

## A Patient's Right to Choose is not Always Black and White: Long Term Care Facility Discrimination and the Color of Care

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# **A PATIENT'S RIGHT TO CHOOSE IS NOT ALWAYS BLACK AND WHITE:**

## **LONG TERM CARE FACILITY DISCRIMINATION AND THE COLOR OF CARE**

SARA GRONNINGSATER†

### INTRODUCTION

In recent years, employers in the medical field have been confronted with patients' requests to have a care provider of a specific race. Such requests have put these care providers in a legal and ethical bind, balancing the need to adhere to patient preferences while also protecting care providers' rights under Title VII of the Civil Rights Act of 1964.<sup>1</sup> Health care employers that foster discriminatory practices by patients would violate the rights of their employees under Title VII.<sup>2</sup> Because there is no way for a legal system to remain neutral to "preference formation," it is completely legitimate for the government and the law to attempt to shape

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<sup>1</sup> See Vida Foubister, *Requests By Patients Can Put Doctors in Ethical Bind*, AM. MED. NEWS(2001), <http://www.ama-assn.org/amednews/2001/01/22/prsb0122.htm> (noting that patients' requests for a caregiver on the basis of race are quite common, but the medical field does not have a policy set forth telling physicians how to handle such situations); Andis Robeznieks, *Hospital Apologizes For Complying With Racial Request*, AM. MED. NEWS(2003), <http://www.ama-assn.org/amednews/2003/10/27/prsb1027.htm> (discussing an incident at a Philadelphia based hospital where the hospital complied with a husband's request that only white hospital staff members care for his pregnant wife).

<sup>2</sup> See 42 U.S.C. §§ 2000e-2(a)-(b) (2012) ("(a) Employer practices. It shall be an unlawful employment practice for an employer -- (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin; or (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin. (b) Employment agency practices. It shall be an unlawful employment practice for an employment agency to fail or refuse to refer for employment, or otherwise to discriminate against, any individual because of his race, color, religion, sex, or national origin, or to classify or refer for employment any individual on the basis of his race, color, religion, sex, or national origin.").

these preferences through laws forbidding racial discrimination.<sup>3</sup> Title VII<sup>4</sup> was enacted because it has long been believed that the achievement of social justice and protection of employees from discrimination in the workplace is valued higher than “free markets” or the “right” to choose based on racial preferences.<sup>5</sup> On the contrary, “[t]he advent of the ‘patients rights’ movement is a relatively recent phenomenon having first taken root in the early 1990’s.”<sup>6</sup> The Federal Nursing Home Reform Act (“OBRA 87”) established a set of national standards which certified nursing facilities must adhere to when dealing with patients’ care and patients’ rights.<sup>7</sup> Giving patients some control over their care, OBRA 87 addressed “the widespread and well-documented abuse and neglect of residents in institutional care,”<sup>8</sup> and legally permitted patients to choose their own care providers.<sup>9</sup> Recently, the United States Court of Appeals for the Seventh Circuit in *Chaney v. Plainfield Healthcare Center*,<sup>10</sup> held that the right to choose a care provider under OBRA 87 excludes the right to choose based on the race or ethnicity of a care provider.<sup>11</sup>

<sup>3</sup> Cass R. Sunstein, *Why Markets Don't Stop Discrimination*, in FREE MARKETS AND SOCIAL JUSTICE 3–9, 151–63 (1997), reprinted in ECONOMIC JUSTICE: RACE, GENDER, IDENTITY AND ECONOMICS 384, 387 (Emma Coleman Jordan & Angela P. Harris eds., 2005).

<sup>4</sup> See 42 U.S.C. § 2000e-2(a)(2) (2012) (“(a) Employer Practices. It shall be unlawful employment practices for an employer -- (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual’s race, color, religion, sex, or national origin.”).

<sup>5</sup> See Sunstein, *supra* note 3, at 389 (“Achievement of social justice is a higher value than the protection of free markets; markets are mere instruments to be evaluated by their effects.”); see generally Norman C. Amaker, *Quittin’ Time?: The Antidiscrimination Principle of Title VII vs. The Free Market*, 60 U. CHI. L. REV. 757 (1993) (discussing the need to balance antidiscrimination policies within Title VII with the need to maintain a “free market”).

<sup>6</sup> Encyclopedia of Everyday Law, *Patients Rights* (2012), <http://www.enotes.com/everyday-law-encyclopedia/patient-rights>.

<sup>7</sup> See generally 42 U.S.C. § 1395i-3 (2012); Steven Peck, *The 1987 Nursing Home Reform Act Established Minimum Standards for Nursing Home Abuse and Neglect*, CALIFORNIA ELDER LAW ATTORNEY BLOG (Feb. 2, 2010, 6:00 AM), <http://www.californiaelderlawattorneyblog.com/2010/02/the-1987-nursing-home-reform-a.html>.

<sup>8</sup> Leonila Vega, *Court Says Right to Choose Providers Doesn't Include Race/Ethnicity*, DIRECT CARE ALLIANCE, INC. (Sept. 13, 2010, 3:36 PM), <http://blog.directcarealliance.org/2010/09/discrimination-versus-consumer-choice-understanding-brenda-chaney-s-case>.

<sup>9</sup> 42 U.S.C. § 1395i-3(c)(1)(A)(i) (2012) (“A skilled nursing facility must protect and promote the rights of each resident, including . . . [t]he right to choose a personal attending physician . . . .”); Angela Snellenberger Quinn, Comment, *Imposing Federal Criminal Liability on Nursing Homes: A Way of Deterring Inadequate Health Care and Improving the Quality of Care Delivered?*, 43 ST. LOUIS U. L.J. 653, 659 n.62 (discussing the rights guaranteed to nursing home residents under OBRA 87, including the “right to choose a personal attending physician”).

<sup>10</sup> 612 F.3d 908 (7th Cir. 2010).

<sup>11</sup> See *id.* at 914; Charles Wilson, *Ind. Ruling Halts Caregiver Choices Based on Race*, ASSOCIATED PRESS (Aug. 23, 2010), [http://www.msnbc.msn.com/id/38819864/ns/us\\_news-life](http://www.msnbc.msn.com/id/38819864/ns/us_news-life) (“Courts have held that patients can refuse to be treated by a caregiver of the opposite sex, citing

Beyond the rigid legal boundaries implemented by Title VII, the Seventh Circuit recognizes that there are remedial measures that long-term health care facilities can take to avoid a similar situation as was faced in *Chaney*. These measures, including the implementation of cultural competency training and behavior contracts, will give care facilities some flexibility in dealing with hostile patients while protecting their employees from overt bigotry.

Brenda Chaney was a Certified Nursing Assistant (“CNA”) who committed herself to caring for others. Picture yourself in Chaney’s shoes, making the same commitment that she has made. You had spent nearly five years caring for your ailing elderly mother, being at her bedside daily, watching her health deteriorate, and seeing her take her last breath. Your routine for the last five years has suddenly come to halt, and in the midst of grieving you have a revelation that your passion and devotion for caring for others did not have to end because of the passing of your mother; there were others out there who could use that same tender care. You decide to go back to school, after raising your own three children and having a successful career as a paralegal, to get your nursing degree. You continue to work full time as a paralegal and take night classes, and within a year and a half, you become a CNA. The excitement of finding your true passion is beyond words, and even more exciting is that you have landed your dream job, caring for the elderly just as you did your mother. But then, imagine everything crashing down around you, being referred to by co-workers as the “black bitch” rather than by name, being secluded from patients, and being reminded on a daily basis that you are different. Your dreams fall to the wayside because of the one thing you cannot control: the color of your skin.

This Comment focuses on the recent Seventh Circuit decision in *Chaney v. Plainfield Healthcare Center*, and the dichotomy between patients’ rights and Title VII. This Comment asserts that Title VII trumps patients’ rights under OBRA 87 and that a long-term health care provider may not adhere to the racial preferences of its residents under any circumstance. The Supremacy Clause dictates that when state and federal law conflict, the federal law will prevail.<sup>12</sup> This Comment examines the Seventh Circuit’s

privacy issues. But the 7th U.S. Circuit Court of Appeals, ruling in Chaney’s case last month, said applying that accommodation to race goes too far.”).

<sup>12</sup> U.S. CONST. art. VI, cl. 2 (“This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.”); *Chaney*, 612 F.3d at 914 (“When two laws conflict, one state, one federal, the *Supremacy Clause* dictates that the federal law prevails.”) (emphasis in original).

decision in *Chaney*, supporting the outcome, but discussing how the opinion articulated is vague, and thus further analyzing options for long-term care facilities confronted with a hostile resident like the one Chaney faced. Part I of this Comment addresses the facts of the case and the court's dispositions. Part II analyzes Title VII and establishes that a long term care facility's policy that adheres to the racial preferences of its residents violates employee's rights under Title VII, and any holding inconsistent with the Seventh Circuit's decision renders Congress's intent for enacting Title VII meaningless. Part II further highlights the fact that race is not a bona fide occupation qualification exception ("BFOQ") under Title VII. Part III examines the Supremacy Clause and explains that the practices or policies set forth by Plainfield are unlawful employment practices under federally mandated law, and further addresses why under Title VII Plainfield cannot escape liability. Part IV takes a brief look at the demographics of nursing homes and discusses the influence of the "baby boomer" generation on racial disparities in nursing homes. Part V reviews the ethical "dilemma" that care providers and facilities face and the implications of the Seventh Circuit's decision in *Chaney*. Lastly, Part VI discusses and expands on the options available to health care providers who find themselves in an ethical bind when patients make race-based care requests, creating a hostile work environment in violation of Title VII

#### I. OVERVIEW: CHANEY V. PLANFIELD HEALTH CENTER

Brenda Chaney, a CNA, brought an action against Plainfield Healthcare Center ("Plainfield") under Title VII of the 1964 Civil Rights Act, claiming "that Plainfield's practice of acceding to the racial biases of its residents is illegal and created a hostile work environment."<sup>13</sup> Chaney was hired by Plainfield as a CNA and her duties included monitoring patients, responding to individual patient requests, and assisting with their general daily living needs.<sup>14</sup> Chaney's daily assignments were noted on her shift sheet,<sup>15</sup> which listed the resident patients that Chaney would be responsible for and their specific health care needs.<sup>16</sup> One of Chaney's patients, Majorie Latshaw, requested that she not be cared for by any black CNAs. As a result, Plainfield specifically wrote "Prefers No Black CNAs" on

<sup>13</sup> *Chaney*, 612 F.3d at 910. Chaney also brought an action for discriminatory discharge, which will not be discussed in this Comment.

<sup>14</sup> *Id.*

<sup>15</sup> *See id.* (each employee received these shift sheets upon arriving at work each day).

<sup>16</sup> *Id.*

Chaney's daily assignment sheet.<sup>17</sup> Plainfield acknowledges to the court that it has a "policy of honoring the racial preferences of its residents in assigning health-care providers,"<sup>18</sup> fearing that not adhering to the choices of its patients would violate state and federal laws concerning patient's rights.<sup>19</sup> Chaney, despite her reluctance, refrained from assisting Latshaw and other similarly situated patients on her assignment sheet who had a similar aversion for black CNAs.<sup>20</sup> These race-based limitations took an emotional toll on Chaney and often left her feeling depressed at the end of her work shifts.<sup>21</sup>

Plainfield's practice of honoring the racial preferences of its patients not only left Chaney feeling alienated by the fact that she could not assist residents in her unit due to her race, but was further "accompanied by racially-tinged comments and epithets from co-workers."<sup>22</sup> A white nurse once called Chaney a "black bitch." Another time a white co-worker looked at "Chaney and asked why Plainfield ' . . . keep[s] on hiring all of these black niggers?'"<sup>23</sup>

Despite adhering to the patients' racial preferences and enduring abuse from co-workers, Chaney was fired after only three months of work.<sup>24</sup> Asserting her employment rights under Title VII against discrimination in the workplace, Chaney brought an action against Plainfield in the United States District Court for the Southern District of Indiana.<sup>25</sup> The district court granted summary judgment for Plainfield on Chaney's claim that Plainfield policies led to a hostile work environment, as defined under Title VII.<sup>26</sup> Chaney and the Equal Employment Opportunity Commission

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.* ("Plainfield maintains that it expected its employees to respect these racial preferences because it otherwise risked violating state and federal laws that grant residents the right to choose its providers . . .").

<sup>20</sup> *Id.* On one occasion, "Chaney found Latshaw on the ground, too weak to stand. Despite wanting badly to help, Chaney had to search the building for a white CNA." *Id.* On another occasion, a patient "refused Chaney's assistance in the shower, asking for a different nurse aide instead." *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> *Id.* at 911.

<sup>23</sup> *Id.* Many commentators have found this term to be offensive. See Randall Kennedy, *A Note On The Word "Nigger,"* <http://www.civilwarliterature.com/01Introduction/TheNWord.htm> (last visited Jan. 19, 2012).

<sup>24</sup> *Chaney*, 612 F.3d at 911. Chaney alleged that at her post-termination hearing Plainfield told her they fired her because she used the word "shitting" in front of a resident, but gave her no other grounds for being fired. *Id.* However, at trial, Plainfield focused on other grounds for the discharge including, "'bed alarm and call light infractions' and 'not doing a shift change.'" *Id.*

<sup>25</sup> *Chaney v. Plainfield Healthcare Ctr.*, No. 1:08-CV-00071, 2009 U.S. Dist. LEXIS 97215 (S.D. Ind. Sept. 29, 2009). Plainfield was also granted summary judgment on the discriminatory discharge claim.

<sup>26</sup> *Id.* at \*19–20. Plainfield was also granted summary judgment on the discriminatory discharge

(“EEOC”) appealed the district court’s decision to the United States Court of Appeals for the Seventh Circuit.<sup>27</sup> The Seventh Circuit reversed the district court’s grant of summary judgment, finding that Chaney was faced with a “racially hostile environment, and the evidence presented at summary judgment allows a jury to conclude that Plainfield took insufficient measures to address it.”<sup>28</sup>

## II. RACISM IN THE WORKPLACE: TITLE VII—HISTORY, PURPOSE, AND JUDICIAL INTERPRETATION

“Racism is the belief that characteristics and abilities can be attributed to people simply on the basis of their race and that some racial groups are superior to others.”<sup>29</sup> Discrimination in the workplace is not a foreign concept, and as long as it continues to exist in “the framework” of society, it will continue in the workplace.<sup>30</sup> Although racism in the workplace exists at all levels of the economic ladder, from blue-collar workers to white-collar workers,<sup>31</sup> it is not always a public overt action. The United States has made significant progress in overcoming racism in the workplace since the Civil Rights movement and the enactment of Title VII, but the issue is far from resolved.<sup>32</sup>

### A. Race Discrimination, Title VII Claims, and the EEOC

Section 703(a)(1) of Title VII makes it illegal “to discriminate against any individual with respect to his . . . terms, conditions, or privileges of employment, because of such individual’s race.”<sup>33</sup> One of the privileges of

claim. *Id.* at \*28–29.

<sup>27</sup> *Chaney*, 612 F.3d .

<sup>28</sup> *Id.* at 915.

<sup>29</sup> Anup Shah, *Racism*, GLOBAL ISSUES (Aug. 8, 2010), <http://www.globalissues.org/article/165/racism>.

<sup>30</sup> Knowledge Galaxy, *Racism in the Workplace*, [http://www.knowledgegalaxy.net/racism\\_in\\_the\\_workplace/racism\\_in\\_the\\_workplace.html](http://www.knowledgegalaxy.net/racism_in_the_workplace/racism_in_the_workplace.html) (last visited Dec. 1, 2010) [hereinafter *Knowledge Galaxy*]; see also Eve Tahmincioglu, *Racial Harassment Still Infecting the Workplace*, <http://www.msnbc.msn.com/id/22575581/ns/business-careers/t/racial-harassment-still-infecting-workplace> (last visited Feb. 2, 2012).

<sup>31</sup> Knowledge Galaxy, *supra* note 30 (“Racism in the workplace exists on the level of white collar employees as well as for blue collar workers.”); see also Jennifer L. Pierce, “*Racing for Innocence*”: *Whiteness, Corporate Culture, and the Backlash Against Affirmative Action*, 26 QUALITATIVE SOCIOLOGY 53, 55 (2003) (“Presumably, those with more education are less likely to rely upon stereotypical beliefs. By contrast, my research focuses on highly educated, middle-class professionals – lawyers – who, as I find, also display such behavior and attitudes.”).

<sup>32</sup> Knowledge Galaxy, *supra* note 30 (noting that the United States has made great bounds in overcoming workplace racism but still has a long way to go); YWCA Central Alabama, *Racial Justice*, <http://www.ywcabham.org/Racial/index.asp> (last visited Jan. 30, 2012).

<sup>33</sup> 42 U.S.C. § 2000e-2(a)(1) (2012); Philip P. Frickey, *John Minor Wisdom Lecture: Wisdom on*

employment is the right to work in a non-racially discriminatory environment.<sup>34</sup> “All workers, therefore, have a cognizable interest under Title VII in discrimination against any race.”<sup>35</sup> The United States Equal Employment Opportunity Commission (EEOC) is responsible for enforcing federally mandated statutes such as Title VII.<sup>36</sup> Title VII forbids discrimination in any aspect of employment, including but not limited to hiring and firing practices, promotions, pay, and job assignments.<sup>37</sup> Title VII prohibits not only intentional discrimination, but also “neutral job policies that disproportionately exclude minorities and that are not job related.”<sup>38</sup>

The EEOC guidelines have helped provide a framework as to race discrimination in the workplace for lower courts, and have been quite influential.<sup>39</sup> When evaluating employment decisions based on race or color, courts, by analyzing the facts, determine whether the claim involves disparate impact or disparate treatment.<sup>40</sup> Disparate treatment involves discrimination when race, as a protected trait, is the motivating factor with regards to the treatment of employees.<sup>41</sup> Disparate impact discrimination is present when there is a neutral policy or practice that has a negative impact on a protected group and does not fit into the bona fide occupational

*Weber*, 74 TUL. L. REV. 1169, 1178–79 (2000).

<sup>34</sup> MATTHEW BENDER & CO.4-21 CIVIL RIGHTS ACTIONS P.21.22 (2010) [hereinafter CIVIL RIGHTS ACTIONS TREATISE]; *see also* Snell v. Suffolk County, 782 F.2d 1094, 1096 (2d Cir. 1986) (“Title VII of the Civil Rights Act of 1964 provides that an employee has a right to a working environment free of racial harassment.”).

<sup>35</sup> CIVIL RIGHTS ACTIONS TREATISE, *supra* note 34.

<sup>36</sup> *See* U.S. Equal Employment Opportunity Commission, *Overview*, <http://www.eeoc.gov/eeoc> (last visited Mar. 1, 2012).

<sup>37</sup> U.S. Equal Employment Opportunity Commission, *Race/Color Discrimination*, [http://www.eeoc.gov/laws/types/race\\_color.cfm](http://www.eeoc.gov/laws/types/race_color.cfm) (last visited Mar. 1, 2012) (“The law forbids discrimination when it comes to any aspect of employment, including hiring, firing, pay, job assignments, promotions, layoff, training, fringe benefits, and any other term or condition of employment.”); UNC Charlotte, *Considering Legal Issues in Employment*, <http://career.unccl.edu/students/effective-interviewing/considering-legal-issues-employment> (last visited Mar. 1, 2012).

<sup>38</sup> U.S. Equal Employment Opportunity Commission, *Facts About Race/Color Discrimination*, <http://www.eeoc.gov/eeoc/publications/fs-race.cfm> (last visited Mar. 1, 2012).

<sup>39</sup> *See* U.S. Equal Employment Opportunity Commission, *Compliance Manual, Section 15: Race and Color Discrimination*, available at <http://www.eeoc.gov/policy/docs/race-color.html> [hereinafter *Compliance Manual*].

<sup>40</sup> Scott H. Kremer, *Comment: The Restructuring of Disparate Impact Analysis – Wards Cove Packing Co. v. Atonio*, 25 NEW ENG. L. REV. 959, 961 (1991); *Compliance Manual*, *supra* note 39, at Section 15-V (“Race and color cases generally fall under one of two categories, depending on which category most suits the facts – disparate treatment and disparate impact.”).

<sup>41</sup> Kremer, *supra* note 40, at 961; *Compliance Manual*, *supra* note 39, at Section 15-V (“Disparate treatment discrimination occurs when race or another protected trait is a motivating factor in how an individual is treated.”).



qualification exceptions (“BFOQ”).<sup>42</sup> Title VII does not allow racially motivated policies “driven by business concerns”<sup>43</sup> or “the negative reactions of clients or customers.”<sup>44</sup>

A plaintiff will only prevail in a Title VII hostile work environment claim when he or she proves: “(1) that the work environment was both subjectively and objectively offensive; (2) that the harassment was based on membership in a protected class; (3) that the conduct was severe or pervasive; and (4) that there is a basis for employer liability.”<sup>45</sup> Furthermore, in *O’Neal v. City of Chicago*, the Seventh Circuit Court of Appeals of Illinois established three categories of materially adverse employment actions under Title VII:

(1) cases in which the employee’s compensation, fringe benefits, or other financial terms of employment are diminished, including termination; (2) cases in which a nominally lateral transfer with no change in financial terms significantly reduces the employee’s career prospects by preventing her from using her skills and experience, so that the skills are likely to atrophy and her career is likely to be stunted; and (3) cases in which the employee is not moved to a different job or the skill requirements of her present job altered, but the conditions in which she works are changed in a way that subjects her to a humiliating, degrading, unsafe, unhealthful, or otherwise significantly negative alteration in her workplace environment.<sup>46</sup>

If an employer’s conduct fits within any one of these three categories a litigant in the Seventh Circuit has a proper Title VII claim against that employer. Chaney’s claim fits in the third category, for she was not permitted to care for those patients who specifically requested only white CNAs, and she was humiliated because of her race by other white CNAs.

<sup>42</sup> Kremer, *supra* note 40, at 962; *Compliance Manual*, *supra* note 39, at Section 15-V (discussing the meaning of disparate impact).

<sup>43</sup> See *Int’l Union v. Johnson Controls, Inc.*, 499 U.S. 187, 199 (1991) (disparate treatment liability “does not depend on why the employer discriminates but rather on the explicit terms of the discrimination.”).

<sup>44</sup> See *Rucker v. Higher Educ. Aids Bd.*, 669 F.2d 1179, 1181 (7th Cir. 1982) (“Title VII is a blanket prohibition of racial discrimination, rational and irrational alike, even more so than of other forms of discrimination attacked in Title VII. . . [Thus,] it is clearly forbidden by Title VII, to refuse on racial grounds to hire someone because your customers or clientele do not like his race.”).

<sup>45</sup> *Mendenhall v. Mueller Streamline Co.*, 419 F.3d 686, 691 (7th Cir. 2005).

<sup>46</sup> *O’Neal v. City of Chi.*, 392 F.3d 909, 911 (7th Cir. 2004) (citing *Herrnreiter v. Chi. Hous. Auth.*, 315 F.3d 742, 744–45 (7th Cir. 2002)).

*B. Judicial Interpretation and Legislative History Do Not Lead To The Establishment of Race Based Bona Fide Occupational Qualification Exception Under Title VII*

Section 703(e) sets out exceptional circumstances in which discrimination based on religion, sex, or national origin is lawful.<sup>47</sup> Consequently, Congress and courts dealing with Title VII claims have recognized various exceptions to unlawful discrimination practices under Title VII. Employer, “as defined in Title VII excludes ‘a bona fide private membership club (other than a labor organization) that is exempt from taxation under 501(c) of the Internal Revenue Code.’”<sup>48</sup> Also excluded from the protection of Title VII’s definition of employer and its ban on employment discrimination are Indian Tribes.<sup>49</sup> Moreover, Title VII includes exceptions for state and local officials that are elected by qualified voters, religious organizations that hire individuals on the basis of religion if they are being hired to further the organization’s religious activities, aliens employed *outside* the United States, members of the Communist Party, and employers engaged in national security in defined circumstances.<sup>50</sup>

<sup>47</sup> Notwithstanding any other provision of this title, (1) it shall not be an unlawful employment practice for an employer to hire and employ employees, for an employment agency to classify, or refer for employment any individual, for a labor organization to classify its membership or to classify or refer for employment any individual, or for an employer, labor organization, or joint labor management committee controlling apprenticeship or other training or retraining programs to admit or employ any individual in any such program, on the basis of his 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, and (2) it shall not be an unlawful employment practice for a school, college, university, or other educational institution or institution of learning to hire and employ employees of a particular religion if such school, college, university, or other educational institution or institution of learning is, in whole or in substantial part, owned, supported, controlled, or managed by a particular religion or by a particular religious corporation, association, or society, or if the curriculum of such school, college, university, or other educational institution or institution of learning is directed toward the propagation of a particular religion. 42 U.S.C. § 2000e-2(e) (2012).

<sup>48</sup> CIVIL RIGHTS ACTIONS TREATISE, *supra* note 34.

<sup>49</sup> 42 U.S.C. § 2000e(b) (2012) (“The term ‘employer’ . . . does not include . . . an Indian tribe.”); CIVIL RIGHTS ACTIONS TREATISE, *supra* note 34 (discussing that Indian tribes are not protected under Title VII from employment discrimination because tribes generally control as well as operate their own affairs and Congress wanted to encourage Indian tribes to further their economic interests, and thus they were exempted from the purview of Title VII); Mitchell Peterson, Student Article, *The Applicability of Federal Employment Law to Indian Tribes*, 47 S.D. L. REV. 631, 631 (2002) (explaining that Title VII “include[s] an express exemption for ‘Indian tribes.’”).

<sup>50</sup> See 42 U.S.C. § 2000e(f) (2012) (“[T]he term ‘employee’ shall not include any person elected to public office in any State or political subdivision of any State by the qualified voters thereof.”); 42 U.S.C. § 2000e-1(a) (2012) (“This title . . . shall not apply to an employer with respect to the employment of aliens outside any State, or to a religious corporation, association, educational

### 1. Well-Settled Case Law Supports the Contention that a Bona Fide Occupational Qualification Does Not Exist For Race

The district court, in essence, created a BFOQ exception for race, contrary to Title VII and well-settled case law, when it held that Plainfield is not liable for the “Prefers No Black CNAs” assignment sheet.<sup>51</sup> “While religion, sex or national origin can, in exceptional cases, be a BFOQ, race cannot.”<sup>52</sup> In *Rucker v. Higher Educational Aids Board*, the Seventh Circuit held that “Title VII is a blanket prohibition of racial discrimination, rational and irrational alike, even more so than of other forms of discrimination attacked in Title VII.”<sup>53</sup>

Among various circuit courts, it has been consistently held that it is unlawful for an employer to discriminate based on race to accommodate clientele.<sup>54</sup> The Second Circuit in *Knight v. Nassau County Civil Service Commission*, held the Commission’s transfer of Knight, a black employee, to the Recruitment Division where he was assigned to specifically deal with minority recruitment, rather than being promoted within the Test Development Division where he originally excelled beyond his white co-workers, was solely based on Knight’s race and was in violation of Title VII.<sup>55</sup> Furthermore, the Eleventh Circuit in *Ferrill v. The Parker Group Inc.*, found that a telephone marketing company that admittedly assigned black employees to make phone calls to black households, and white employees to make phone calls to white households, was liable for intentional discrimination under Title VII for making race-based job assignments.<sup>56</sup>

As noted above, case law strongly supports the contention that no BFOQ exists for race. Consequently, Plainfield’s belief that the BFOQ for

institution, or society with respect to the employment of individuals of a particular religion to perform work connected with the carrying on by such corporation, association, educational institution, or society of its activities.”); 42 U.S.C. § 2000e-2(f) (2012) (stating that members of the Communist Party are not entitled to Title VII’s protection); 42 U.S.C. § 2000e-2(g) (2012) (excluding employers engaged in national security from Title VII’s requirements); CIVIL RIGHTS ACTIONS TREATISE, *supra* note 34 (noting the various exceptions to Title VII protection recognized by Congress and the various courts).

<sup>51</sup> *Chaney v. Plainfield Healthcare Ctr.*, No. 1:08-CV-00071, 2009 U.S. Dist. LEXIS 97215, at \*19 (S.D. Ind. Sept. 29, 2009).

<sup>52</sup> CIVIL RIGHTS ACTIONS TREATISE, *supra* note 34; *Malhotra v. Cotter & Co.*, 885 F.2d 1305, 1308 (7th Cir. 1989) (stating that the BFOQ defense is not available when discrimination is based on an individual’s race, color, or ethnicity).

<sup>53</sup> *Rucker v. Higher Educ. Aids Bd.*, 669 F.2d 1179, 1181 (7th Cir. 1982).

<sup>54</sup> See *EEOC vs. St. Anne’s Hospital of Chi., Inc.*, 664 F.2d 128, 133 n.7 (7th Cir. 1981); *Miller v. Tex. Bd. of Barber Exam’rs* 615 F.2d 650, 652 (5th Cir. 1980); *Burwell v. Eastern Air Lines, Inc.*, 633 F.2d 361, 370 n.13 (4th Cir. 1980).

<sup>55</sup> *Knight v. Nassau County Civil Serv. Comm’n*, 649 F.2d 157, 159–60, 162 (2d Cir. 1981).

<sup>56</sup> *Ferrill v. The Parker Group Inc.*, 168 F.3d 468, 472–73 (11th Cir. 1999).

discriminatory hiring practice based on gender translates into the same exception with regards to race is tenuous.<sup>57</sup> Additionally, the contention that if patients' discriminatory preferences are not adhered to, the right to bodily integrity is violated due to the highly intrusive nature of health care services, is mere conjecture.<sup>58</sup> The Seventh Circuit in *Rucker* reasoned that Congress failed to include race as a BFOQ because race discrimination was generally more common than other types of discrimination, such as gender discrimination.<sup>59</sup> Gender discrimination is of a different sort than race discrimination. Unlike sex, Congress considered and explicitly rejected a race-based BFOQ.<sup>60</sup> Furthermore, with the repeal of the Jim Crow Laws, "there are no recognized privacy rights based on race."<sup>61</sup> Contrary to the case law that Plainfield cited to support its assertion that race, like gender discrimination, is tolerated in the medical field,<sup>62</sup> the Seventh Circuit properly noted that the "privacy interest that is offended when one undresses in front of a doctor or nurse of the opposite sex does not apply to race."<sup>63</sup>

## 2. Legislative History of Title VII Establishes that Congress Purposefully Excluded Race as a Bona Fide Occupational Qualification

It is apparent when looking at the legislative history behind the enactment of Title VII of the Civil Rights Act of 1964, that this Act was established to protect individuals like Chaney from the exact treatment that Chaney endured

<sup>57</sup> See Brief of Appellee at \*25–26, *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908 (7th Cir. 2010) (No. 09-3661), 2010 WL 2157107.

<sup>58</sup> See Brief of Appellee, *supra* note 57, at \*26.

<sup>59</sup> *Rucker v. Higher Educ. Aids Bd.*, 669 F.2d 1179, 1181 (7th Cir. 1982); Appellant's Reply Brief at \*2, *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908 (7th Cir. 2010) (No. 09-3661), 2010 WL 2157108.

<sup>60</sup> 110 CONG. REC. 2550 (1964) (remarks of Congressman Emmanuel Celler) ("We did not include the word 'race' because we felt that race or color would not be a bona fide qualification, as would be 'national origin.' That was left out. It should be left out.").

<sup>61</sup> Appellant's Reply Brief, *supra* note 59, at \*2.

<sup>62</sup> See Brief of Appellee, *supra* note 57, at \*27 (citing *AFSCME Local 567 v. State of Michigan*, 635 F. Supp. 1010, 1013 (E.D. Mich. 1986)); *Philips v. County of Allegheny*, 515 F.3d 224, 235 (3d Cir. 2008) ("Individuals have a constitutional liberty interest in personal bodily integrity protected by the Due Process Clause of the Fourteenth Amendment.").

<sup>63</sup> *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908, 913 (7th Cir. 2010). The Court also explained that "[j]ust as the law tolerates same-sex restrooms or same-sex dressing rooms, but not white-only rooms, to accommodate privacy needs, Title VII allows an employer to respect a preference for same-sex health providers, but not for same-race providers." *Id.*

while employed at Plainfield Healthcare Center. “Congress’ primary concern in enacting the prohibition against racial discrimination in Title VII . . . was with ‘the plight of the [African American] in our economy.’”<sup>64</sup> Congress worried that with the integration of blacks into society, the goal of the Civil Rights Act of 1964 would not be achieved unless the trends that were evident prior to the Civil Rights movement were reversed.<sup>65</sup> Consequently, during the Civil Rights movement, “it was clear to Congress that ‘the crux of the problem was to open employment opportunities for [African Americans] in occupations which have been traditionally closed to them,’ and it was to this problem that Title VII’s prohibition against racial discrimination in employment was primarily addressed.”<sup>66</sup>

Additionally, Congressional hearings preceding the enactment of Title VII support the assertion that Congress did not intend to include race as a BFOQ. The majority of courts agree that Congress’s failure to include race as a BFOQ was intentional.<sup>67</sup> Senator Williams offered an amendment to Title VII, requesting that race be included as a BFOQ. Senator Williams, in his attempt to get support for his amendment to Title VII, brought to the other Senators’ attention the multimillion dollar businesses in the South that are operated solely by “[African American] citizens” and businesses that “cater exclusively to [African American] clientele.”<sup>68</sup> Senator Williams believed that without this amendment those businesses would be destroyed.<sup>69</sup> Congressman Celler responded to the offered amendment, stating, “[w]e did not include the word ‘race’ because we felt that race would not be a bona fide qualification, as would ‘national origin.’ That was left out. It should be left out.”<sup>70</sup> The amendment was ultimately rejected, “ayes 70, noes 108.”<sup>71</sup> Therefore, the legislative history of Title VII demonstrates that Congress considered a race-based BFOQ, but ultimately rejected its inclusion.<sup>72</sup> Consequently, “the district court’s Order

<sup>64</sup> *United Steelworkers of Am. v. Weber*, 443 U.S. 193, 202 (1979) (citing 110 CONG. REC. 6548 (1964) (remarks of Sen. Humphrey)).

<sup>65</sup> *See id.* at 202 (“Congress feared that the goals of the Civil Rights Act -- the integration of blacks into the mainstream of American society -- could not be achieved unless this trend were reversed.”); *see also* 110 CONG. REC. 7220 (1964) (remarks of Sen. Clark).

<sup>66</sup> *Weber*, 443 U.S. at 203 (citations omitted).

<sup>67</sup> *See id.* at 201–02; *Rucker v. Higher Educational Aids Bd.*, 669 F.2d 1179, 1181 (7th Cir. 1982); Appellant’s Brief at \*17, *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908 (7th Cir. 2010) (No. 09-3661), 2010 WL 2157106 (“[M]ost courts agree that the failure of Congress to include a race BFOQ provision was an intentional act.”).

<sup>68</sup> 110 CONG. REC. 2550 (1964).

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> 110 CONG. REC. 2563 (1964).

<sup>72</sup> *See* 110 CONG. REC. 7217 (1964) (statement of Sen. Clark & Sen. Case); *see generally* 110

[for summary judgment in favor of Plainfield] constitutes a judicial amendment to Title VII, which explicitly prohibits BFOQ's based on race."<sup>73</sup> The district court exceeded its bounds in creating an exception when Congress' intent in enacting Title VII was explicit.<sup>74</sup>

### III. PLAINFIELD'S FAILURE TO ESCAPE LIABILITY

The district court wrongfully absolved Plainfield from liability. The court held that

Plainfield could not be held liable for creating a hostile work environment by implementing discriminatory staff assignments because the "policy clearly represented a good-faith effort to conform to the mandates of Indiana law."<sup>75</sup> In granting summary judgment the district court failed to realize that Plainfield's policy "is itself an unlawful employment practice and a *per se* violation of Title VII."<sup>76</sup>

#### *A. Discriminatory Liability: Plainfield's Blatant Disregard for The Supremacy Clause, Long Standing Constitutional Principles & Section 708 of Title VII*

Plainfield argued that the Supremacy Clause is inapplicable because Indiana's residential

rights do not conflict with federally mandated Title VII.<sup>77</sup> Furthermore, the district court's holding that Plainfield's decision to leave the patient's preference on the assignment sheet was reasonable, as a good faith effort to conform to Indiana law,<sup>78</sup> is a blatant disregard for constitutionally

CONG. REC. 2250-63 (1964) (House discussion on whether race and color should be a BFOQ exception).

<sup>73</sup> Appellant's Brief, *supra* note 67, at \*17.

<sup>74</sup> *See id.*

"Judicial amendment of a statute is justified only in limited circumstances, such as where Congress provided no rule on the subject before the court, where it is necessary to save the statute from being struck down as unconstitutional, where Congress essentially authorized the courts to legislate on an issue, or where the statute would otherwise create an absurdity. . . . 'Courts do not create exceptions to statutes every time it seems that the legislature overlooked something. . . . The judge will create a statutory exception only when . . . it is necessary to save the statute from being held unconstitutional, or when they have great confidence that the legislature could not have meant what it seemed to [s]ay . . .'" *Id.* (quoting *Crawford v. Ind. Dep't of Corr.*, 115 F.3d 481, 484-85 (7th Cir. 1997).

<sup>75</sup> *Chaney v. Plainfield Healthcare Ctr.*, No. 1:08-CV-00071, 2009 U.S. Dist. LEXIS 97215, at \*14-15 (S.D. Ind. Sept. 29, 2009).

<sup>76</sup> Brief of the Equal Employment Opportunity Commission As Amicus Curiae in Support of Plaintiff-Appellant and Reversal at \*20, *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908 (7th Cir. 2010) (No. 09-3661), 2009 U.S. 7th Cir. Briefs LEXIS 76 [hereinafter *EEOC Amicus Curiae*].

<sup>77</sup> *See* Brief of Appellee, *supra* note 57, at \*21; *Chaney*, 2009 U.S. Dist. LEXIS 97215, at \*18.

<sup>78</sup> *See Chaney*, 2009 U.S. Dist. LEXIS 97215, at \*19. ("Plainfield cannot reasonably be held liable

mandated principles. “The U.S. Supreme Court has interpreted the Supremacy Clause<sup>79</sup> to stand for the proposition that ‘[a] state statute is void to the extent that it actually conflicts with a valid federal statute.’”<sup>80</sup> Indiana law governing long-term care facilities provides that a resident has a right to “choose a personal attending physician and other providers of service.”<sup>81</sup> Allowing a patient to choose his or her care provider on the basis of race, in accordance with Indiana’s patient’s rights provisions, would render Title VII meaningless. Reconciliation of the overly broad rights granted to a patient to “choose its care provider” on the basis of race under Indiana law, with the limiting factor set forth under Title VII, that such choice cannot be manifested by a discriminatory preference, is not possible. Therefore, the Supremacy Clause renders the portion of Indiana statute allowing for discriminatory preferences in the care setting void.

Section 708 of Title VII specifically supersedes state laws that permit unlawful employment practices, which the following cases illustrate.<sup>82</sup> For example, *Utility Workers Union of America v. Southern California Edison Company* dealt with this exact issue, holding that “Section 708 strongly implies that any state law which requires or permits the doing of an act which would be an unlawful employment practice under Title VII . . . whether or not it is ‘protective,’ is invalid.”<sup>83</sup> The district court and Plainfield interpreted Indiana law to mandate job assignments and segregation on the basis of race.<sup>84</sup> Allowing Plainfield to act in a manner

for adopting a policy that permits a client to espouse racial bias, when that policy clearly represented a good-faith effort to conform to the mandates of Indiana law.”)

<sup>79</sup> U.S. CONST. art. VI, cl. 2 (“This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treatise made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.”).

<sup>80</sup> Appellant’s Brief, *supra* note 67, at \*19 (quoting *Edgar v. Mite Corp.*, 457 U.S. 624, 631 (1982)).

<sup>81</sup> *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908, 913–14 (7th Cir. 2010) (quoting 410 IND. ADMIN. CODE 16.2-3.1-3(n)(1) (2011)); *see also* Brief of Appellee, *supra* note 57, at \*22 (discussing how the Indiana Administrative Code resident rights provisions establish guidelines that long term care facilities must adhere to when establishing policies that directly affect residents; these guidelines include, but are not limited to: the right to receive services with reasonable accommodations to individual needs and preferences, to make choices about aspects of care that are significant to the resident, and the right to be cared for in a manner that maintains the resident’s dignity in recognition of the patient’s individuality).

<sup>82</sup> 42 U.S.C. § 2000e-7 (2012) (“Nothing in this title shall be deemed to exempt or relieve any person from any liability, duty, penalty, or punishment provided by any present or future law of any State or political subdivision of a State, other than any such law which purports to require or permit the doing of any act which would be an unlawful employment practice under this title.”).

<sup>83</sup> *Utility Workers Union of Ame. v. S. Cal. Edison Co.*, 320 F. Supp. 1262, 1264 (C.D. Cal. 1970).

<sup>84</sup> *See Chaney v. Plainfield Healthcare Ctr.*, No. 1:08-CV-00071, 2009 U.S. Dist. LEXIS 97215, at \*18 (S.D. Ind. Sept. 29, 2009) (stating that if Plainfield had removed the racial notation preference on patient forms that would have violated Indiana regulations).

consistent with this interpretation, as the Seventh Circuit properly observes, is a clear violation of Title VII.<sup>85</sup> Consequently, consistent with Section 708, Plainfield remains liable, contrary to what it believed was required of them under Indiana law.<sup>86</sup>

*B. Neither Customer Preferences Nor The Business Necessity Doctrine Provide Support For Unlawful Employment Practices Against a Federally Mandated Law*

Plainfield's assertion that the patients' privacy rights are paramount to any rights that Chaney had as an employee of Plainfield is unwarranted.<sup>87</sup> Plainfield defends its unlawful acts, attempting to distinguish this case from cases in which customer preference was found to be unlawful under Title VII<sup>88</sup> by stating that a long-term care facility has obligations to its patients that other employers do not have.<sup>89</sup> The Seventh Circuit properly dismissed Plainfield's claim, recognizing that it is well settled that "racial preferences of . . . customers is not a defense under Title VII for treating employees differently based on race."<sup>90</sup> Furthermore, EEOC's guidance manual and case precedent have established that neither customer nor client preferences can ever excuse or rationalize disparate treatment of employees based on race.<sup>91</sup>

Plainfield's use of the business necessity doctrine as a defense to its unlawful employment practices is misplaced. The "business necessity" defense is available only in cases involving disparate impact, and not cases

<sup>85</sup> *Chaney*, 612 F.3d at 914 ("If Plainfield's reading of the regulation (requiring it to instruct its employees to honor a patient's racial preferences) were correct, it would conflict with Title VII.").

<sup>86</sup> *See id.* ("Title VII does not, by contrast, contain a good-faith 'defense' that allows an employer to ignore the statute in favor of conflicting state law."); *see also* 110 CONG. REC. 7216 (1964) ("Section 708 of this title vests in this Commission the authority to determine the effectiveness of State or local action in the field of fair employment . . . Title VII leaves State and local [] laws untouched, except where they are in conflict with it.").

<sup>87</sup> *See Chaney*, 2009 U.S. Dist. LEXIS 97215, at \*19; Brief of Appellee, *supra* note 57, at \*19.

<sup>88</sup> *See* Brief of Appellee, *supra* note 57, at \*19.

<sup>89</sup> *Chaney*, 612 F.3d at 913.

<sup>90</sup> *Id.* The court cites various cases that support its conclusion including *Johnson v. Zema Sys. Corp.*, 170 F.3d 734, 744 (7th Cir. 1999) (finding that evidence of a segregated sales force supported a Title VII claim); *Village of Bellwood v. Dwivedi*, 895 F.2d 1521, 1530 (7th Cir. 1990) (stating that if a merchant refuses to hire a black worker because he believes that his customers do not like blacks, and will not continue to do business at the merchant's shop if he continues to hire blacks, this refusal constitutes discrimination because it is treating individuals different on account of their race).

<sup>91</sup> *Rucker v. Higher Educ. Aids Bd.*, 669 F.2d 1179, 1181 (7th Cir. 1982) ("[I]t is clearly forbidden by Title VII, to refuse on racial grounds to hire someone because your customers or clientele do not like his race."); EEOC Amicus Curiae, *supra* note 76, at \*10 ("Longstanding Circuit precedent and EEOC guidance establish that client or customer preference cannot excuse or justify race-based disparate treatment of employees.").



that involve intentional discrimination.<sup>92</sup> An case where the business necessity doctrine was a proper defense to unlawful discrimination in the employment sector came from the Fifth Circuit in *Baker v. City of St. Petersburg*.<sup>93</sup> In *Baker*, the St. Petersburg Police Department restricted the work assignments of black officers to the policing of black citizens, which was found to violate equal protection and Title VII.<sup>94</sup> However, the court noted two situations where the assignments of blacks to specific tasks based on their race would be acceptable: “For example, the undercover infiltration of an all-[African American] criminal organization or plainclothes work in an area where a white man could not pass without notice. Special assignments might also be justified during brief periods of unusually high racial tension.”<sup>95</sup> The discrimination that Chaney faced as an employee of Plainfield cannot be justified under the business necessity doctrine. Chaney was a CNA with the same qualifications as her white co-workers, but she was restricted from performing her duties in the same respect because of her race. Consequently, by no means is Plainfield’s use of racial preferences a “facially neutral policy.”<sup>96</sup>

#### IV. THE DEMOGRAPHICS OF NURSING HOMES AND THE “BABY BOOMER” GENERATION

It is no revelation that the two largest groups of people found in long-term care facilities are nurse’s aides and residents, who are often “racially and ethnically disparate.”<sup>97</sup> One of the major factors that influence racial disparity between residents and their care providers is the overrepresentation of minorities working as nurse’s aides,<sup>98</sup> and the over-

<sup>92</sup> 42 U.S.C. § 2000e-2(k)(2); Appellant’s Brief, *supra* note 67, at \*22 (quoting *Miller v. Tex. State Bd. of Barber Exam’rs*, 615 F.2d 650, 653 (5th Cir. 1980)) (“The [BFOQ] exception applies to intentional and unintentional discrimination but the business necessity doctrine is apparently limited to practices which are facially neutral but discriminatory in operation.”).

<sup>93</sup> See *Baker v. City of St. Petersburg*, 400 F.2d 294 (5th Cir. 1968).

<sup>94</sup> See *id.* at 295.

<sup>95</sup> *Id.* at 301 n.10.

<sup>96</sup> Appellant’s Brief, *supra* note 67, at \*22.

<sup>97</sup> Celia Berdes & John M. Eckert, *Race Relations and Caregiving Relationships: A Qualitative Examination of Perspectives From Residents and Nurse’s Aides in Three Nursing Homes*, 23 RESEARCH ON AGING 109, 109 (2001) (“It is hardly a revelation to people who have worked in nursing homes that the two largest groups found there, residents and nurse’s aides, are often racially and ethnically disparate.”); Northwestern University, *Majority of Nursing Home Aides Experience Racism From Residents and Staff*, SCIENCE BLOG (Nov. 2002), <http://scienceblog.com/community/older/2002/D/20024416.html> [hereinafter SCIENCE BLOG].

<sup>98</sup> See Berdes & Eckert, *supra* note 97, at 109–10 (explaining that there are three major factors that “are at work in the racial disparity of residents and aides in nursing homes,” one being the overrepresentation of minority nurses aides); see also SCIENCE BLOG, *supra* note 97.

predominance of white nursing home residents.<sup>99</sup> The underrepresentation of African Americans in nursing homes can be explained by two factors. First, among African Americans there is a cultural preference for home care. As a result of this preference, African American's generally use nursing homes at "a rate between one-half and three-quarters of that of Whites."<sup>100</sup> Second, the "baby boomer" generation,<sup>101</sup> consisting of those people who were born between 1945 and 1964, is marching towards retirement.<sup>101</sup> In 2009, 76% of the "baby boomer" generation was white, while only 10% was African American.<sup>102</sup> The preference of African Americans to seek home care, the underrepresentation of African Americans in the "baby boomer" generation seeking long-term care, and the overrepresentation of minority care providers are factors that greatly influence the racial disparity of residents and care providers.

The majority of these individuals who seek refuge in long-term care were born during a time of racial isolation, and what was once legally and socially acceptable has drastically changed with the passage of the Civil Rights Act.<sup>103</sup> Today, "baby boomers" are experiencing many changes, including those involving health care.<sup>104</sup> The effects of aging are "increasingly defined and experienced as the gradual loss of autonomy

<sup>99</sup> See Berdes & Eckert, *supra* note 97, at 110 (discussing a statistical breakdown of racial distribution of nursing home residents in Cook County, Illinois, and noting that out of 231 nursing homes, "the 189 facilities in which whites constituted more than 50% of the population had on average 10% African American residents; 66 (35%) of these had no African Americans at all, and an additional 15 (8%) had only one African American resident."); see also SCIENCE BLOG, *supra* note 97.

<sup>100</sup> Berdes & Eckert, *supra* note 97, at 110.

<sup>101</sup> See Patrick M. Gavin & Joanne R. Lax, *When Residents and Family Harass Staff: The Tightrope Between Regulatory Compliance, Risk Management and Employment Liability*, LONG TERM CARE & THE LAW 1 (Feb. 27, 2008) (American Health Lawyers Association Seminar Materials); see also Shelly Klaessy, *Research and Trends: Baby Boomer Values Give Insight Into Buying Decisions, MANAGEMENT-MARKETING-LEASING TODAY*, Oct. 2005 [hereinafter *Research and Trends*] ("These first wave Boomers (numbering nearly 37 million), were born between 1946 and 1955, and are between 50 and 59 years of age today.").

<sup>102</sup> See Metropolitan Life Insurance Company, *Demographic Profile of America's Older Babyboomers* (2010), available at <http://www.metlife.com/.../Profiles/mmi-older-boomer-demographic-profile.pdf>; see also United States Census Bureau, *The Older Population in the United States: 2009*, available at [http://www.census.gov/population/www/socdemo/age/older\\_2009.html](http://www.census.gov/population/www/socdemo/age/older_2009.html).

<sup>103</sup> *Research and Trends, supra* note 101 (stating that baby boomers have a view of the world vastly different from other generations); Gavin & Lax, *supra* note 101, at 1 (noting that baby boomers were raised with values of what was legally and socially acceptable that differ from those values of younger generations, not born in the "baby boomer" era).

<sup>104</sup> See *Research and Trends, supra* note 101 (stating that baby boomers are "currently experiencing changes in family priorities, changes in health, and changes in how they experience the world around them."); see also John Carvel & Jeevan Vasagar, *Plan to Withdraw Treatment from Racist Patients: Zero Tolerance of Abuse Under New Guidelines*, THE GUARDIAN, Jan. 25, 2002, <http://www.guardian.co.uk/society/2002/jan/25/raceequality.NHS> (explaining how "[r]acist hospital patients who persistently refuse care from doctors and nurses of a different ethnic origin will lose their right to treatment under the NHS").

culminating in admission to a nursing home.”<sup>105</sup> The feeling of vulnerability caused by a loss of autonomy, which at times is coupled with the onset of illness, can lead to a more overt expression of racist views.<sup>106</sup> However, the feeling of autonomy and onset of illness will not completely define or explain why some elderly patients overtly express their racist views because the “motivational foundations of human behavior have enormous complexity.”<sup>107</sup> One researcher has described categorization of “irrational prejudice to be ambiguous” where those individuals who grew up during times of racial isolation have beliefs that members of a particular group have characteristics that they do not in fact have, or a belief that most members of a group have certain characteristics when only a few do.<sup>108</sup>

#### V. FACING THE DILEMMA: IMPLICATIONS OF THE SEVENTH CIRCUIT DECISION

*Chaney* has set precedent in the Seventh Circuit and established a bright line rule for the medical field: the right to choose a care provider does not lend itself to a right to choose based on the race of a care provider. The issue presented in *Chaney* is not novel; cases analogous to *Chaney*’s have settled before a judicial opinion on the merits was rendered.<sup>109</sup> Since this is the first time a judicial opinion has been rendered on this particular issue, it is imperative that the implications be discussed. It is also important that members of the medical field begin a dialogue on how to remedy the conflicting obligations set forth by OBRA 87 and Title VII.

##### A. Void for Vagueness?

The Seventh Circuit has established a bright line rule in *Chaney* that patients’ rights are

<sup>105</sup> Maureen Armour, *A Nursing Home’s Good Faith Duty “To” Care: Redefining a Fragile Relationship Using the Law of Contract*, 39 ST. LOUIS L.J. 217, 229 (1994).

<sup>106</sup> See Carvel & Vasagar, *supra* note 104 (explaining that the expression of racist views “can often become more overt among the elderly people when they are confused or when suffering from diseases that affect their inhibitions, so they can become uninhibited.”); see also Berdes & Eckert, *supra* note 97, at 118 (noting that many nurse’s aides have in the study forgiven racist comments by patients because they understand that the patients were born during a different generation and were often senile).

<sup>107</sup> Sunstein, *supra* note 3, at 385.

<sup>108</sup> Sunstein, *supra* note 3, at 388–89.

<sup>109</sup> See, e.g., Gary S. Starr & Peter J. Murphy, *Elder Law: Patient Choice Versus Employee Rights: Conflicting Obligations?*, CONNECTICUT LAW TRIBUNE, Jan. 24, 2011 available at <http://www.ctlawtribune.com/getarticle.aspx?ID=39404> (discussing the settlement decision in *EEOC v. HiCare Inc.*); Charles Wilson, *Ind. Ruling Halts Caregiver Choices Based on Race*, ASSOCIATED PRESS, Aug. 23, 2010, available at <http://www.guardian.co.uk/world/feedarticle/9232635> (mentioning a case involving an Indianapolis nursing home similar to *Chaney* the resulted in an \$85,000 settlement).

*not* paramount to the rights of employees under Title VII, and that promoting a hostile work environment can lead to legal ramifications. However, the question still remains, what exactly would it take to be held legally responsible for the promotion of a hostile work environment? Justice Ginsberg, in her dissent in *AMTRAK v. Morgan*,<sup>110</sup> makes clear that hostile work environment claims are “fundamentally different from claims based on ‘discrete facts’ because the discrimination accumulates over an extended period of time.”<sup>111</sup> However, despite the fact that such claims are not always easily identifiable at the outset, “[i]t is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined. . . . [because] [v]ague laws may trap the innocent by not providing fair warning.”<sup>112</sup> The test set out by the court – that a minority employee must show that the work environment was both objectively and subjectively hostile, and that the conduct was severe – is vague, and allows for arbitrary opinions of whether a certain set of facts lends themselves to the creation of a hostile work environment. Consequently, “if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them.”<sup>113</sup>

In Chaney’s case, the bigotry was obvious, but it is not always going to be so clear. It is not the law that is vague in this instance, but the standard. The Seventh Circuit follows an overly flexible standard of how to identify a “hostile work environment,” and gives barely thought out suggestions on how to deal with hostile patients. If Plainfield had *not* written “Prefers No Black CNAs” on the assignment sheet, and instead pulled Chaney aside and voiced the patient’s concerns with having Chaney as her care provider, and Chaney by her own free will chose to respect the patients request, would this have constituted the creation of a hostile work environment? Or, what happens if a patient is extremely ill but acting in a discriminatory manner towards the facility’s health care staff. Would staffers have a claim against the care facility if they chose to let the patient remain because of his or her health condition? There is no quick bright line answer to any of these scenarios, but it is these scenarios that may lead to future claims, which is why the court’s vague opinion needs to be fleshed out beyond the legalities of Title VII and hostile work claims.

<sup>110</sup> 536 U.S. 101 (2002).

<sup>111</sup> Pete Lareau, *Lareau on Aftermath of Lily Ledbetter Fair Pay Act*, 2009 EMERGING ISSUES 3783 (2009).

<sup>112</sup> *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972)

<sup>113</sup> *Id.*

*B. The “Dilemma” Between Respecting Patient’s Autonomy While Protecting The Rights of Health Care Employees*

There are many psychological issues that patients and their families face when a loved one is admitted into a long-term care facility, but psychological issues do not give patients a free pass to act in a discriminatory manner towards their care providers.<sup>114</sup> *Chaney* sheds light on the obvious “tensions within anti-discriminatory discourses in hospice care that are concerned both with fairness in policies and practices and with the need to combat discrimination.”<sup>115</sup> The different “philosophies of hospice care and anti-discriminatory discourses play a significant role in constructing the nature of staff dilemma in their responses to incidents of racial harassment.”<sup>116</sup> The recurring theme seems to be that of “dilemma.” There is Plainfield’s dilemma, between adhering to patient preferences in accordance with Indiana law, while protecting the rights of its employees under Title VII. Additionally, there is Chaney’s dilemma, choosing to abide by the patient’s discriminatory request and Plainfield’s instructions not to care for the patient, and her right to non-discriminatory treatment under Title VII. The term dilemma, as one researcher phrased it, refers “to potentially problematic and unresolvable tensions within representations of perceptions, emotions and actions.”<sup>117</sup>

Condoning racial harassment or discriminatory preferences at the expense of care providers, as Plainfield did, cannot be justified. “Racist behavior needs to be addressed as an institutional issue, not a personal one.”<sup>118</sup> *Chaney* has shed light on the fact that the management of hostile patients should be a “team decision.” Chaney was faced with repeated bigotry without the support of her colleagues or Plainfield. There was nowhere for Chaney to turn; her attempt to seek advice and remedy the situation was dismissed by the facility when it determined that the patient’s preferences were paramount to her rights as an employee. The Seventh Circuit correctly dismissed Plainfield’s theory of the superiority of patients’

<sup>114</sup> See Lidi Schapira et al., *Racism in the Chemotherapy Infusion Unit: A Nurse’s Story*, 13 THE ONCOLOGIST 1177, 1179 (2008), available at <http://theoncologist.alphamedpress.org/cgi/reprint/13/11/1177> (“Illness is not an excuse for racism. If [care facilities] allow this language to go unchallenged [the facilities] become accomplices.”); see also Julia Neuberger, *Commentary: A Role for Personal Values . . . and Management*, 318 BRITISH MED. J. 1130, 1130 (1999).

<sup>115</sup> Yasmin Gunaratnam, *‘We Mustn’t Judge People . . . But’: Staff Dilemmas in Dealing With Racial Harassment Amongst Hospice Service Users*, 23 SOC. OF HEALTH & ILLNESS 65, 66–67 (2001).

<sup>116</sup> *Id.* at 70.

<sup>117</sup> *Id.* at 71.

<sup>118</sup> Schapira et al., *supra* note 114, at 1180.

rights. A nurse's professional practice is founded on his or her code of professional conduct, respecting the autonomy and privacy of individual patients regardless of race, religion, values, or practices. However, the code of professional conduct is insufficient when racist abuse and bigotry is present, and where such action encroaches on the wellbeing of medical staffers and other patients.<sup>119</sup>

The court's holding implicates the need to engage long-term care providers in a new way of thinking. It is important now that long-term care facilities promote a method of "[d]iagnostic thinking [to] help[] sort through the possible reasons or motivations of [a] patient [who asserts a discriminatory preference]. Was he feeling helpless, scared, or out of control?"<sup>120</sup> Engaging in this type of diagnostic thinking will allow the facilities to take part in more appropriate responses oriented toward putting the patient at ease.<sup>121</sup> If the patient's behavior cannot be managed, then further action need be taken, as discussed *infra* in Section VI.

A facility need not take the easy route and dismiss the discriminatory preferences by isolating the patient, "[t]o do so would be to miss the real tragedy and ignore the toxic legacy of racism."<sup>122</sup> In adhering to the patient's preferences, Plainfield ignored the "tragedy" at hand. The Seventh Circuit, by rendering its decision against Plainfield, has forced Plainfield and other similarly situated care facilities to confront the issue of discrimination in their facilities. Plainfield's solution, to isolate the hostile patient from Chaney, and shift the patient's care to a non-minority caregiver "has significant logistic disadvantages and sets a dangerous precedent," because the accommodation of racist behavior breaches accepted standards of health care that have been acknowledged by society.<sup>123</sup> If a patient fails to reform his or her behavior, it may be appropriate for a care facility to release the patient from its care. Since all

<sup>119</sup> See Pippa Gough, *Commentary: Courteous Containment is Not Enough*, 318 BRITISH MED. J. 1131, 1131 (1999), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1115523/> (explaining that the starting point for nurses is to care for and treat all patients with respect and autonomy despite their patients' attitudes, values, or beliefs. But this type of treatment does not suffice when there is a case of racist abuse and bigotry); see also Charles Easmon, *Commentary: Isolate the Problem*, 318 BRITISH MED. J. 1130, 1130 (1999).

<sup>120</sup> Schapira et al., *supra* note 114, at 1180.

<sup>121</sup> See *id.*; see also Helen Tinsley-Jones, *Racism: Calling a Spade a Spade*, 40 PSYCHOTHERAPY: THEORY, RES., PRAC., TRAINING 179, 183 (2003).

<sup>122</sup> See Schapira et al., *supra* note 114, at 1180; see also Gough, *supra* note 119, at 1131 (discussing the case of a racist patient, and explaining that "[t]reatment [of the patient] continued once the environment had been modified to suit the racist view [of the patient]. A mini apartheid was created. [However,] [m]ere containment, with no expression of repugnance for the views being aired or more positive action, seems to be professionally and morally questionable.").

<sup>123</sup> Schapira et al., *supra* note 114, at 1180 ("[A]ccommodating racist behavior can be thought of as a breach of commonly accepted standards for society as a whole.").

patients are entitled by law to provide care in a reasonable manner, a physician that does not believe he or she can meet this standard of care for a particular patient is “entitled to terminate [the] healthcare relationship provided that [the physician and facility] act reasonably to ensure continuity of care for the patient.”<sup>124</sup> Furthermore, “differences in the accounts of the same incident can be located in differences in professional caring roles, responsibilities and status, where doctors . . . can have significantly less day-to-day contact and emotional involvement with service users.”<sup>125</sup> Because one health care professional is not entirely offended by the behavior of a patient does not discount the feelings of another health care professional, and facilities should be respectful of each individual employee’s feelings.

The implications and the solutions discussed above, and *infra* in Part VI, are not necessarily applicable to situations involving emergency care or the presence of life-threatening illness. It is understood in the medical field that these types of situations influence the manner in which discriminatory confrontations are managed due to the level of care needed at that particular time.<sup>126</sup> For example, if a cardiac arrest patient is about to go under for life saving heart surgery and is acting hostile towards the staff of an emergency facility, making requests for doctors based on race, the facility cannot refuse to treat the patient, but will also not be liable if they do not abide by the patient’s request. However, in the long-term care setting, *Chaney* establishes the need for policy reform, as taking any action that promotes or allows discriminatory behavior to fall by the wayside will be a step backwards in terms of combating racial discrimination. Even though care facilities “have no jurisdiction over beliefs, prejudices, or comments made outside [of] treatment facilities, [they] can enforce a culture of tolerance and civility [from] within.”<sup>127</sup>

<sup>124</sup> University of Illinois at Chicago College of Medicine, Ethics in Clerkships, <http://www.uic.edu/depts/mcam/ethics/difficult.htm> (last visited Mar. 9, 2011); see also Harris County Medical Association, Physician Patient Relationship, <http://www.hcms.org/Template.aspx?id=247> (last visited Mar. 9, 2011) (“Physicians have a duty to support continuity of care for their patients; therefore, they may not discharge a patient as long as further treatment is medically indicated.”).

<sup>125</sup> Gunaratnam, *supra* note 115, at 78.

<sup>126</sup> Schapira et al., *supra* note 114, at 1180 (“We recognize that there is a spectrum of personal values and ethical mandates that influence the behavior and responses of individual nurses and doctors, and the presence of life-threatening illness will likely influence how such confrontations are managed.”); Dov Steinmetz & Hava Tabenkin, *The ‘Difficult Patient’ As Perceived By Family Physicians*, 18 FAM. PRAC. 495, 495 (2001) (“Various social and medical conditions were found to be difficult for physicians.”).

<sup>127</sup> Schapira et al., *supra* note 114, at 1180.

VI. CHANEY FALLS SHORT: HOW TO AVOID THE LEGAL AND ETHICAL BIND BETWEEN ADHERING TO PATIENT'S RIGHTS UNDER THE NURSING HOME REFORM ACT AND EMPLOYEE'S RIGHTS UNDER TITLE VII

The court was correct when it drew a line between patient's rights and the rights of employers, essentially finding that "[w]hen consumer direction comes up against choices based on race and ethnicity, workers' civil rights are implicated and they trump the right to choose health care providers."<sup>128</sup> However, the court fell short in its suggestion to long-term care facilities on how to avoid the dichotomy between unlawful employment practices and hostile residents.<sup>129</sup> Health care providers have long been under the impression that patients are free to choose their care providers based on discriminatory characteristics until the Seventh Circuit's decision in *Chaney*.<sup>130</sup> It is no secret that "[e]lderly residents who grew up in an era of racial intolerance . . . may revert to behavior learned in youth and young adulthood. The behavior may include racial slurs or demeaning behavior towards racial minorities,"<sup>131</sup> which will consequently lead to a hostile work environment. Some solutions that the court suggested, including cultural competency and behavior contracting, are well-thought solutions; but their implementation needs to be developed. Cultural competency training generally focuses on the health care providers, while behavior contracting focuses on a shared initiative between the patient and care providers.

A. Cultural Competency Training

Cultural competency is a strategy that has recently gained attention as a method to

<sup>128</sup> Vega, *supra* note 8.

<sup>129</sup> See *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908, 915 (7th Cir. 2010) ("[A] long-term care facility confronted with a hostile resident has a range of options. It can warn residents before admitting them of the facility's nondiscriminatory policy, securing the resident's consent in writing; it can attempt to reform the resident's behavior after admission; and it can assign staff based on race-neutral criteria that minimize the risk of conflict.").

<sup>130</sup> See Foubister, *supra* note 1 (noting that the American Medical Association's guidelines only emphasize that caregivers cannot choose to accept or decline patients on discriminatory characteristics, but says that patients are not bound by the same obligations as the care facilities); see also National School Boards Association, Employment Discrimination Against Caregivers, <http://www.nsba.org/SchoolLaw/Federal-Regulations/Archive/Employmentdiscriminationagainstcaregivers.txt> (last visited Mar. 9, 2011) (stating that even federal equal opportunity laws "do not prohibit discrimination against caregivers per se").

<sup>131</sup> Gavin & Lax, *supra* note 101, at 12.



improve the quality of health care, as well as to eliminate both racial and ethnic disparities in health care.<sup>132</sup> The broad range of patient perspectives in health care, influenced by patient's social or cultural backgrounds, is inevitable due to the increasing diversity of the United States.<sup>133</sup> Patient preferences are driven by, but not limited to, shared languages, cultural preferences, and social experiences.<sup>134</sup> Consequently, because of the vast spectrum of cultural attitudes and experiences, cultural competence on the part of the physician is necessary for they have taken on the responsibility of caring for these patients. “[C]ross-cultural competence – defined as ‘the knowledge, skills, attitudes, and behavior required of a practitioner to provide optimal health care services to persons from a wide range of cultural backgrounds’ – is key to providing quality health care, [and] exposure to a racially diverse environment helps providers acquire such competence.”<sup>135</sup> It would be much more difficult to implement a similar type of training with patients. If a patient has racist feelings due to a visceral aversion to African Americans, any opportunity for exchanges on controversial issues involving race would likely not advance a mutual understanding between the white patient and the African American care provider on issues of racial stereotyping and discrimination.<sup>136</sup>

Many health care providers tend to justify discriminatory employment practices as a means to accommodate the preferences of patients, who tend to be more comfortable with same-race care providers.<sup>137</sup> Even though

<sup>132</sup> Joseph R. Betancourt et al., *Cultural Competence and Health Care Disparities: Key Perspectives and Trends*, 24 HEALTH AFF. 499, 499 (2005) (“Cultural competence has gained attention as a potential strategy to improve quality and eliminate racial/ethnic disparities in health care.”); see also *Sponsors, Researchers and Government Examine How to Increase Minority Clinical Trial Participation*, GUIDE TO GOOD CLINICAL PRAC. NEWSL., June 2007 (“[C]ultural competency . . . refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.”).

<sup>133</sup> See Betancourt et al., *supra* note 132, at 499; *Developing Cultural Competence at Long-Term Care Facilities: Policies, Staff Training Recommended*, NURSING HOME REG. MANUAL NEWSL., Feb. 2009.

<sup>134</sup> Frederick M. Chen et al., *Patients' Beliefs About Racism, Preferences for Physician Race, and Satisfaction With Care*, 3 ANNALS OF FAMILY MED. 138, 138 (2005); see also Janice Hopkins Tanne, *Patients Are More Satisfied With Care From Doctors of Same Race*, BMJ, Nov. 9, 2002, at 1057.

<sup>135</sup> Helen Norton, *Stepping Through Grutter's Open Doors: What the University of Michigan Affirmative Action Cases Mean For Race-Conscious Government Decisionmaking*, 78 TEMP. L. REV. 543, 571–72 (2005).

<sup>136</sup> See Robert M. Entman, *Young Men of Color in the Media: Images and Impacts*, JOINT CENTER FOR POL. & ECON. STUD. 1, 31 (2006) (noting that research has demonstrated that unless white participants taking part in exchanges on controversial issues with African Americans have been educated in advance on the subtleties of racial discrimination and stereotyping, these exchanges will not lead to a mutual understanding).

<sup>137</sup> See Norton, *supra* note 135, at 572. (“Thornier, in my view, is the contention that race-conscious hiring of health care professionals is justified to accommodate the preferences of patients of color who feel more comfortable with same-race doctors.”); see also Somnath Saha et al., *Do Patients Choose Physicians of Their Own Race?*, 19 HEALTH AFF. 76, 82 (2000).

many of the studies focusing on patient preferences have focused on the preferences of minorities, attitudes that shape these preferences are present in all patients, no matter their race, religion, or national origin. The studies that have demonstrated that patients of color prefer health care providers of the same race “also found that significant numbers of minorities prefer not to have doctors of their own race, perhaps reflecting ingrained racial stereotypes that would only be reinforced by accommodating such preferences.”<sup>138</sup> Health care providers that emphasize to their patients that cross-cultural competence is a primary measure in their hiring and promotion decisions will ease patients’ concerns that their health care provider will not understand their personal issues due to cultural barriers.<sup>139</sup> A racially diverse workforce that is culturally competent will not only increase the trust that a patient has for his or her care provider, but will enhance the health institution’s legitimacy by facilitating interactions among racially diverse colleagues, lending to the exchange of varying perspectives and approaches to improve patient health care.<sup>140</sup> Race matching can facilitate deliberate discriminatory decisions that “reinforce[] unconscious bias,”<sup>141</sup> and can hurt medical professionals’ relationships with their patients.

The importance of cultural competency is not a novel concept, but the discussion of mandating cultural competency training in the medical field is a recent phenomenon.<sup>142</sup> “The goal of cultural competence is to create a health care system and workforce that is capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency.”<sup>143</sup> Cultural competency teachings are not meant to make care providers feel as if they are incompetent or racist, they are meant to enhance professional development and facilitate the education of care providers on the latest science in communications and communicating

<sup>138</sup> Norton, *supra* note 135, at 573.

<sup>139</sup> Norton, *supra* note 135, at 573; Saha et al., *supra* note 137, at 81.

<sup>140</sup> See Norton, *supra* note 135, at 574; see also Grutter v. Bollinger, 539 U.S. 306, 332 (2003) (“In order to cultivate a set of leaders with legitimacy . . . it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity. All members of our heterogeneous society must have confidence in the openness and integrity of the educational institutions that provide this training.”).

<sup>141</sup> Norton, *supra* note 135, at 564 (“[I]ndividuals of all races often unconsciously use stereotypes as cognitive short-cuts to make sense of an information-laden world by placing newly-encountered items into previously created categories with ascribed meanings.”).

<sup>142</sup> See Susan J. Landers, *Mandating Cultural Competency: Should Physicians Be Required To Take Courses?*, AM. MED. NEWS, Oct. 19, 2009, <http://www.ama-assn.org/amednews/2009/10/19/prsa1019.htm>.

<sup>143</sup> Betancourt et al., *supra* note 132, at 499.

effectively across cultures.<sup>144</sup> Cultural competency has been proven to make a difference in health care providers' knowledge, attitudes and skills, and leads to increased satisfaction in patient care.<sup>145</sup> The vast amount of studies that have been done in the medical field "provide overwhelming evidence . . . [that] [m]inority patients appear to be getting worse care and having worse outcomes than white patients with the same health problems."<sup>146</sup> Even though *Chaney* dealt more specifically with patient preferences and not the resulting care of the patient, the court could have used the precedent set forth by its holding to send a message to the medical field that training such as cultural competency will relieve a lot of the problems that the medical field faces with regards to hostile patients and patient preferences.

Trust is a fundamental part of the patient-care provider relationship.<sup>147</sup> To even begin to build trust between patients and their care providers, institutions such as Plainfield must facilitate interaction between the patient and the care provider, rather than hinder it by adhering to the racial preferences of their patients. A greater number of interactions between the patient and their care provider will generally lead to an increase in the patient's trust of that care provider.<sup>148</sup> There is no telling whether this would have been the outcome in *Chaney's* case, but it would likely have alleviated any hostility that *Latshaw* had towards *Chaney*, potentially increasing her trust in *Chaney* as her care provider. It has been noted that "[w]hen patients are satisfied with their physicians' style, effective communication, leading to improved adherence and health outcomes, becomes more likely."<sup>149</sup>

In 1994, a survey found that only 13 out of 78 responding medical

<sup>144</sup> Landers, *supra* note 142 ("The goal of this set of teachings is not about making anybody feel they are incompetent or racist in any way. It is about professional development. It is about learning the latest science in communications and communicating across cultures.").

<sup>145</sup> Myrtle Croasdale, *Cultural Competency Training Has An Impact*, AM. MED. NEWS, June 20, 2005, <http://www.ama-assn.org/amednews/2005/06/20/prsd0620.htm>; Mary Catherine Beach et al., *Cultural Competence: A Systematic Review of Health Care Provider Educational Interventions*, 43 MED. CARE 356, 362–63 (2005).

<sup>146</sup> Myrtle Croasdale, *Research Documents Disparities, But Solutions Remain Elusive*, AM. MED. NEWS, Apr. 4, 2005, <http://www.ama-assn.org/amednews/2005/04/04/prl20404.htm>.

<sup>147</sup> Doescher et al., *Racial and Ethnic Disparities in Perceptions of Physician Style and Trust*, 9 ARCHIVES FAM. MED. 1156, 1157 (2000) ("Trust is a fundamental component of the patient-physician relationship."); see also Carolyn Clancy et al., 42.2 J. FAM. PRAC. 129, 129 (1996) ("A bond to someone you trust may be healing in and of itself. This relationship is essential when guiding patients through the health system.").

<sup>148</sup> See Doescher et al., *supra* note 147, at 1162; see also David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 MILBANK Q. 171, 175 (1996) ("[I]nterpersonal trust is based primarily on social interactions over time. Interpersonal trust builds on the patient's experience of the doctor's competent, responsible, and caring responses.").

<sup>149</sup> Doescher et al., *supra* note 147, at 1156.

institutions offered cultural sensitivity courses.<sup>150</sup> However, recent trends in health care are evidence that cultural competency training is a positive initiative for the medical field,<sup>151</sup> and that it is important to teaching physicians to become more patient-centered by teaching them the relevant skills.<sup>152</sup> In 2004 it was found that out of “8,000 graduate medical educational programs surveyed in the United States, 50.7 percent offered cultural competence training in 2003-2004, up from 35.7 percent in 2000-2001.”<sup>153</sup>

To facilitate a growth in trust and understanding between patients and their care providers, a medical facility must understand what a cultural competency training program would include. The program training should not only discuss overall cultural competence, but should also focus on the specific population groups and health issues that are relevant to the particular community that their facility serves.<sup>154</sup> An institution should also address the linguistic needs of its patients, including “organizational, clinical, and linguistic competence.”<sup>155</sup> Additionally, there are a number of effective cultural competency training programs already in existence, including Cross-Cultural Health Care Program, Management Sciences for Health, and Center for Cross-Cultural Health.<sup>156</sup> Established programs have proven to be very effective and generally provide a consultant as part of the package to explain the program and the best method of implementation.<sup>157</sup> Lastly, an institution can choose to institute a cultural competency training program developed by them. The benefit of this method is that a specific institution’s training department knows its organization’s culture best, and

<sup>150</sup> Doescher et al., *supra* note 147, at 1162.

<sup>151</sup> See Betancourt et al., *supra* note 132, at 501 (noting that many health care insurers have mandated cultural competency training for their internal medical doctors, nurses and case managers); see also Jason A. Wolf, *The Role of Cultural Competence in Delivering Positive Patient Experiences: 4 Focal Points*, BECKER'S HOSP. REV., Aug. 11, 2011, <http://www.beckershospitalreview.com/hospital-management-administration/the-role-of-cultural-competence-in-delivering-positive-patient-experiences-4-focal-points.html>.

<sup>152</sup> See Doescher et al., *supra* note 147, at 1162; see also, Fredric M. Wolf et al., *A Controlled Experiment in Teaching Students To Respond To Patients' Emotional Concerns*, 62 J. MED. EDUC. 25, 25 (1987).

<sup>153</sup> Betancourt et al., *supra* note 132, at 502.

<sup>154</sup> Alloy Educ., *Providing Cultural Competency Training For Your Nursing Staff*, MINORITYNURSE.COM, <http://www.minoritynurse.com/print/220> [hereinafter *Minority Nurse*]; see also BETANCOURT ET AL., FIELD REPORT, CULTURAL COMPETENCE IN HEALTH CARE: EMERGING FRAMEWORKS AND PRACTICAL APPROACHES 7 (2002).

<sup>155</sup> *Minority Nurse*, *supra* note 154.

<sup>156</sup> *Minority Nurse*, *supra* note 154.

<sup>157</sup> *Minority Nurse*, *supra* note 154; see also Anthony Cirillo, *Cultural Sensitivity Training: One Step in Achieving Person-Centered Care*, ABOUT.COM, <http://assistedliving.about.com/od/caringforclients/a/cultural-sensitivity-training.htm> [hereinafter *Cultural Sensitivity Training*].

would generally have a good grasp of what approaches are most effective.<sup>158</sup> If this is the chosen method, it is important for the institution to seek the advice of a consultant who has the experience and expertise in cross-cultural health issues.<sup>159</sup> No matter what, cultural competency training programs are an essential step in breaking the barriers of discrimination in the health field because “cultural issues are alive and well and constantly changing.”<sup>160</sup>

While cultural competency is useful to the staff of long-term care facilities, giving them a better understanding of how patients’ racial preferences can undermine staff morale while also educating them on religious and cultural practices of America’s diverse population, it is unlikely that this type of training can completely change the racial attitudes ingrained in some patients. While cultural competency training may have advanced Chaney’s understanding of her patients’ culture and religion and increased the trust that her patients had in her ability to care for them, it may not have had any affect on the way Latshaw viewed Chaney.

Both racial isolation and the ideal that African Americans are undereducated and less intelligent than whites<sup>161</sup> can have a potentially grave effect on patients, such as Latshaw’s views on minority care providers. Individuals often have tendencies toward “remembering unfavorable behaviors associated with the outgroup.”<sup>162</sup> Moreover, when weight is given to individuals who tend to confirm a given stereotype rather than those who disconfirm it, the result is the continued existence of a given stereotype, specifically that African Americans are inferior and less educated than whites.<sup>163</sup> When a white patient has a superiority complex, the thought of having a care provider that a patient views as inferior to himself or herself is difficult for the patient to grasp, even if their care provider is “culturally competent.” Furthermore, if a patient generally adheres to egalitarian ideals, holding themselves out as non-racists, theorists believe that “unrecognized negative feelings and cognitive

<sup>158</sup> *Minority Nurse*, *supra* note 154; *Cultural Sensitivity Training*, *supra* note 157.

<sup>159</sup> *See Minority Nurse*, *supra* note 154; *see also Cultural Sensitivity Training*, *supra* note 157.

<sup>160</sup> *Minority Nurse*, *supra* note 154.

<sup>161</sup> *See generally* Charles H.F. Davis III, *Black People Genetically Predisposed To Be Less Intelligent?*, FRESHXPRESS, April 30, 2010, <http://thefreshxpress.com/2010/04/harvard-student-says-black-people-genetically-predisposed-to-be-less-intelligent>; *see also* Herbert L. Foster, *Educators’ and Non-Educators’ Perceptions of Black Males: A Survey*, 1 J. AFR. AM. MEN 37 (1995).

<sup>162</sup> Entman, *supra* note 136, at 6.

<sup>163</sup> Entman, *supra* note 136, at 6 (discussing the fact that individuals let their ideals about individuals be shaped by those who confirm stereotypes rather than those who disconfirm stereotypes); *see also* Sarah Murray, *Humanizing The Accused Gang Defendant*, TRIAL BEHAVIOR CONSULTING, <http://www.trialbehavior.com/publications/articles/HumanizingGang>.

associations concerning persons of color [still exist], which can lead to prejudicial behavior.”<sup>164</sup>

In situations where there is a visceral reaction towards a particular racial group, it is unlikely that cultural competency training alone will remedy a circumstance involving a hostile patient with discriminatory preferences. Issues involving race are sensitive matters, and it is difficult to get even young individuals “who are both old enough to understand concepts like stereotyping and fairness, and young enough, one would hope, to change their views—to communicate honestly and remain open to other groups’ views.”<sup>165</sup> In order to make any progress, in conjunction with cultural competency training, there must be inter-group dialogues and educational interventions. More frequent interactions between hostile patients and their minority care providers may allow for the diminishment of any distrust a patient may have in their care provider, while also promoting education in racial discourse.<sup>166</sup> Dialogues and interventions of this nature are not going to have an immediate effect on race relations in long-term care facilities but can move race relations in long-term care facilities in a positive direction, towards defeating discriminatory stereotypes.

### *B. Behavior Contracting*

The court, in discussing alternatives for Plainfield, suggested that not only should facilities notify patients of their nondiscrimination policy, “securing the resident’s consent in writing,” but that health care facilities should “attempt to reform the resident’s behavior after admission”<sup>167</sup> if such behavior is leading to a hostile work environment. It is imperative that long-term care providers set forth their zero-tolerance discrimination policies at the outset of every patient’s care. This will act as a notification to all patients that racist behavior will not be tolerated under any circumstances. Further, if a patient is hostile during his or her time at a facility, it is important for the facility to set forth some type of behavior contact with the patient to remedy his or her behavior. While the *Chaney* court found that behavior contracts might be appropriate under certain circumstances, the court failed to realize that it is difficult to implement behavior contracts when you have a “resident scream[ing] racial epithets at

<sup>164</sup> Entman, *supra* note 136, at 11.

<sup>165</sup> Entman, *supra* note 136, at 31.

<sup>166</sup> Entman, *supra* note 136, at 31 (discussing how to reduce the negative image of black males portrayed by the media); see also Roy J. Lewicki & Edward C. Tomlinson, *Trust and Trust Building*, BEYOND INTRACTABILITY, Dec. 2003, <http://www.beyondintractability.org/node/2608>.

<sup>167</sup> *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908, 915 (7th Cir. 2010).

the minority employee while he or she is merely trying to do their job.”<sup>168</sup> Due to the reality of these situations, the court should have had more developed suggestions for healthcare institutions, guiding them to appropriately contract with hostile patients. It may not be the court’s responsibility to discuss the implementation of behavior contracts, but because the Seventh Circuit’s decision will have far reaching implications, a more elaborate explanation is necessary to prevent an influx of similar litigation.

Behavior contracts can be an extremely effective tool for altering aggressive behavior, and can “be a positive learning experience leading to mutual understanding and improved relations between patients and staff.”<sup>169</sup> Effective behavior contracts attempt to change a patient’s problematic behavior.<sup>170</sup> Problematic behavior is defined as any behavior that may lead to self-injury or that creates a hostile work environment.<sup>171</sup> During Chaney’s employment at Plainfield there was a point where she could not even render Latshaw assistance when she fell because of Latshaw’s request for only white care providers. Latshaw’s behavior was extremely problematic. Her restriction on who could render her immediate aide during a time of need could have led to the exacerbation of an injury or gravely affected her health. The implementation of a behavior contract to alter Latshaw’s behavior could have effectively improved Chaney and Latshaw’s relationship.

For a behavior contract to be effective, it must include statements of responsibility from both the patient and the facility, the use of behavioral terms, monitoring, review, utilization of a staff monitor, and a specified time frame.<sup>172</sup> The behavior contract should set a goal, written with the patient’s input, describing the *desired* behavior and not the behavior that

<sup>168</sup> THOMAS P. GODAR, WHYTE HIRSCHBOAEK DUDEK S.C. SPECIAL REPORT, ANTI-DISCRIMINATION LAWS TRUMP RESIDENTS’ RACIAL PREFERENCE 1, 1 (2010).

<sup>169</sup> Ramiro Valdez, *The Behavior Contract as a Positive Patient Experience*, ESRD NETWORK, <http://www.esrdnetwork.org/assets/pdf/conflict/RVContractArticle-reformatted11-03.pdf>.

<sup>170</sup> See *id.* (“Appropriate and effective behavior contracts set a goal of a change in problematic behavior.”); see also SOUTHEASTERN KIDNEY COUNCIL, TO CONTRACT OR NOT TO CONTRACT 1, <http://www.esrdnetwork6.org/utills/dpc/BehaviorGuidelines.pdf> (discussing how behavior contracts can be an effective way to motivate change).

<sup>171</sup> Valdez, *supra* note 169; see also Tony Belak, *How to Handle Difficult Behavior in the Workplace*, MEDIATE.COM, Feb. 2004, <http://www.mediate.com/articles/belak4.cfm> (“Difficult behavior can inhibit performance in others and will only deteriorate if left alone.”).

<sup>172</sup> Valdez, *supra* note 169; see also *Nursing Management of Aggression*, PSYCHIATRIC NURSING, Jan. 2011, [http://nursingplanet.com/pn/nursing\\_management\\_aggression.html](http://nursingplanet.com/pn/nursing_management_aggression.html) (explaining that effective behavioral contracts require detailed information about unacceptable behaviors, acceptable behaviors, and consequences for breaking the contract).

they wish the patient to stop.<sup>173</sup> Not only should the contract point out the role of the patient, but also the role the clinic will play in achieving the desired goals.<sup>174</sup> It is the care facility's responsibility to "inform patients they have the right to make suggestions for improving the clinic."<sup>175</sup> The facility must set a time frame with the patient, as not doing so may make a patient feel as if they are on "probation" and could lead to a lack of commitment in trying to reform negative behaviors that lead to hostile work environments.<sup>176</sup> A staff monitor can track the progress between the physician and the patient, noting whether either party is keeping its end of the agreement.<sup>177</sup> The contract should also notify the patient of the consequences for non-compliance.<sup>178</sup>

Behavior contracts have been found to be beneficial to both the patient and the care provider, allowing for the parties in the contract to communicate openly with one another, addressing and discussing the matter, and reaching a resolution that is satisfactory.<sup>179</sup> If a satisfactory resolution is not reached, and the relationship between the patient and physician becomes "irretrievabl[y] broken," a physician, along with the facility, may choose to terminate the relationship and discharge the patient from the care facility.<sup>180</sup> If the care facility and physician collectively

<sup>173</sup> Valdez, *supra* note 169 ("The goal is stated as the desired behavior, **NOT** as the behavior to be stopped."); see also SOUTHEASTERN KIDNEY COUNCIL, *supra* note 170, at 6 ("Avoid using a behavior contract as a way to threaten or intimidate a patient, since neither will produce the long-term results that are desired. Also, avoid wording that is negative – never degrade a patient. ").

<sup>174</sup> Valdez, *supra* note 169 (explaining that in order for a behavior contract to be successful it must state the role of *both* the patient and the clinic or caregiver); see also *supra* Part III.A (describing cultural competence as a means of gaining patient trust. A clinic can use cultural competency training as their "role" in facilitating a successful behavior contract, stating that they will ensure that all of their caregivers have cross-cultural competence, which will help caregivers maintain an understanding of each individual patient's needs).

<sup>175</sup> Valdez, *supra* note 169; see also SOUTHEASTERN KIDNEY COUNCIL, *supra* note 170, at 6 ("Include the patient in the process. Being involved in the goal-setting process will allow a patient to assume responsibility for a goal, and thus motivate him/her to achieve the goal. ").

<sup>176</sup> Valdez, *supra* note 169; SOUTHEASTERN KIDNEY COUNCIL, *supra* note 170, at 7 ("All contracts should have a clear beginning and ending date so that the patient doesn't feel as though he/she is left hanging. ").

<sup>177</sup> Valdez, *supra* note 169; SOUTHEASTERN KIDNEY COUNCIL, *supra* note 170, at 7 ("Make sure that all of the team's efforts and the patient's progress are recorded somewhere, and include specific documentation in the patient's record. ").

<sup>178</sup> Jennifer L. Griffin, *Addressing Problem Patient Behavior in a Physician Practice*, BIRMINGHAM MED. NEWS, Apr. 1, 2005, available at [http://www.burr.com/\\_x734/April%202005%20BMN%20Article.pdf](http://www.burr.com/_x734/April%202005%20BMN%20Article.pdf); SOUTHEASTERN KIDNEY COUNCIL, *supra* note 170, at 6 ("Implement consequences for failure to adhere to contracts that are meaningful to the patient, but that veer away from threatening language. ").

<sup>179</sup> See Griffin, *supra* note 178; see also Valdez, *supra* note 169 ("Behavior contracts are being used more and more . . .").

<sup>180</sup> Griffin, *supra* note 178 ("In the event the physician-patient relationship becomes irretrievably broken, a physician may decide it is appropriate to discharge a patient from his or her practice."); see also American Medical Association, *Ending the Patient-Physician Relationship*, <http://www.ama->



decide that such a drastic measure needs to be taken, the decision must be made with great care, possibly seeking the advice of an attorney to avoid potential claims of patient abandonment, or violations of antidiscrimination laws or ethical guidelines.<sup>181</sup>

In cases similar to *Chaney*, behavior contracts would encourage the patient to allow any nurse to care for them, regardless of the nurse's race, culture, or religion. The contract could establish that the facility will put forth a support system for the patient, ensuring that the patient remains comfortable while working to overcome any fears he or she may have in allowing an individual of another race to care for them. However, it would be difficult to implement a rigid time frame for the contract. A facility like Plainfield could set an agreement with the patient that the contract will remain in place for a period of time, until the patient and care provider have the opportunity to build a positive relationship. It is important that the patient and the care provider get to know one another to enable the patient to begin to trust the care provider despite their differences. A patient's refusal to act in a manner consistent with the desired behavior expressed in the contract would be a breach of the contract. The contract would set forth the consequences of non-compliance, such as releasing the patient from the facility's care. However, the contract must specifically discuss and explain how the removal of the patient would be implemented, as to not violate the legal and ethical obligations owed to the patient.

Behavior contracts can be a means of averting a patient's focus away from discriminatory feelings, and instead toward obtaining the best health care possible. Also, at a time when a patient feels as though he or she is losing all control of their life, behavior contracts will give the patient a measure of satisfaction, knowing that he or she does have a say in his or her treatment, essentially reducing the power struggle between the patient and the care provider. A behavior contract is not a legally binding contract, but is a moral obligation on the part of both the care facility and patient that can only work if both parties are active in initiating change.

[assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/ending-patient-physician-relationship.page](http://assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/ending-patient-physician-relationship.page) (last visited Mar. 1, 2012) [hereinafter AMA] (describing instances where it may be necessary to end the patient-physician relationship).

<sup>181</sup> Griffin, *supra* note 178 (noting that it can be risky to discharge a patient for non-compliance with behavior contracts, and that to further protect the care facility and the physician, one should seek legal advice and guidance before such measures are taken); *see also* AMA, *supra* note 180 (warning physicians to follow appropriate steps when terminating the patient-physician relationship).

## CONCLUSION

Title VII would be rendered meaningless if the Seventh Circuit held that a long-term care facility could grant patient preferences made on discriminatory grounds.<sup>182</sup> The Seventh Circuit's holding allows the United States to continue to progress towards racial equality, rather than revert to the days when discrimination was rampant.<sup>183</sup> Discrimination is the corollary of stigma, and it is evident that "[a]t the heart of stigma lies fear – fear that those who are stigmatized threaten society."<sup>184</sup> Both "[s]tigma and discrimination are self-perpetuating. A stigmatized group suffers discrimination, while discrimination underlines and reinforces stigma."<sup>185</sup> These "self-perpetuating" discriminatory attitudes and beliefs cannot be tolerated, nor afforded any preferential treatment under any circumstances, and the Seventh Circuit properly recognized this.

Complying with a patient's wish to have a white-only care provider leads to a hostile work environment for non-white employees.<sup>186</sup> The Seventh Circuit, reversing the lower court, "pointed out that in order to impose liability for a racially hostile work environment, a minority [employee] must show that the work environment was both objectively and subjectively hostile, and that the conduct was severe and pervasive."<sup>187</sup> Any reasonable person would conclude that Chaney faced an abusive and hostile work environment while employed at Plainfield.<sup>188</sup> "Plainfield's exclusion of Chaney from certain residents and work areas solely on account of her race created a racially-charged situation that 'poisoned the work environment' and created 'fodder' for co-workers' racially

<sup>182</sup> See *supra* Part II.B.2 (discussing Congress' intent for not making race a BFOQ).

<sup>183</sup> See Martin Foreman, *Stigma and Discrimination*, HEPATITIS & AIDS RESEARCH TRUST (Mar. 11, 2011, 7:53 PM), <http://www.heart-intl.net/HEART/Stigma/Comp/StigmaandDiscrimination.htm> ("Stigma is as old as history. . . . but stigma remains, based on one or more factors, such as . . . class . . . ethnicity, [and] religious belief . . . . Stigma is applied by society and borne or possessed by groups and individuals. By defining deviance and confirming exclusion, stigma reinforces social norms . . . . The corollary of stigma is discrimination."); see also OVCSupport.net, *Action on Stigma and Discrimination: What is Stigma and Discrimination*, <http://www.ovcsupport.net/s/index.php?i=234> (last visited Feb. 2, 2012) ("Stigma is about beliefs and attitudes. Discrimination relates to actions. Both are based on negative views of people simply because they are seen as belonging to a particular group.").

<sup>184</sup> Foreman, *supra* note 183.

<sup>185</sup> Foreman, *supra* note 183.

<sup>186</sup> See *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908, 915 (7th Cir. 2010); see also John Stone, *Public Law: Seventh Circuit Finds Racially Hostile Work Environment Based on Nursing Home Honoring Patient's Racial Preferences*, NAT'L LEGAL RES. GROUP, INC. (Jan. 12, 2011, 4:04 PM), <http://www.nlrg.com/public-law-legal-research/bid/52880/PUBLIC-LAW-Seventh-Circuit-Finds-Racially-Hostile-Work-Environment-Based-on-Nursing-Home-Honoring-Patient-s-Racial-Preferences>.

<sup>187</sup> Maria Greco Danaher, *Patient's Preference Does Not Trump Duty To Abstain From Race-Based Assignments*, 12 LAW. J. 9, 9 (2010).

<sup>188</sup> Danaher *supra* note 187.

derogatory remarks.”<sup>189</sup>

Setting precedent in this area of litigation, the Seventh Circuit asserted that the “ethical bind” between patient preferences and Title VII employment discrimination is avoidable when a long-term care facility is faced with a hostile resident.<sup>190</sup> The court made vague suggestions to long-term care facilities that find themselves in the same position as Plainfield. The two options suggested by the court that seem the most promising when dealing with hostile patients, cultural competency training and behavioral contracting, can be very successful when implemented correctly.<sup>191</sup>

The decision reached by the Seventh Circuit has brought to light the “dilemma” that medical care facilities face when hostile patients exercise their discriminatory preferences. Unfortunately, the Seventh Circuit’s opinion left a huge gray area for care facilities, forcing facilities to determine when a specific situation promotes a hostile work environment and what within the parameters of the law the facility can do to remedy the situation. This Comment attempts to address the methods that a care facility can use to ensure compliance with Title VII and OBRA 87. The standard set forth by the *Chaney* court to identify the “promotion of a hostile work environment” may have been inadequate, however, the court’s decision brought attention to these important “dilemmas.” Attention to these dilemmas of anti-discriminatory practice present society with positive opportunities to develop policy while focusing on the emotional ‘climate’ surrounding equal opportunities within organizations, which can ultimately lead to changes in hostile patients’ behavior and the manner in which this behavior is dealt with.<sup>192</sup>

<sup>189</sup> Danaher *supra* note 187.

<sup>190</sup> *See Chaney*, 612 F.3d at 915.

<sup>191</sup> *See id.*

<sup>192</sup> Gunaratnam, *supra* note 115, at 81.