Articles

Expanding Accountability: Using the Negligent Infliction of Emotional Distress Claim to Compensate Black American Families Who Remained Unheard in Medical Crisis

NIA JOHNSON, MBE, JD[†]

Black Americans have constantly been victims of health disparities and unequal treatment in healthcare facilities. This is not new. However, more attention has been paid to accounts from Black Americans alleging that their providers ignored them or their families in crisis, leading to grave consequences. Though we do have a medical malpractice system that is equipped to remedy physical manifestations of medical negligence, there has been minimal dialogue about how to hold provider accountable for more abstract medical grievances like ignoring Black patients. This Article argues that the negligent infliction of emotional distress claim is an appropriate forum to address this issue.

[†] PhD Candidate in Health Policy, Harvard University. A special thank you to Angela Onwuachi-Willig, Dean of Boston University School of Law, for encouraging me to think more deeply on the topic of torts and race, to Professor Christopher Robertson and Professor Michele Goodwin for your gracious edits and thoughtful advice, to the Hastings Law Journal Symposium for an intellectually stimulating forum to refine this Article, and to Kelly Christensen, JD for being a wonderful sounding board for this project.

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INTRODUCTION

One of the most poignant issues present in medical care for Black patients is the unwillingness of providers to listen to Black patients' needs and concerns. We have seen this issue manifest in countless ways—from studies confirming that Black patients are routinely undertreated for pain due to beliefs about Black patients' biological differences[1] to a Black physician who died after having her Covid-19 pain undertreated and her other symptoms trivialized by other physicians.[2] But issues with providers ignoring the concerns of Black patients and their families should not be surprising. This is a long-term consequence of the systemic oppression of Black patients by healthcare systems, healthcare providers, and the United States government. As our understanding of race as a public health issue grows, America has started to do the work of cleaning up the grime of racism that has leaked out from the healthcare system.[3] Although there are a range of medical malpractice claims that can be brought to address the physical aspects of these harms, there are fewer legal claims to address the emotional horror of advocating for a family member while understanding that if action is not taken, they will die.

Negligent Infliction of Emotional Distress ("NIED") claims could be an appropriate avenue. They have met resistance in court due to a variety of concerns. These claims are often framed as frivolous or unquantifiable. However, this Article will argue that the NIED claim may be an appropriate avenue to start compensating Black Americans who were traumatized by being maimed or by watching their loved ones die because healthcare providers did not prioritize their concerns. Though this Article utilizes bystander NIED cases, the principles argued in this Article should also be applied to cases where the plaintiff is a victim of NIED. Black patients are at great risk for implicit bias in care and the medical errors that accompany it. It is time for the law to address that issue.

Part II of this Article will examine two cases where the patients' outcomes hinged on physicians listening to Black family members. The first case will look at *Spears v. Rosen*—the nationally known story of a young Black girl named Jahi McMath, whose family fought to keep her on life support after she was declared brain dead.[4] The second case will look at *Johnson v. Cedars-Sinai*

1. Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. U.S.A. 4296, 4296 (2016).

2. John Eligon, *Black Doctor Dies of Covid-19 After Complaining of Racist Treatment*, N.Y. TIMES, (Dec. 24, 2020), https://www.nytimes.com/2020/12/23/us/susan-moore-black-doctor-indiana.html; Dakin Andone, *A Black Doctor Died of Covid-19 Weeks After Accusing Hospital Staff of Racist Treatment*, CNN (Dec. 25, 2020), https://www.cnn.com/2020/12/24/us/black-doctor-susan-moore-covid-19/index.html.

3. David R. Williams, Yan Yu & James S. Jackson, *Racial Differences in Physical and Mental Health: Socio-Economic Status, Stress and Discrimination*, 2 J. HEALTH PSYCH. 335, 348 (1997).

4. Nia Johnson, *Legal and Bioethical Implications of a Misdiagnosed Brain Death — Spears v. Rosen*, 43 AM. J. LAW MED. 468, 468 (2018).

Medical Center—the story of a middle-class Black American woman named Kyira Dixon,[5] who died shortly after giving birth.[6] Part III of this Article will recount a brief history of Black Americans' experience with the medical system, from the Middle Passage to Covid-19. Part IV of this Article will discuss the various ways race is addressed in tort law and why using a race-based framework for addressing NIED claims is important. Part IV will also walk through a thought experiment that outlines how a race-based NIED framework could work. This Article is not meant to disparage health providers. Rather, it argues that unchecked implicit bias in healthcare facilities is not only unacceptable but should be able to be addressed in court. The NIED claim could be the right tool for change.[7] Casualness is a recurring theme we see in the accounts of Black Americans' experience with health providers in the United States. This Article uses the term to refer to the relaxed concern of health providers when presented with concerns of Black patients' immediate medical needs or when providing Black patients with bioethical principles of autonomy, beneficence, nonmaleficence, or justice, even when the circumstances are urgent. But this theme must be eradicated from the medical profession. And if it cannot be eradicated, it should not continue without consequences, and looking toward NIED claims as an opportunity for equity is an important way to create accountability.

I. A TALE OF TWO CASES: *SPEARS V. ROSEN* AND *JOHNSON V. CEDARS-SINAI MEDICAL CENTER*

A. A MATERNAL REQUEST FOR MEDICAL INTERVENTION: *SPEARS V. ROSEN*

Jahi McMath, a 13-year-old girl from Compton, California, was the pride and joy of her family's life.[8] She was diagnosed with pediatric obstructive sleep apnea.[9] Although snoring is a main symptom, this condition also has a strong

5. The media has used multiple spellings of Kyira Dixon's name. This Article will use the spelling from the *Johnson v. Cedars-Sinai Medical Center* complaint.

6. Plaintiff's Complaint for Damages at 2–3, Johnson v. Cedars-Sinai Medical Center, No. BC655107, 2017 WL 1157300 (Cal. Super. Ct. 2017).

7. *See generally* DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 37–38 (2015); Elizabeth N. Chapman, Anna Kaatz & Molly Carnes, *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504, 1508 (2013); Joe Fassler, *How Doctors Take Women's Pain Less Seriously*, ATLANTIC, (Oct. 15, 2015), https://www.theatlantic.com/health/archive/2015/10/emergency-room-wait-times-sexism/410515/; Sandhya Somashekhar, *The Disturbing Reason Some African American Patients May Be Undertreated for Pain*, WASH. POST (Apr. 4, 2016), https://www.washingtonpost.com/news/to-your-health/wp/2016/04/04/do-Blacks-feel-less-pain-than-Whites-their-doctors-may-think-so/.

8. Plaintiff's Complaint for Damages for Medical Malpractice at 1, Spears v. Rosen, No. RG15760730, 2015 WL 880721 (Cal. Super. Ct., Mar. 3, 2015) [hereinafter *Plaintiff's Complaint for Damages for Medical Malpractice*].

9. *Id.* at 2.

correlation with death in children.[10] Her physician, Dr. Frederick S. Rosen, recommended that Jahi undergo an adenotonsillectomy (removal of the tonsils and adenoids), an uvulopalatopharyngoplasty (removal of the soft palate and uvula), and a submucous resection of her bilateral turbinate at the UCSF Benioff Children's Hospital.[11] The plaintiff's complaint cited that the procedure was a risky one.[12] On December 9, 2013, Dr. Rosen started the operation. He found that her carotid artery was in an anatomically anomalous location but did not alert any of the post-operative staff of this issue. This type of anomaly posed an increased risk of hemorrhaging during recovery.[13]

After initially being denied permission to see Jahi, her parents Latasha Spears Winkfield and Marvin Winkfield, entered the pediatric intensive care unit thirty minutes after her surgery was completed.[14] They found her coughing up blood and expressed concern about the amount of blood that they saw.[15] The nursing staff said that the bleeding was normal and taught Latasha Winkfield how to suction blood from Jahi's mouth.[16] After suctioning the blood from her daughter's mouth for sixty minutes, another nurse came back and "admonished" her for doing so because it could disrupt necessary blood clots for recovery.[17] Although she stopped, Latasha Winkfield saw her daughters bandages grow even more bloody and became increasingly worried. This led her to call Jahi's grandmother, Sandra Chatman, an experienced nurse. Chatman rushed to the hospital late on December 9, 2013 and was immediately taken aback by the amount of blood she saw in the receptacle that collected blood from the suctioning device.[18] Chatman inquired about whether the blood in the receptacle was Jahi's, and said that it was an excessive amount of bleeding. She insisted that the nurses contact a physician immediately. A physician never came.[19] By 12:30 a.m., Chatman looked at the equipment that monitored Jahi's heartrate and the blood oxygenation level had significantly dropped. She started yelling for the medical staff to institute a code indicating cardiopulmonary arrest. At that point, a physician finally arrived at Jahi's bedside.[20] The medical team made several attempts at resuscitation—lasting well into the early morning of December 10,

10. M. G. Greene & J. L. Carroll, *Consequences of Sleep-Disordered Breathing in Childhood*, 3 CURRENT OP. PULM. MED. 456 (1997); Julie C. Lumeng & Ronald D. Chervin, *Epidemiology of Pediatric Obstructive Sleep Apnea*, 5 PROC. AM. THORACIC SOC'Y 242, 242–43, 250 (2008); Debra Goldschmidt, *Jahi McMath, California Teen at Center of Brain-Death Controversy, Has Died*, CNN (June 29, 2020), https://www.cnn.com/2018/06/29/health/jahi-mcmath-brain-dead-teen-death/index.html.

11. *Plaintiff's Complaint for Damages for Medical Malpractice*, *supra* note 8, at 2.

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.* at 3.

19. *Id.*

20. *Id.*

2013, with the hospital staff constantly trying to intubate her and pumping two liters of blood out of her lungs.[21] By December 11, it became clear that Jahi had suffered severe brain damage. Within a day, the family was informed that Jahi had been put on an organ donor list and that her life support would be terminated by December 13.[22] The complaint describes how the family felt that the hospital administration did not inform them of anything that was going on and that they were simply pushing the family to terminate life support for the purpose of donating their child's organs.[23] These devastating events led to Jahi being shuttled to multiple hospitals by her family in the hope that her condition could be reversed and to quite a few other malpractice cases—*Winkfield v. Children's Hospital Oakland*, *McMath v. Rosen*, and *McMath v. California*.[24] All of the issues presented by the family related to malpractice, NIED, and dignity for Jahi.[25] However, all of the cases were either dismissed or focused on issues of jurisdiction and civil procedure. Very rarely do we see issues of race or NIED addressed.

The behavior exhibited by the hospital and medical staff turned Jahi McMath's story into a nationally known controversy over brain death—questioning what is death and how soon one should be taken off of life support if declared brain dead.[26] However, another issue in this story is the casualness with which the physicians treated Jahi's health and her family's concerns. Latasha Winkfield and Sandra Chatman brought a claim for NIED against Dr. Rosen.[27] They argued that they witnessed Jahi, their daughter and granddaughter, respectively, bleed out while the medical staff ignored their frequent requests for medical intervention.[28] They also argued that from the moment that Chatman advised Winkfield that Jahi's bleeding was indicative of complications from the surgery, they were "aware that Jahi was being harmed by the inadequate and substandard nursing care she was receiving at CHO, by

21. *Id.* Research has shown that although most parents prefer to witness the intubation or other invasive procedures as a form of moral support for their loved ones, intubation of children can be traumatic for the family members that witness the procedure. Josée Gaudreault & Franco A. Carnevale, *Should I Stay or Should I Go? Parental Struggles When Witnessing Resuscitative Measures on Another Child in the Pediatric Intensive Care Unit*, 13 PEDIATRIC CRITICAL CARE MED. 146, 146 (2012); L. A. Gavin & T. A. Roesler, *Posttraumatic Distress in Children and Families After Intubation*, 13 PEDIATRIC EMERG. CARE 222, 222 (1997); Wendy Ward-Begnoche, *Posttraumatic Stress Symptoms in the Pediatric Intensive Care Unit*, 12 J. SPECIALIST PEDIATRIC NURSING 84, 87 (2007).

22. *Plaintiff's Complaint for Damages for Medical Malpractice*, *supra* note 8, at 4.

23. *Id*.

24. Rachel Aviv, *What Does It Mean to Die?*, NEW YORKER (Jan. 29, 2018), https://www.newyorker.com/magazine/2018/02/05/what-does-it-mean-to-die.

25. Winkfield v. Children's Hospital Oakland, No. C 13-5993, 2014 U.S. Dist. LEXIS 8560, at *3–4 (N.D. Cal. Jan. 22, 2014); McMath v. California, No. 15-cv-06042-HSG, 2016 WL 7188019, at *1–2 (N.D. Cal., Dec. 12, 2016); Plaintiff's Complaint for Damages and Wrongful, McMath v. Rosen, No. RG15796121 (Cal. Super. Ct. Dec. 9, 2015). *See also Dismissal with Prejudice*, BLACK'S LAW DICTIONARY (11th ed. 2019).

26. Johnson, *supra* note 4, at 469.

27. *See generally Plaintiff's Complaint for Damages for Medical Malpractice*, *supra* note 8.

28. *Id.* at 2–3.

her surgeon who had not checked on the status of his patient or by the other medical staff at CHO."[29] Winkfield became so distraught by the sight of Jahi's suffering that she had to be admitted to UCSF Benioff Children's Hospital Oakland for observation.[30] Because the medical staff was unwilling to listen to the concerns of Latasha Winkfield and Sandra Chatman, Jahi's condition deteriorated. Jahi was pushed further and further down on the figurative priority list of her providers, and it ultimately led to her diagnosis of brain death. Her subsequent heart death and liver failure occurred in 2018.[31] Furthermore, her family was forced to watch this tragedy take place as they begged and pleaded on her behalf. Had the providers been willing to listen to the cries of her family, it is more than likely that all of this trauma would have been avoided.

B. WATCHING YOUR WIFE'S SLOW DEATH: *JOHNSON V. CEDARS-SINAI MEDICAL CENTER*

Kyira Dixon was a 39-year-old multi-lingual African-American woman who spent her days running companies and drag-racing.[32] She spent time living abroad in China and was described by her husband, Charles Johnson, IV, as being so full of a "zest for life" that he "couldn't wait to see what was going to happen next."[33] Dixon and her husband (son to television personality and attorney Judge Glenda Hatchet) were overjoyed to bring their second son into the world.[34] Dixon was in excellent health and never missed a prenatal appointment.[35] The family had recently relocated to Los Angeles, California to engage in new career opportunities, and Dixon transferred her prenatal care and obstetrics planning to Dr. Benham Kashchi. Johnson's complaint alleges that shortly before her elective cesarean section, Dixon's care was transferred again to Dr. Arjang Naim. However, allegedly, both physicians were present in the operating room for the procedure.[36]

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29. *Id.* at 6.

30. *Id.*

31. *See generally* Johnson, *supra* note 4 (providing an analysis of Jahi's original diagnosis of brain death and the controversy surrounding whether that diagnosis was accurate); Samantha Schmidt, *Jahi McMath, the California Girl in Life-support Controversy, Is Now Dead*, WASH. POST (June 29, 2018), https://www.washingtonpost.com/news/morning-mix/wp/2018/06/29/jahi-mcmath-the-calif-girl-declared-brain-dead-4-years-ago-is-taken-off-life-support/.

32. *Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.: Hearing Before the Subcomm. on Health of the Comm. on Energy and Com.*, 115th Cong. 13 (2018) (statement of Charles S. Johnson, IV, Founder, 4Kira4Moms) [hereinafter Johnson, IV].

33. *Id.*

34. *Id.*; Angela Helm, *Kira Johnson Spoke 5 Languages, Raced Cars, Was Daughter in Law of Judge Glenda Hatchett. She Still Died in Childbirth*, THE ROOT (Oct. 19, 2018), https://www.theroot.com/kira-johnson-spoke-5-languages-raced-cars-was-daughte-1829862323.

35. Helm, *supra* note 34.

36. Plaintiff's Complaint for Damages for Wrongful Death and Negligent Infliction of Emotional Distress at 2, Johnson v. Cedars-Sinai Medical Center, No. BC 655107 (Cal. Super. Ct. 2017).

On April 12, 2016, Johnson was present with his wife at every step of the birth of their second son, Langston Johnson. By 3:04 p.m., the operation was complete, and Dixon was engaging in skin-to-skin bonding with their child.[37] However, within the next two hours, Dixon's condition changed. At 4:45 p.m., Dixon's uterine fundus (the top, rounded portion of the uterus across from the cervix)[38] began to rise above her umbilicus. This is indicative of uterine atony, which can lead to postpartum hemorrhaging.[39] Within an hour, her fundus had not lowered, and blood became present in her catheter, coloring her urine red. By this point, Dr. Naim had been notified twice.[40] Dixon initially was treated for her pain and labs were ordered. At 6:12 p.m., an evaluation of her vitals indicated that her white blood count, red blood count, hemoglobin, and hematocrit were all abnormal.[41] At 6:44 p.m., an emergency CAT scan of Dixon's abdomen and pelvis were ordered by Dr. Stuart Martin, a different physician. Dr. Martin's records indicate that Dixon's abdominal pain was becoming difficult to control, that he had concerns that Dixon had a pelvic hematoma, and that there was still blood in Dixon's catheter.[42] At 7:13 p.m., Dr. Kathryn Sharma, another physician, noted that Dixon had not expelled any substantive urine since 5 p.m.—indicating that she had been slowly bleeding out for two hours.[43] Dr. Naim was alerted again, but still did not come back to check on Dixon.[44]

The next steps followed at an eerily slow, steady pace. Between 7:35 p.m. and 8:01 p.m., more labs were reported that indicated even higher abnormal levels in her vitals.[45] Another physician, Dr. Sara Churchill, visited Dixon and her husband, noting that she still was not producing urine despite having been given fluids.[46] Dr. Naim finally made his way to the bedside at 8:47 p.m. and proceeded to examine Dixon.[47] He was aware that the symptoms Dixon had were indicative of a hematoma.[48] At 10:55 p.m., a member of the nursing staff informed the physicians that Dixon's blood pressure was low. The team changed her blood-pressure cuff, and her blood pressure was still low.[49] At 11:25 p.m., Dr. Naim was alerted that Dixon might be hemorrhaging.[50] Surgical consent was

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37. *Id.* at 3.

38. NCI Dictionary of Cancer Terms, NAT'L CANCER INST. (2011), https://www.cancer.gov/publications/dictionaries/cancer-terms (last visited July 31, 2021).

39. *Complaint for Damages for Wrongful Death and Negligent Infliction of Emotional Distress*, *supra* note 36, at 3.

40. *Id.* at 4.

41. *Id.*

42. *Id.* at 5.

43. *Id.*

44. *Id.*

45. *Id.* at 5–6.

46. *Id.* at 6.

47. *Id.*

48. *Id.*

49. *Id.* at 7.

50. *Id.*

given at 11:30 p.m. By 11:42 p.m., Dr. Churchill and Dr. Sharma were at Dixon's bedside, and she expressed that she felt "more groggy than before."[51] Another ultrasound was performed, and free flowing blood was found in her abdominal region.[52] Dixon was taken to surgery at 12:30 a.m. with three liters of blood in her abdomen and died on the operating table at 2:22 a.m. on April 13, 2016.[53] The CAT scan that was requested six hours earlier was never performed.[54]

Johnson, like the McMath-Winkfield-Chatman family, also brought a NIED claim. He alleged that he was present with his wife from the moment she was admitted to the moment she was brought into her final surgery.[55] He sat next to the bedside and near where her urine and, later, blood drained. He witnessed all of the steps between the birth of their son and her death. He discussed treatment options with his wife while she was in pain and watched her grow pale as she hemorrhaged over a seven-hour period.[56] He repeatedly asked the medical staff why more was not being done to keep his wife from deteriorating and why the CAT scan was not being performed.[57] Johnson was very aware that his wife was in pain and was deteriorating with each passing hour.[58] To quote the complaint,

> Plaintiff Charles Johnson, IV did suffer serious and severe emotional disturbance, distress and shock and injury to his nervous system, all of which has caused, and continues to cause, and will cause in the future, serious mental and emotional suffering, in an amount in excess of the minimum jurisdiction of this court.[59]

Currently *Johnson v. Cedars-Sinai Medical Center* is pending.[60] However, Johnson testified before Congress in 2018 about the perils of Black women giving birth in the United States and the need to rectify the disparities in maternal mortality.[61]

Jahi McMath and Kyira Dixon had very different conditions, were in different stages of their lives, and were from different parts of the Southern California region. However, they died with a similar and glaring theme: casualness from the physicians that cared for them and an unwillingness of the

51. *Id.*
52. *Id.*
53. *Id.* at 8.
54. *Id.* at 7.
55. *Id.* at 16–17.
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.* at 18.
60. Johnson v. Cedars-Sinai Medical Center, No. BC 655107 (Cal. Super. Ct. 2017), http://www.lacourt.org/casesummary/ui/casesummary.aspx?casetype=civil.
61. Johnson, IV, *supra* note 32, at 12.

medical teams to listen to their families. Although tragic, it is not surprising. Black Americans were not brought to this country with the intention of being integrated into the healthcare system. The residual effects of them seeking out care in a space that was not designed for them has led to these types of outcomes. The third part of this Article will examine the history that brought the United States healthcare system to this point.

II. A Brief History of Disparities and Casual Treatment of Black Patients

The law has not developed a comprehensive way to address implicit bias in medical malpractice. Implicit bias and principles of nondiscrimination have not been integrated in the standard of care, which is critical for establishing legal standards for patients seeking relief through medical malpractice suits.[62] This may be because many believe that treating patients in a discriminatory manner is so obviously egregious that it does not need to be said. However, implicit and explicit racial bias have always been a feature of the medical profession and still are today. This section aims to give a brief history of this dynamic.

Health disparities between White and Black Americans span from the conception of the colonies to the Covid-19 pandemic. Our nation has seen everything from slaves as victims of medical experimentation to Black Americans dying from Covid-19 at disproportionate rates.[63] An unwillingness to listen to Black American patients has also consistently existed throughout history. Initially, this was a purposeful choice. Before enslaved Africans were even brought onto slave ships, they were handled with no decency. They were frequently victims of malnutrition, horrific sanitation conditions, constant lacerations from shackles and ropes, and extreme psychological trauma.[64] Once in the Middle Passage, slaves spent six months to a year shackled to each other, in what was effectively a crawl space, while being shipped to the Americas.[65] The holds beneath the decks were rampant with disease due to the poor sanitation, the consistent death of slaves shackled together, and abysmal nutrition.[66] In an effort to hide their condition before sale, the enslaved Africans were forced above deck to dance.[67] One in eight enslaved Africans died in the

62. Marcia Boumil & Paul Hattis, Medical Liability in a Nutshell 43 (4th ed. 2017).

63. Rajiv Sethi, Divya Siddarth, Nia Johnson, Brandon Terry, Julie Seager, Mary Travis Bassett & Merideth Rosenthal, *Who is Dying and Why? COVID-19 Rapid Response Impact Initiative* 9 (2020), https://ethics.harvard.edu/files/center-for-ethics/files/19cwhoisdying.pdf (last visited July 31, 2021); *See generally* Keith Wailoo, *Historical Aspects of Race and Medicine: The Case of J. Marion Sims*, 320 JAMA 1529–30 (2018).

64. Sowande M. Mustakeem, Slavery at Sea: Terror, Sex, and Sickness in the Middle Passage 56–57 (2016).

65. *Middle Passage, Definition, Conditions, Significance, & Facts*, Britannica, https://www.britannica.com/topic/Middle-Passage-slave-trade (last visited July 31, 2021).

66. *Id.*

67. *Id.*

Middle Passage, largely because of the terrible conditions on the ships.[68] In fact, the poor condition of slaves brought through the Middle Passage was so widely known that it was not uncommon for those interested in purchasing slaves to be wary that the condition of slaves were different than advertised.[69]

Once brought to the United States, slaves were largely ignored by physicians, except when it had to do with their value as property. Although the Antebellum southern United States was a generally unhealthy region for both Whites and Blacks, it was not unusual for a slave to be considered useless if they were in poor health.[70] A physician was hired to examine slaves in these three general instances: to evaluate the market value of the slave upon purchase or legal dispute, for medical experimentation purposes, and, occasionally, to see a slave that was sick.[71] Unless medical care was coming from homeopathic slave healers and other community leaders,[72] medical care functioned as a way for physicians to profit off of medical advancement made at the expense of slaves or as a method for masters to make sure that the bare minimum was done to keep their slaves alive.[73]

The use of medicine as a mechanism of capitalism and selfishness by White slaveholders and doctors bred suspicion and distrust of White physicians in Black Americans.[74] However, the Reconstruction Era forced former slaves and other freedmen to attempt to engage with Western medicine.[75] This infrastructural shift of medicine that occurred after the Civil War took newly freed slaves from the plantations that held them in bondage, but also forced them to find White physicians instead of using homeopathic slave healers.[76] Healers were rarely certified by medical licensing entities, which forced them outside of the mainstream medical market, or the medical market in general.[77] The medicine of traditional slave healers was considered witchcraft and

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68. Chudi Zhong, Daisy Zhan, Ethan Czerniecki, *Remembering the Middle Passage*, DUKE UNIV. 1, 3 (2019), https://bigdata.duke.edu/sites/bigdata.duke.edu/files/site-images/Team3ExecutiveSummarySlides.pdf.

69. MUSTAKEEM, *supra* note 64, at 57–58.

70. *See* Waddill v. Chamberlayne, 1735 Va. LEXIS 3 (Apr. 1, 1735) (A case involving a slave that was considered worthless because they had an incurable illness); McCeney v. Duvall, 21 Md. 166, 168, 170 (Ct. App. Md. 1864) (A case that considered a slave of no value because she had a prolapsed uterus); HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT 26 (2008).

71. McCeney v. Duvall at 172; WASHINGTON, *supra* note 70, at 25, 30–31.

72. WASHINGTON, *supra* note 70, at 48.

73. TODD L. SAVITT, MEDICINE AND SLAVERY: THE DISEASES AND HEALTH CARE OF BLACKS IN ANTEBELLUM VIRGINIA 149, 293–301 (1981).

74. WASHINGTON, *supra* note 70, at 48.

75. Cheryl A. Wells, *Sick from Freedom: African-American Illness and Suffering during the Civil War and Reconstruction by Jim Downs, and: Doctoring Freedom: The Politics of African American Medical Care in Slavery and Emancipation by Gretchen Long*, 60 CIV. WAR HIST. n.2 192, 193 (2014) (book review).

76. *Id.* at 194.

77. GRETCHEN LONG, DOCTORING FREEDOM: THE POLITICS OF AFRICAN AMERICAN MEDICAL CARE IN SLAVERY AND EMANCIPATION 126 (Reprint ed. 2016).

superstition.[78] Also, many of these individuals struggled with minimal literacy, which hindered their ability not only to apply for licensure, but to advocate for themselves.[79] Healers who practiced this necessary form of medicine were expected to "join the 'better classes' of African Americans who supported the [medical] Bureau and its activities."[80] However, even those "better classes" who engaged in what was considered legitimate medicine faced immense hurdles to enter the profession. Centralized medicine also negatively impacted Black physicians. Black physicians who entered the profession through formal channels found themselves shunned by White physicians who refused to acknowledge their status as equals.[81] Additionally, power started shifting into the hands of new organizations, such as the American Medical Association, and these organizations excluded African Americans well past the Reconstruction Era.[82]

By the Civil Rights Era, hospital segregation had become the most common way to maintain White supremacy in healthcare. Hospitals were segregated well before this point in history, but Jim Crow laws and oppressive norms made sure that Black Americans understood that they would not be able to receive equal care in the United States. Although *Plessy v. Ferguson* stated that separate but equal facilities for Black Americans was the law of the land,[83] it was very clear that hospital spaces for Black Americans were not equal. Black Americans were routinely housed in the boiler rooms of hospitals and were not assessed as often as White patients.[84] Even when Black patients received treatment, they received worse care than White patients; hospital personnel treated them as if they were second-class patients.[85] Black male and female patients were forced to use the same restrooms, even though White male and female patients had separate restrooms. Black women even gave birth in elevators in segregated hospitals.[86]

Entities such as the American Medical Association continued to work to delegitimize Black physicians. This directly hurt the Black providers by keeping them from gaining hospital employment, not only hindering them from working with Black patient populations in segregated hospitals, but also by functionally

78. *Id.*

79. *Id.* at 116.

80. *Id.* at 126.

81. *Id.* at 129–130, 137.

82. *Id.* at 130, 136–137.

83. Plessy v. Ferguson, 163 U.S. 537 (1896).

84. Jeff Kunerth, *AMA Apologizes for Racist Past*, ORLANDO SENTINEL, https://www.orlandosentinel.com/news/os-xpm-2008-07-11-ama11-story.html (last visited July 31, 2021); Brent Staples, *Traveling While Black: The Green Book's Black History*, N.Y. TIMES (Jan. 25, 2019), https://www.nytimes.com/2019/01/25/opinion/green-book-black-travel.html (last visited July 31, 2021).

85. *See id.*

86. *See* CAN I GET A WITNESS?: THIRTEEN PEACEMAKERS, COMMUNITY-BUILDERS, AND AGITATORS FOR FAITH AND JUSTICE (Charles Marsh, Shea Tuttle & Daniel P. Rhodes, eds. 2019); Kunerth, *AMA Apologizes for Racist Past,* ORLANDO SENTINEL, https://www.orlandosentinel.com/news/os-xpm-2008-07-11-ama11-story.html.

encouraging White patients to falsely believe that Black providers did not have comparable training compared to White physicians.[87] For 350 years, White physicians were not required to treat Black patients at all. In fact, they were allowed to ignore and exploit Black patients for most of history.[88] The passage of the Civil Rights Act of 1964 and the Medicare and Medicaid legislation of 1966 made these practices illegal by tying the threat of removing federal funding to discriminatory practices.[89]

Almost sixty years after the desegregation of hospitals, one would think that this shameful legacy would have worked its way out of the medical profession. Sadly, this is not the case. Across the board, Black Americans are 1.16 times more likely to die from ailments and accidents than White Americans.[90] Black Americans are 1.22 times more likely to die from heart disease and 1.72 times more likely to die from hypertension.[91] According to the National Healthcare Quality and Disparities Report, Black Americans received worse care than White Americans when compared across forty percent of healthcare quality measures.[92] This is relative to Black Americans receiving better care than White Americans in only fifteen percent of quality measures. In addition, multiple research studies have shown that Black patients are less likely to receive care that is comparable to the care received by White Americans.[93] Black Americans are also more likely to be hospitalized for asthma, with 220.8 Black children admitted to the hospital for asthma per 100,000 compared to 45.9 White children per 100,000 cases.[94] Black women also have pregnancy-related deaths that are over three times higher than White women.[95] Even with a college education or more, Black women have a five times higher pregnancy-related mortality rate compared to White women.[96] In recent studies surveying Black American opinions on healthcare, just under one-third of Black Americans

87. *The History of African Americans and Organized Medicine*, AM. MED. ASS'N (last visited July 31, 2021), https://www.ama-assn.org/about/ama-history/history-african-americans-and-organized-medicine.

88. *The 1619 Project*, N.Y. TIMES (last visited July 31, 2021), https://www.nytimes.com/interactive/2019/08/14/magazine/1619-america-slavery.html.

89. DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 137 (4th ed. 2002).

90. Marilyn S. Nanney, Samuel L. Myers, Jr., Man Xu, Kateryna Kent, Thomas Durfee & Michele L. Allen, *The Economic Benefits of Reducing Racial Disparities in Health: The Case of Minnesota*, 16 INT'L J. ENV'T. RES. PUB. HEALTH 742, 742 (2019).

91. *Id.*

92. AGENCY FOR HEALTHCARE RESEARCH AND EQUALITY, 2018 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 71–79 (2019).

93. Hoffman et al., *supra* note 1, at 4298.

94. AGENCY FOR HEALTHCARE RESEARCH AND EQUALITY, *supra* note 92, at 71–79.

95. SAMANTHA ARTIGA, OLIVIA PHAM, KENDAL ORGERA & USHA RANJI, RACIAL DISPARITIES IN MATERNAL AND INFANT HEALTH: AN OVERVIEW, ISSUE BRIEF: KAISER FAMILY FOUNDATION (2020), https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief.

96. *Id.*

reported "experiencing discrimination in clinical encounters."[97] Furthermore, twenty-two percent "avoided seeking health care for themselves or family members due to anticipated discrimination."[98] Black patients are less likely to receive newer and more innovative treatments for cardiovascular diseases compared to White patients.[99] It has also been proven that in many settings physicians rely on race and bias to make clinical decisions.[100] Black patients are less likely to receive surgeries they need, are coerced into more expensive surgeries more often, and are often undertreated for pain.[101] Even Black infants are at risk, with Black babies being more likely to die when cared for by non-Black providers.[102]

The coronavirus pandemic has created one of the starkest reckonings for the United States' failures in mitigating health disparities between Black Americans and White Americans. In all states, Black Americans are dying of Covid-19 at rates unequal to their share of the population, regardless of income.[103] This is compared to Latinx Americans who, based on available Covid-19 data, are only dying at rates equal to their share of the population in New York.[104] Thirty-one percent of Black Americans have stated that they know someone who has tested positive for Covid-19, compared to twenty-one percent of White Americans.[105] Twenty-four percent of Black Americans know someone who has died from Covid-19, compared to only ten percent of White Americans. [106] And though one would hope that Black Americans were spared the troubling pattern of physicians ignoring Black patients, they were not. Dr. Susan Moore, an Indianapolis physician, gave a troubling account on her Facebook page of how she had to "beg for proper medical care" after testing positive for Covid-19.[107] She repeatedly asked for pain medication from her physician at Indiana University Health North Hospital, and she was repeatedly denied access to it.[108] She stated that her physician ignored symptoms and simply said, "[y]ou're not even short of breath."[109] She was even denied access

97. Sara N. Bleich, Mary G. Findling, Logan S. Casey, Robert J. Blendon, John Benson, Gillian K. SteelFisher, Justin M. Sayde & Carolyn Miller, *Discrimination in the United States: Experiences of Black Americans*, 54 HEALTH SERV. RES. 1399, 1399 (2019).

98. *Id.*

99. MATTHEW, *supra* note 7, at 58.

100. *Id.* at 58; *See* Chapman et al., *supra* note 7; *See* Hoffman et al., *supra* note 1.

101. MATTHEW, *supra* note 7, at 60; Somashekhar, *supra* note 7.

102. MATTHEW, *supra* note 7, at 60.

103. Sethi et al., *supra* note, at 63.

104. *Id.*

105. THE ECONOMIST & YOUGOV, JUNE 21–23, 2020 - 1500 US ADULT CITIZENS 58 (2020), https://docs.cdn.yougov.com/cjd35jrh5o/econTabReport.pdf (last visited July 31, 2021).

106. *Id.* at 60.

107. Stefan Sykes, *Black Physician's Covid-19 Death Demonstrates Bias of U.S. Health Care System, Peers Say*, NBC NEWS (Dec. 28, 2020, 2:43 PM), https://www.nbcnews.com/news/us-news/black-physician-s-covid-19-death-demonstrates-bias-u-s-n1252290.

108. CNN, *supra* note 2.

109. *Id.*

to remdesivir, an antiviral drug used to treat hospitalized Covid-19 patients.[110] She was later discharged from Indianapolis University Health North Hospital but was readmitted to a different hospital twelve hours later.[111] She died soon afterwards.[112]

The American medical system is not as far removed from racist medicine as we might hope. Though the eugenics movement that promoted biological differences in Black Americans was hundreds of years ago, some of those principles are present in the minds of medical school students today.[113] In a profession that provided enough discretion to physicians to put Black patients into a hospital basement instead of a treatment room, we ought not be surprised that that same discretion—combined with silent stereotypes ingrained in American society—could lead to Black Americans receiving disparate treatment. The idea that we have come so far that we do not need to question whether implicit bias can rear its ugly head in the midst of care is unfounded. This could be naturally assumed based on the medical profession's history with racialized medicine, the intentional hampering of Black American health, and other grievances. But if it was not enough, we can see through the data that Black American patients experience worse outcomes and treatment in hospitals, nursing homes, and other healthcare facilities.[114] The United States has never been good at completely cleansing individuals of their racist tendencies, as we can see in the research above. Though these institutions may not have intentionally perpetuated racist ideas, they are hiring or already have hired providers with underlying racist views. It is one thing for these individuals to have these views in their private lives, but allowing for these biases to interfere with the care of their patients is unacceptable. However, using the law as a viable weapon against racism in healthcare could help make providers more aware of when they are leaning on racial biases to make medical decisions and encourage healthcare entities to dedicate more of their resources into preventing these types of mistakes. Furthermore, making providers fully engaged with the consequences of their biases would, hopefully, force them to actively consider their own prejudices in providing care.

110. *Id.*

111. CNN, *supra* note 2.

112. *Id.*

113. Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L. ACAD. SCI. U.S.A. 4296, 4298–4300 (2016).

114. *See infra* at 1684–85.

III. PENALIZING IMPLICIT BIAS AS A FORM OF NEGLIGENCE

A. TORT LAW, MEDICAL MALPRACTICE, AND RACE

Regarding race and tort law scholarship, Richard Delgado's *Words That Wound: A Tort Action for Racial Insults, Epithets, and Name-Calling* argues that a separate tort is required for racial insults.[115] He states that psychological damage can come from racial insults, making it difficult for victims of said insults to connect with loved ones, to experience race-neutral interactions with others, and in some cases, can lead to mental illness.[116] Delgado also finds multiple cases where intentional infliction of emotional distress claims were successful when dealing with racialized language.[117] However, none of these cases rely on the explicit impact of racial insults; they either focus on protecting the employee-employer relationship or are built on more obscure legal theories or statutes.[118] He emphasizes that there are other important cases where the racial insult was not considered severe enough and did not succeed in court.[119] Delgado argues that because determining what is considered "severe" is up to the court's discretion, the intentional infliction of emotional distress claims are often inadequate.[120] He also states that the "courts generally have not recognized the gravity of racial insults within the rubric of the tort of intentional infliction of emotional distress."[121]

Camille Nelson's *Considering Tortious Racism* also gives valuable insight about the impact of racism on mental health and how the tort system could remedy this issue. Nelson argues that the law privileges intent and not impact.[122] This puts a Black plaintiff suing for a racialized tort offense at a disadvantage from the beginning because many discriminatory offences at this stage of history can be categorized as unintentional. Nelson also states that in order to experience true equality and compensation for Black Americans, one must start with "revisiting traditional, even archaic, legal principles with equality-seeking norms in mind."[123] She uses the Thin-Skull plaintiff and the Eggshell personality to explore ways to use the negligence framework for addressing racialized torts.[124] Like Delgado, Nelson argues that the consequences of racism can lead to mental illness and cites psychologists' accounts and scientific studies to

115. *See generally* Richard Delgado, *Words That Wound: A Tort Action for Racial Insults, Epithets, and Name-Calling*, 17 HARV. C. R.-C. L. L. REV. 133 (1982).
116. *Id.* at 137.
117. *Id.* at 155.
118. *Id.* at 153–55.
119. *Id.* at 155.
120. *Id.* at 156.
121. Delgado, *supra* note 115, at 157.
122. Camille A. Nelson, *Considering Tortious Racism*, 9 DEPAUL J. HEALTH CARE L. 905, 908 (2005).
123. *Id.* at 909.
124. *Id.*

support her claim.[125] She reminds us that "[i]nstances of racialized abuse leave long-lasting mental scars, which are seldom recognized by the legal system."[126] She also frames her negligence analysis within the definition of risk, stating that shifting to a negligence model that addresses the risk of engaging in racist behavior relieves the Black plaintiff of proving the intent of the defendant.[127] Negligence solely focuses on the conduct and outcome of the action, an appropriate approach for addressing racialized torts.[128]

Civil rights laws do apply in hospital settings and have been successful in healthcare settings in some specific areas: desegregation cases (de facto and de jure), discrimination against a patient, and discriminatory policies against Medicaid patients.[129] A successful discrimination case was *Atakpa v. Perimeter OB-GYN Associates*, in which a Nigerian immigrant was required to take an HIV test as a prerequisite for prenatal care.[130] This procedure was not required for non-African patients, thus allowing the plaintiff to bring a Title IV claim.[131] Though these victories are important, they mostly focus directly on policy and state action; they do not focus on the actions of providers. Even in *Atakpa*, the plaintiff was able to prove an affirmative action by a physician.[132] However, the issue that is unaddressed is passive action, when providers are not brazen enough to openly discriminate but may do so privately.

The Covid-19 pandemic has modified most medical malpractice laws in the United States.[133] Almost all of the states have laws protecting hospitals and healthcare providers from liability during public health emergencies.[134] Thirty-four states have provided civil liability protections for providers giving emergency care, with sixteen of those states passing laws specifically referring to the Covid-19 pandemic.[135] Some states have extended protections to nursing homes as well.[136] Although these protections are critical during a time when hospitals are overrun and struggling to cope with the Covid-19 pandemic, it has created limited recourse for patients and their families.[137] For example, a Black

125. Nelson, *supra* note 123, at 919, 921.

126. *Id.* at 920.

127. *Id.* at 941.

128. *Id.* at 941–42.

129. Dayna Bowen Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 DEPAUL J. HEALTH CARE L. 793, 808–09, 811, 812 (2005).

130. *Id.* at 811.

131. *Id.*

132. *Id.*

133. Valerie Gutmann Koch, *How States are Protecting Health Care Providers from Legal Liability in the COVID-19 Pandemic*, BILL OF HEALTH (May 5, 2020), http://blog.petrieflom.law.harvard.edu/2020/05/05/legal-liability-health-care-covid19-coronavirus-pandemic.

134. *Id.*

135. Koch, *supra* note 133.

136. Sean Campbell, *The Nursing Home Didn't Send Her to the Hospital, and She Died*, PROPUBLICA, https://www.propublica.org/article/the-nursing-home-didnt-send-her-to-the-hospital-and-she-died?token=TX9NklTTWeUexijRZs27SMb0Jb7olHMX (last visited July 31, 2021).

137. *Id.*

woman named Palestine Howe experienced infected bedsores in a nursing home in North Carolina.[138] Her daughters repeatedly asked for her to be admitted to a hospital, but she ultimately died at her nursing home.[139] Due to the Covid-19 medical malpractice legislation, Palestine's family is unable to pursue a case against the nursing home.[140] These laws are being passed during emergency conditions and we do not yet know the impact they will have on patients. However, it is worth examining how these laws will impact patients, especially if the pandemic does not subside by 2021.

Regarding the NIED claim, Restatement Third of Torts states that an individual is liable for negligent conduct that causes serious emotional harm to another when it "places the other in danger of immediate bodily harm and the emotional harm results from the danger" or "occurs in the course of specified categories of activities, undertakings, or relationships in which negligent conduct is especially likely to cause serious emotional harm."[141] There are also available claims described in Section 48 of the Restatement Third when emotional harm befalls an individual who experienced bodily harm.[142] The argument in this Article could even extend to an individual who was physically injured under similar circumstances. NIED claims are most viable when an individual has experienced physical harm due to another individual's reckless actions.[143]

NIED claims generally exist within the negligence framework and are designed to be a mechanism that acknowledges that "damages for severe emotional distress may be recovered 'when they result from the breach of a duty owed the plaintiff that is assumed by the defendant or imposed on the defendant as a matter of law, or that arises out of a special relationship between the two.'" [144] However, NIED claims have met resistance from their inception. Courts were wary of awarding damages for emotional injury because they did not want "fraudulent" or "frivolous" claims to enter the court.[145] As a practical matter, emotional injury is also very difficult to measure when calculating damages.[146] There are also concerns that NIED is unfair to defendants, in that defendants are forced to incur the financial burden of consequences that are arguably separate from the negligent act.[147] Frequent reasons for the dismissal of NIED claims are

138. *Id.*
139. *Id.*
140. *Id.*
141. RESTATEMENT (THIRD) OF TORTS § 47 (Am. Law Inst. 2012).
142. *Id.* § 48.
143. *Id.* § 47.
144. Christensen v. Superior Court, 54 Cal. 3d 868, 890 (1991) (quoting Marlene F. v. Affiliated Psychiatric Medical Clinic, Inc., 48 Cal. 3d 583, 590 (1989)).
145. John J. Kircher, *The Four Faces of Tort Law: Liability for Emotional Harm*, 90 MARQUETTE L. REV. 789, 808 (2006).
146. *Id.*
147. *Id.*

statutory requirements for the claim not being met, that the individual did not display enough emotional distress, or that a family member was not close enough to the victim.[148] A type of medical malpractice case that has actually been successful in moving NIED claims through the courts is from individuals who were misdiagnosed with HIV by a provider.[149]

Another example of a case that has been successful with similar facts to both *Spears* and *Johnson* is *Henderson v. Vanderbilt University*, where a family alleged that the emotional distress they suffered as a result of their daughter's medical team's negligence amounted to an NIED claim.[150] The plaintiffs alleged that they experienced extreme emotional distress due to "Vanderbilt's failure to appropriately treat the child's shock [which] caused a chain reaction that ultimately led to the child's stroke and death," thus invoking the legitimacy of the NIED claim.[151] However, the case involves a White family and a White patient, and naturally does not allege race as an issue here. Racialized negligence is rarely the platform used in NIED cases. This is not to say that Black Americans are not bringing NIED claims, but many claims do not rest on issues of race or discrimination as a cause for NIED. When issues of race are alleged in an NIED claim as the reason for the negligent treatment, even outside of the medical malpractice context, the claim tends to fail.[152]

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148. Finnegan v. Patients Comp. Fund, 263 Wis. 2d 574, 595 (2003); Greene v. Esplanade Venture P'ship, 172 A.D.3d 1013, 1016 (2019); Squeo v. Norwalk Hosp. Ass'n, 316 Conn. 558, 599–600 (2015).

149. *See* Hedgepeth v. Whitman Walker Clinic, 22 A.3d 789, 820 (D.C. 2011); Estate of Amos v. Vanderbilt Univ., 62 S.W.3d 133, 139 (Tenn. 2001).

150. Henderson v. Vanderbilt Univ., 534 S.W.3d 426, 428 (Tenn. Ct. App. 2017). Rodney and Tammy Henderson alleged that Vanderbilt University's Pediatric Intensive Care Unit undertreated their 10-year-old daughter, Halle, for flu-related septic shock. *Id.* at 427. Though the hospital staff did give Halley fluids and medication, they did not place a central line, perform an echocardiogram, or call for a cardiology consult. *Id.* at 427–28. After repeatedly asking the hospital staff for a cardiology consult for their daughter during the twelve hours that she was under Vanderbilt's care, Halle went into cardiac arrest. *Id.* at 428. Halle was then diagnosed with brain death. *Id.* The events leading to her brain death were directly witnessed by her mother, who was present in the room when she went into cardiac arrest, and indirectly witnessed by her father, who ran into the room when he heard his wife screaming and her child's machine's sounding. *Id.* Tammy Henderson had to take four Xanax per day to manage her depression and anxiety after the death of her child. *Id.* She attempted to end her life twice and stopped participating in social activities. *Id.* at 428–29. The Henderson court stated that the purpose of an NIED claim is to allow for the plaintiff "to recover for emotional injuries that result from another's negligence." *Id.* at 432. The court clarified that NIED claims in Tennessee fall into two categories: 1) "Ramsey-type claims," citing analysis from *Ramsey v. Beaver*, where a bystander witnesses the event while it is happening, and 2) "Eskin-type claims," citing analysis from *Eskin v. Bartee*, where the bystander witnesses the event after it had occurred. *Id.* at 438. The court agreed with the plaintiffs that witnessing multiple events of failed medical care satisfied the *Ramsey* standard. *Id.* at 438–39. They acknowledged that the negligence was not "sudden" like many other NIED claims, but that the suddenness of an event does not determine the plaintiff's ability to recover for the negligence. *Id.* at 440–43. Furthermore, the court addressed that prior Tennessee case law has always allowed for medical negligence to be the originating tort for NIED claims, and that allowing for Vanderbilt to invite the state to adopt a sweeping rule that disallows NIED claims based on medical negligence would be inappropriate. *Id.* at 440, 448–50.

151. *Id.* at 429.

152. *See generally* Dilworth v. Goldberg, 914 F. Supp. 2d 433 (S.D.N.Y. 2012) (A Black, incarcerated individual brought a claim of negligent infliction of emotional distress against prison guards that allegedly denied

I would argue that NIED is one of the most efficient places to start to acknowledge the role of implicit racial bias in medicine. The viability of NIED claims depends on negligence, especially in the context of racial biases because it is inherently negligent for a provider to give treatment based on their own biases, if that can be proven. To start, tort law and negligence claims rely on the relationship between the plaintiff, defendant, and risk. Tort law works to shield individuals from risky behaviors of those who owe them a duty and deter individuals who owe a duty to others from engaging in unreasonably risky behavior.[153] If a physician tunes out their patients because of the color of their skin, that is even more egregious. Furthermore, the standard of care should not only encompass medical treatments that patients are given, and the time needed to administer the treatments, but also avoiding implicit bias and casualness with marginalized patients. I would go further and argue that physicians cannot adequately engage with their duty effectively without listening to the concerns of their patients. Patients expect their physicians to listen to them and find that to be a hallmark of a competent provider.[154] If physicians are selectively listening to their patients or leaning on their biases to determine which patient gets their listening ear, that kind of behavior should be considered a breach of their duty to the patient. The very nature of the body requires that a physician listen to a patient tell them what feels or is wrong. I would argue that is where the duty to the patient starts. Once a physician starts tuning out their patients, they have fallen over the line into legal negligence. The negligence claim itself is designed to account for injuries that are not intentional but that result from the risky behavior of the defendant. Engaging in bias may be accidental, but it comes

him care, was beaten by other inmates at the request of the guards after needing medical care, and called him racial epithets. He also alleged that New York Medical Center failed to provide him care and were not trained to recognize abuse and worsening conditions of inmates, though they were contracted to provide care to individuals at this facility); Carthan v. Snyder (In re Flint Water Cases), 329 F. Supp. 3d 369 (E.D. Mich. 2018) (relying on the rationale of *Daley v. La Croix*, 384 Mich. 4, 179 N.W.2d 390 (1970) (Residents affected by the Flint Water Crisis brought a negligent infliction of emotional distress claim against the engineering companies that facilitated running the lead-tainted water from the Flint River to their homes); Swanson v. City of New York, 2017 U.S. Dist. LEXIS 114071 (E.D.N.Y. 2017) (A Black, incarcerated individual brought a negligent infliction of emotional distress claim alleging that he was denied adequate care, subjected to cruel and unusual punishment, did not receive the standard of care for his condition, and the medical employees that treated him at George Mitcham Detention Center were not trained or supervised appropriately); Freeman v. United States, 2014 U.S. Dist. LEXIS 37801 (N.D. Cal. 2014) (A Black patient brought a negligent infliction of emotional distress claim against San Francisco Veteran Administration Medical Center alleging that he was not warned about all of the risks of his surgery, that the head nurse where he was receiving care implied that Black patients were not allowed in her unit, and that said nurse yelled at him to "shut up" while he was yelling out in pain from surgery complications).

153. Stephen Perry*, Torts, Rights, and Risk*, *in* PHILOSOPHICAL FOUNDATIONS OF THE LAW OF TORTS, 51–52 (John Oberdiek ed., 2014).

154. Justin Jagosh, Joseph Donald Boudreau, Yvonne Steinart, Mary Ellen MacDonald & Lois Ingram, *The Importance of Physician Listening from the Patients' Perspective: Enhancing Diagnosis, Healing, and the Doctor-Patient Relationship*, 85 Patient Educ. Couns. 369, 369 (2011).

at a very high cost—it is risky. And if the cost is life or death, then the law should consider more serious measures.

B. Addressing Racialized Implicit Bias in the Negligent Infliction of Emotional Distress Claim

In both *Spears* and *Johnson*, the plaintiffs brought claims of NIED to address the impact of watching their loved one die before their eyes, due to negligence.[155] However, neither party cited race in their legal proceedings as the reason for the negligent care.[156] This is understandable because, as we know from previous analysis, NIED is rarely successful when tied to race.[157] But if race is tied to disparate treatment, it is worth exploring a legal framework for protecting Black patients. Sometimes it is easy to dismiss NIED as a minimal or frivolous claim, but it could be a useful way to approach this issue.

Suppose we lived in a country where health disparities were well-documented, the data regarding discrimination against non-White patients was fully accounted for, and the pleas of Black patients were taken seriously enough to reform the legal system. Health disparities would not only be documented by government agencies but would be gathered by hospitals themselves and analyzed through patient satisfaction and community surveys. Narratives of Black patients would, again, be taken seriously. Dr. Susan Moore's disbelief at a White physician telling her, "you aren't even short of breath," and the patient insisting, "yes I am," would be viewed as foul play.[158] Kyira Dixon anxiously saying to her husband for hours, "Charles, I feel so cold; Charles, I don't feel right" without a member of her medical team coming to check on her would be a red flag in how we practice medicine.[159] Jahi McMath's mother stating with despair, "[N]o one was listening to us, and I can't prove it, but I feel in my heart: if Jahi was a little white girl, I feel we would have gotten a little more help and attention," and her grandmother saying that Jahi's healthcare provider treated them like, "he thought we [they] were dirt," would be deeply alarming.[160] And yet, though it would be alarming, it would not be surprising considering the history the United States has with treating Black patients poorly and contemporary data showing that even medical students hold false biological ideas about Black Americans.[161] We would be aware that this behavior presents itself early in medical training and has grave consequences for Black Americans.

155. *Plaintiff's Complaint for Damages for Medical Malpractice*, *supra* note 8, at 10; *Complaint for Damages for Wrongful Death and Negligent Infliction of Emotional Distress*, *supra* note 36, at 14.

156. *Plaintiff's Complaint for Damages for Medical Malpractice*, *supra* note 8, at 10; *Complaint for Damages for Wrongful Death and Negligent Infliction of Emotional Distress*, *supra* note 36, at 14.

157. *See infra* Part III.A.

158. Adone, *supra* note 2.

159. Charles Johnson IV, *supra* note 32, at 3.

160. Aviv, *supra* note 24.

161. *See generally* Hoffman et al., *supra* note 1, at 4296.

We would also desire a more compassionate and accurate system as we strive to provide equitable care.

How could one use the tort law system to address the emotional trauma that Black patients experience when they are not listened to? One could use the intentional infliction of emotional distress claim. However, the average provider would argue that they were not using racial slurs or other language typically found in intentional infliction of emotional distress cases involving race. They would also argue that they were not intentionally ignoring Black patients to create emotional distress for them or their families. However, negligent tort law could be an avenue for solving this problem. Negligent tort law would not only allow for the law to acknowledge that there was a grave injustice but would also start to encompass the nuances of implicit bias. NIED presents an opportunity, although at this stage it could be perceived as imperfect because it needs more exploration. Medical malpractice as a whole has heavily relied on physical manifestations: surgeries on the wrong body part, deaths, or injuries due to careless mistakes, and other manifestations of imperfect practice.[162] However, as the science on mental health and trauma expands, the law will need more nuanced ways to evaluate what the standard of care should be. More study is admittedly needed in this area of NIED and race, but the consequences of not addressing this issue are clear.

The thought experiment above addresses implicit bias and how it is experienced through the Black lens. It also looks to tort law as a potential avenue to address the emotional trauma that Black Americans experience in the healthcare system far too often. Thinking about the intersection of NIED, implicit bias, and how it is experienced through the Black lens is beneficial for practical and substantive reasons. From a practical standpoint, utilizing the NIED claim could be a good place to start because it is treated as a secondary claim. Because it is not a traditional malpractice claim, it may be easier to convince judges and attorneys to incorporate more novel arguments and approaches. If a racialized bias framework works well in NIED claims, it could encourage more courts to implement this framework in more established claims like wrongful death or medical negligence. It is possible that lawmakers could feel hesitant to completely reform current malpractice law to incorporate implicit bias into medical negligence claims. However, asking lawmakers to look at the role of racial bias through the lens of NIED may actually make them feel more comfortable about trying an alternative approach.

From a substantive standpoint, a race-based NIED framework would make a difference in the pursuit of racial equity for three reasons. First, the trauma addressed in a NIED claim is fundamentally applicable when considering the historical and present casualness in the treatment of Black patients. Second, the

162. *See generally* MARCIA MOBILIA BOUMIL & PAUL A. HATTIS, MEDICAL LIABILITY IN A NUTSHELL (4th ed. 2011) (outlining traditional medical malpractice rules and occurrences).

historical carelessness that physicians and the healthcare system have shown Black Americans is well-documented, and this historical context makes deaths like those of Jahi and Kyira even more traumatic to Black Americans than to the average individual.[163] Historical injustices against Black Americans in healthcare have caused long term trauma in Black American communities, and scientists have confirmed that trauma can be genetically passed down to other generations.[164] For most of history legal protections were minimal and, in some cases, nonexistent for Black Americans.[165] This combination of immorality, unethical behavior, and legal fickleness has led to massive cultural trauma for Black Americans in the healthcare area. In *The Trauma of the Routine: Lessons on Cultural Trauma from the Emmett Till Verdict*, the author argues for the expansion of the definition of cultural trauma to not just include events that are unexpected, but rather those that are expected and reconfirm fears that individuals already have.[166] History has consistently confirmed to Black Americans that their lives are not valuable and that their dignity is disposable.[167] Building on this analysis, one could argue that Black communities actually experienced cultural trauma due to racist medicine and a lack of protections throughout history. If this was the constant narrative passed down throughout history, how can one reasonably expect Black Americans to trust any social or regulated service, much less their healthcare or healthcare professional? One probably cannot. A Black family member bringing forth a malpractice suit is not just engaging with the emotional distress from watching their family member die or from being at risk of death themselves. Black Americans are also carrying with them the suspicion that the trend of casual treatment of Black bodies is actually what killed their family member. Families cannot help but wonder if their family member was always going to be in this position—where their advocacy would not make a difference—or if they would be treated like they are less important. The Black malpractice plaintiff is bringing to the courtroom a special type of helplessness—one filled with suspicion, confusion, and pain.

Lastly, utilizing more race-based NIED claims could provide a stronger deterrent for hospitals and healthcare providers, not because physicians are bad

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163. Bleich, *supra* note 97, at 1399; *see also* Yamiche Alcindor et al., *With a History of Abuse in American Medicine, Black Patients Struggle for Equal Access,* PBS NEWSHOUR (Feb. 24, 2021, 6:40 PM), https://www.pbs.org/newshour/show/with-a-history-of-abuse-in-american-medicine-black-patients-struggle-for-equal-access (last visited July 31, 2021).

164. Nagy A. Youssef, Laura Lockwood, Shaoyong Su, Guang Hao & Bart P.F. Rutten, *The Effects of Trauma, with or Without PTSD, on the Transgenerational DNA Methylation Alterations in Human Offsprings*, 8 BRAIN SCI. 83, 4 (2018).

165. *See generally* WASHINGTON, *supra* note 70 (recounting an anthology of Black American medical injustices throughout United States history); REBECCA SKLOOT, THE IMMORTAL LIFE OF HENRIETTA LACKS (2010) (documenting the story of Henrietta Lacks, a Black woman whose cells were used by Johns Hopkins University for experimentation and medical advancement without her consent).

166. Angela Onwuachi-Willig, *The Trauma of the Routine: Lessons on Cultural Trauma from the Emmett Till Verdict*, 34 SOC. THEORY 335, 336 (2016).

167. *See id.* at 342.

people, but because the historical role of Black Americans in the United States' healthcare system was to serve as exploited chattel. And even though much of this has been codified out of explicit existence, one cannot run from their original story. Although we cannot reform the minds of every citizen who has been indoctrinated into racist patterns and behaviors, we can deter them. The reality is that healthcare facilities will use resources to further their institution's agenda. Facilities pay for new equipment, new buildings, trainings for their staff, and many other things. This could encourage healthcare facilities to actually invest in Black lives by prompting hospitals to pour more resources into racial bias elimination training for providers and creating a more compassionate and equitable healthcare system. Furthermore, the Covid-19 pandemic has created the perfect opportunity for the healthcare industry to reform their practices to become fairer and more efficient. By utilizing race-based NIED claims, we can push hospitals and healthcare providers to understand that "implicit" bias is not an excuse. Engaging with a casualness towards Black patients is something to be overcome, and if it cannot be, it will not go unnoticed.

This claim is also important for many racial minorities and marginalized groups. Although this Article addresses the concerns of Black Americans, many other members of racially marginalized or stigmatized health groups could benefit from this shift. There will likely be collective trauma for Latinx communities as we learn more about the involuntary hysterectomies at the southern border, and address the evidence that overweight individuals and smokers are victims of stigma that can affect how they are treated by providers.[168] Many times carrots are appropriate, but sometimes a stick is required to orchestrate change. After all, in many of these experiences, the patient's family has paid the ultimate price—the loss of a loved one simply because their pleas were ignored.

CONCLUSION

In some form, medical error and medical malpractice will always be a part of the legal landscape. No one is perfect in their profession, and there are countless unfortunate incidents. And yet, we are willing to establish a tort system that penalizes a natural part of any profession: mistakes. Why not utilize the current framework to take a stronger and novel stance for relief for Black Americans? Furthermore, the trauma of these families is also a force to be reckoned with and needs to be treated as important. There is something symbolic about bringing a viable claim to court. It is a signal to the plaintiff that their voice

168. Kelly D. Brownell & Rebecca M. Puhl, *Stigmatized Patients' Right to Equal Treatment*, 8 ETHICS J. AMA 298, 299–302 (2006); Elliot Spagat & Jeff Amy, *Democrats to Investigate Forced Surgery Claims in Georgia*, WASH. POST, (Sept. 15, 2020, 5:27 PM), https://www.washingtonpost.com/health/nurse-questions-medical-care-at-immigration-jail-in-georgia/2020/09/14/1eed5708-f701-11ea-85f7-5941188a98cd_story.html; *see also* Strasel v. Seven Hills Ob-Gyn Assoc., 170 Ohio App. 3d 98, 101 (2007).

is being heard and understood. It is also a signal that there is force behind their allegations. Not providing a way to penalize providers for ignoring the voices of their patients trivializes the realities of many Black Americans. It ignores that they are participating in a system that was not designed for them, has excluded them, has taken advantage of them for profit, and will not hesitate to discriminate against them implicitly, even if it leads to the loss of life. This is not a diatribe against mistakes made in the medical profession; no practitioner in any discipline is perfect, and the Covid-19 pandemic has shown us that health providers are our most valuable assets. However, because they are essential to our society, it is important to hold them accountable. This is a cry for accountability when healthcare decisions are made from a biased place. The reality is that these outcomes are not only frequent, but terrifying for Black patients, and have led some to use their voices and platforms to encourage other Black Americans to find other places to receive medical care.[169]

If we want Black Americans to fully engage with the healthcare system, we have to make it safer for them. On principle, they are owed a listening ear and a forum for their concerns because they are members of this nation. Legally, they are owed the same listening ear and forum for their concerns because of civil rights legislation. There is valid historical trauma present between healthcare institutions and Black Americans that warrants additional attention and concern.[170] Furthermore, if we keep glossing over this issue—one that has been constant in the dynamic between Black Americans and the United States healthcare system—the healthcare system will lose credibility as a safe space for an individual to come and get care. And it may not be immediate, but it will be a slow exodus that could lead to greater risk-taking by minority communities in hopes of protecting themselves. The consequences of mistrust are upon us as we speak—Black Americans have elevated rates of Covid-19 vaccine hesitancy compared to other minorities and to White Americans.[171]

The law has a valuable and innovative opportunity here. It can force the healthcare system to actually become a place where all are not just welcome but are safe and heard. It can foster an environment where hospitals train physicians to listen to all of their patients, not just the ones to whom they relate. NIED claims are more than symbolic claims. They are serious opportunities to force accountability on an industry that has historically excluded most marginalized groups in this country. It would also start to move the needle in tort law discourse to address how tort law can provide a means for analyzing Black healthcare trauma, even if imperfect at the moment. There is history that gives context to

169. Khadeen and Devale Ellis, *Literally, Dying To Have A Baby*, DEAD ASS, STITCHER (July 30, 2019), https://www.stitcher.com/s?eid=62910266.

170. *See generally* Nia Johnson & Lance Wahlert, *Urban Bioethics: A Call for the Prestige*, 28 CAMBRIDGE Q. HEALTHCARE ETHICS 509 (2019).

171. Ari Ne'eman, Masha Kuznetsova & Nia Johnson, *COVID-19 and Vaccines: A Longitudinal Analysis by Race/Ethnicity and Gender* (unpublished manuscript).

how traumatizing healthcare has been towards Black Americans; why is this context not brought into the legal analysis that evaluates the seriousness of NIED claims? It is more than emotional disturbance, but rather a confirmation of how unsafe it is to obtain medical care in this country. It is a signal that advocacy is also subject to a racial hierarchy. This prognosis has no place in the future of our healthcare industry. Let us use tort law to help set a new tempo.

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