially congruent public defender, should they desire it).

390. Wygant v. Jackson Bd. of Educ., 476 U.S. 267, 314 (1986) (Stevens, J., dissenting).

391. 29 C.F.R. § 1604.2(a)(2) (2012).

392. *See* 110 CONG. REC. 7217 (1964) (prepared statement of Sen. Clark and Sen. Case) (explaining that although Title VII prohibits race discrimination, a movie director "could specify that he wished to hire someone with the physical appearance of a Negro").

393. *See* K. Anthony Appiah, *Stereotypes and the Shaping of Identity*, 88 CAL. L. REV. 41, 47 (2000) (arguing that "we ought to admit the possibility of a BFOQ in the case of race, as the federal law does not, because there seems nothing harmful, in a realist production, in requiring that we have actors who look—and sound—like people of whatever racial identity they are representing").

is not only morally unobjectionable, but is also commonsensical. Thus, a race BFOQ would formally allow racial discrimination in these limited situations.

CONCLUSION

In 2020, the simultaneous emergence of the Covid-19 pandemic and the resurgence of the Black Lives Matter movement shined a spotlight on longstanding racial injustices entrenched in American society, including its healthcare system. The racial disparities that persist in both medical treatment and health outcomes are shocking and disgraceful. For years, politicians, policymakers, and healthcare professionals have grappled with how to close this gap, to little avail. Meanwhile, people of color continue to pay the price—living sicker and dying younger than their White counterparts. Racial-concordance research demonstrates a way forward by showing that Black people, and perhaps other racial minorities, receive better, more equitable care when they have the choice to be treated by physicians of their same race. Racially concordant healthcare is not a panacea, but it can help promote fairness within a medical system long riddled with injustice.

Allowing healthcare employers to discriminate in favor of minority physicians may seem provocative and radical to some. But as this Article demonstrates, it is consistent with Title VII's BFOQ doctrine, which acknowledges that sometimes employment discrimination is justifiable. Although the BFOQ provision currently only permits employers to discriminate based on sex, religion, and national origin, there is good reason to add race to the law. A race-based BFOQ for physicians who primarily treat patients of a particular race is factually justified. For Black people in particular, patient-physician racial concordance increases health services utilization; improves communication, satisfaction, and adherence to medical regimens; reduces physician bias; and in some cases can directly produce better health outcomes. A race-based BFOQ for physicians is also legally justified, for it would protect not just one but all three of the third-party interests—therapy, safety, and privacy—that courts recognize as valid justifications for the BFOQ defense. A race BFOQ for physicians is also legally consistent with judicial recognition that BFOQs may be especially appropriate in the healthcare setting. Finally, a race-based BFOQ is morally justified. Giving patients of color more choice in who treats them comports with contemporary notions of patient autonomy. It promotes racial equity in healthcare, both by enhancing patients'

ability to select a physician of their same race, should they desire it, and by incentivizing more people of color to join the medical profession. And while permitting any form of race discrimination is a serious matter that warrants intense scrutiny, a race BFOQ for physicians would result in relatively benign discrimination based not on malignant stereotypes or an effort to exclude all non-minorities from practicing medicine but rather on a desire to empower minority patients to select a physician who can provide them with the best possible care.

If Black and Brown lives truly matter—and they do—the law must do its part to remedy the gross racial inequities that persist within the healthcare system. Amending Title VII's BFOQ provision to allow healthcare employers to make race-conscious hiring decisions in order to meet patients' needs is a potentially effective step in the long road toward healthcare equality. Increasing access to minority doctors will give patients who value racial congruency and cultural competency greater freedom to select a physician who shares their same race. As patient-physician racial concordance is known to improve medical care, allowing a race BFOQ for physicians is a form of discrimination that will not only improve, but *save* lives. Had Susan Moore been able to see a Black physician when she contracted Covid-19, perhaps she would still be alive today.