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Fordham School of Law

# Metro LALSA

**Pa'lante VI: Alzando Nuestra Voz**

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**Panel: Community Lawyering and  
Housing Advocacy**

## **CLE Materials**

- Community Lawyering: An Approach to Addressing inequalities in Access to Health Care for Poor, of Color and Immigrant Communities
- Speaker Biographies

## **Suggested Readings**

*Lawyers as Resource Allies in Workers' Struggles for Social Change*, NEW YORK CITY LAW REVIEW, Vol 13:213

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*CLE credits have been approved in accordance with the requirements of the New York State CLE Board for a maximum of **one and a half** transitional and nontransitional professional practice credit hours.*

# COMMUNITY LAWYERING: AN APPROACH TO ADDRESSING INEQUALITIES IN ACCESS TO HEALTH CARE FOR POOR, OF COLOR AND IMMIGRANT COMMUNITIES

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## INTRODUCTION

“Luchando, creando poder popular!”<sup>1</sup> shouted Yorelis Vidal outside of Wyckoff Heights Medical Center (Wyckoff Hospital), a private hospital in Brooklyn, New York. On February 28, 2002, Ms. Vidal led members and supporters of Make the Road by Walking (Make the Road), a community-based organization in the Bushwick area of Brooklyn,<sup>2</sup> in protesting against discriminatory practices at Wyckoff Hospital and Woodhull Medical and Mental Health Center, a local public hospital. Make the Road contended that the hospitals were failing to provide qualified interpreters for immigrants with limited English proficiency (LEP)<sup>3</sup>, which was resulting in miscommuni-

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1. Translated from Spanish to English, the chant means “struggling, creating people power!”

2. See <http://www.maketheroad.org> for additional information about Make the Road by Walking (last visited Nov. 1, 2004).

3. Limited English proficiency, or LEP, is a phrase used to describe the limited ability, or inability, of many people living in the United States to speak, read or comprehend English. See Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (2004); Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52,762, 52,763 (Aug. 30, 2000), available at <http://www.hhs.gov/ocr/lep/guide.html> (describing LEP persons as individuals who “cannot speak, read, write or understand the English lan-

cation and confusion about their diagnoses and treatment.<sup>4</sup> Lawyers and organizers of New York Lawyers for the Public Interest (NYLPI), a civil rights organization in New York City that advocates for equality in the delivery of health care services, joined protestors from Make the Road. In the months leading up to the protest, NYLPI provided members of Make the Road with legal and non-legal advice to address the substandard care that some Bushwick community members had received at Woodhull and Wyckoff Hospitals.<sup>5</sup>

In addition to the protest, Make the Road and NYLPI conducted a joint press conference to announce the filing of civil rights complaints against both hospitals.<sup>6</sup> The complaints, which were filed with the New York State Attorney General's Office, alleged that the hospitals had violated Title VI of the Civil Rights Act of 1964.<sup>7</sup> Title VI

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guage at a level that permits them to interact effectively with health care providers and social service agencies"). *See also* COMM. ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED. OF THE NAT'L ACADS., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 87–88 (2003) (discussing linguistic barriers to accessing health care).

4. As a result of inadequate language services at Woodhull Hospital and Wyckoff Hospital, members of Make the Road who spoke only Spanish and had limited English proficiency contended that they did not receive the same level of medical services as patients who were able to speak English well. *See* Press Release, New York Lawyers for the Public Interest, *Civil Rights Action Filed Against Two Brooklyn Hospitals: "Make the Road by Walking," New York Lawyers for the Public Interest Hold Protest/Press Conference, File Legal Action; Claim Wyckoff and Woodhull Hospitals Violate Civil Rights Laws by Not Providing Interpretation and Translation Services for Non-English Speaking Patients* (Feb. 21, 2002), at <http://stage.nylpi.org/pub/pr1.pdf> (last accessed Nov. 1, 2004). They argued that under Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (2004), such unequal access to federally-funded medical services constitutes discrimination on the basis of national origin. *See, e.g.,* *Lau v. Nichols*, 414 U.S. 563, 568–69 (1974) (holding that school district's failure to provide monolingual Chinese-speaking students with English classes constituted discrimination under Title VI because students did not have equal access to educational services funded by federal government).

5. Information about NYLPI can be found at <http://www.nylpi.org> (last accessed Nov. 1, 2004).

6. At this press conference, Make the Road members shared their experiences at both hospitals through prepared written statements written in Spanish and English. Make the Road also distributed a report that included survey results indicating patients were denied interpreters during their medical encounters. *See* New York Lawyers for the Public Interest, *supra* note 4.

7. *See* Make the Road by Walking & New York Lawyers for the Public Interest, Discrimination Complaint submitted to State of New York, Office of the Attorney General Civil Rights Bureau (Feb. 21, 2002), available at <http://www.nylpi.org/mdrmain.html>. The complaint was filed with an administrative agency, as opposed to federal or state court, because there is no longer a private right of action to enforce complaints grounded on a disparate impact theory under Title VI. *See Alexander v. Sandoval*, 532 U.S. 275, 293 (2001) (holding that no private right of action exists for disparate impact regulations promulgated under Title VI). *See also* discussion *infra* Part II.

and its regulations<sup>8</sup> prohibit hospitals that receive federal funds, such as Medicaid and Medicare,<sup>9</sup> from intentionally discriminating against or engaging in practices that have the effect of discriminating against persons on the basis of their race, color or national origin.<sup>10</sup> Practices that have disparate effect on LEP persons constitute discrimination on the basis of national origin.<sup>11</sup>

By combining legal recourse and community organizing, Make the Road and NYLPI demonstrated the effective use of a social change strategy generally referred to as “community lawyering.”<sup>12</sup> This approach focuses on engaging lawyers to de-emphasize litigation as the primary tool for advancing social justice. Instead, community lawyering encourages lawyers to critically and creatively examine non-traditional forms of advocacy such as organizing and other grassroots actions as a way of addressing the legal and non-legal problems of their clients.<sup>13</sup> Community lawyering can also be described as a more participatory process that fosters collaboration between attorneys and clients, rather than fostering—if not perpetuating—the dependency

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8. 42 U.S.C. § 2000d (2000). Under Title VI, federal agencies are authorized to promulgate regulations to implement the mandate of the statute. *See* 42 U.S.C. § 2000d-1 (2000).

9. *See* 42 U.S.C. § 1396d (2004) (explaining the federal health insurance program for individuals who are poor and/or with disabilities); 42 U.S.C. § 1395 (2004) (explaining the federal health insurance program for the elderly and certain individuals with disabilities).

10. 42 U.S.C. § 2000 (2004). *See also* 28 C.F.R. § 42.104(b)(2) (2004) (stating that federally funded programs shall not utilize criteria or methods of administration which “have the effect of subjecting individuals to discrimination because of their race, color, or national origin . . . .”); *Sandoval*, 532 U.S. at 275 (stating that Section 601 of Title VI prohibits discrimination based on race, color, or national origin for programs receiving federal funds, and explaining that the Department of Justice promulgated regulations under Title VI which prohibit activities that have the effect of discrimination); Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 264 (2003) (stating that many hospitals must comply with Title VI anti-discrimination provisions because they receive federal money through Medicare and Medicaid programs).

11. *See* *Lau v. Nichols*, 414 U.S. 563, 568 (1974).

12. I use the term “community lawyering” to refer to the progressive social justice form of advocacy that encourages lawyers to collaborate actively with their clients in evaluating solutions to legal and non-legal problems that their clients face. As a staff attorney at NYLPI, I viewed my role as a “community lawyer” to mean that I would work in partnership with my community clients and utilize multiple forms of advocacy, including organizing, litigation, media events, community education and workshops and public demonstrations to address their individual as well as systemic problems. For additional discussion of “community lawyering,” particularly as it applies to health discrimination cases, *see* discussion *infra*, Part III.

13. *See id.*

that most clients have on their lawyers to solve their legal problems in a conventional attorney-client relationship.<sup>14</sup>

Community lawyering approaches may be particularly useful in the context of health care, especially in poor, of color and immigrant communities where access to health care is often deficient.<sup>15</sup> It offers marginalized communities the opportunity to actively engage in addressing health disparities in their neighborhood, forcing medical providers to give quality care to the community.<sup>16</sup> Community lawyering and its participatory process is an approach that lauds community empowerment as its ultimate goal. It enables community members to develop the skills and knowledge needed to challenge future discriminatory practices and policies.<sup>17</sup> Moreover, the creative community-based strategies of community lawyering may overcome the difficulties imposed on litigation by the Supreme Court's opinion in *Alexander v. Sandoval*,<sup>18</sup> which held that there is no private right of action to enforce the disparate impact regulations of Title VI.<sup>19</sup>

Therefore, a critical examination of community lawyering's potential for improving access to care for marginalized communities is necessary. This Article provides such an examination by analyzing the problem of unequal access to care through the lens of civil rights and exploring the use of community lawyering as an alternative to conventional modes of dismantling discrimination. Part I of this Article discusses health disparities faced by racial and ethnic communities and highlights three particular manifestations of health care discrimination. Part II discusses Title VI and its limited utility in health discrimination cases as a result of *Sandoval*. Part III discusses community lawyering as a strategy for addressing inequalities in health access. This part uses the collaboration between Make the Road and NYLPI as an example of creative community lawyering's effectiveness in an attempt to eviscerate discriminatory health policies and practices. Part IV turns to a discussion of the advantages and limitations of community lawyering in the health care context. This Article then concludes by recommending that health lawyers engage in community lawyering in order to break down barriers to care, and to empower subjugated communities whose health care needs have too often been ignored.

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14. *See id.*

15. *See* discussion *infra* Part III.A.

16. *See* discussion *infra* Part IV.A.

17. *See id.*

18. 532 U.S. 275 (2001). For discussion of the limitations placed on health care litigation by the *Sandoval* opinion, see discussion *infra* Part II.

19. *See Sandoval*, 532 U.S. at 293.

## I.

UNEQUAL ACCESS TO HEALTH CARE AND QUALITY  
HEALTH CARE SERVICES

Overt discrimination in the delivery of health care services marked a bleak period in our history. Segregated facilities,<sup>20</sup> denial of care on the basis of race and ethnicity,<sup>21</sup> substandard medical care due to under-funded medical facilities,<sup>22</sup> lack of medical facilities in communities of color,<sup>23</sup> denial of admitting privileges to hospitals necessary for training of physicians of color,<sup>24</sup> and human research experiments conducted without informed consent<sup>25</sup> are significant examples of the blatant discrimination experienced by African-Americans and other people of color. There is no doubt that these discriminatory practices have consequently affected the health out-

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20. See Larry J. Pittman, *A Thirteenth Amendment Challenge to Both Racial Disparities in Medical Treatments and Improper Physicians' Informed Consent Disclosures*, 48 ST. LOUIS U. L.J. 131, 156 (2003) (stating how African Americans historically received care from segregated facilities that provided poor quality care); Michael S. Shin, *Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 CAL. L. REV. 2047, 2050–51 (2002) (describing how African American patients were only allowed to receive care from “colored” facilities).

21. See Pittman, *supra* note 20, at 154–56 (providing a historical account of decades of intentional denial of care experienced by African Americans from white physicians). See also W. MICHAEL BYRD & A. CLAYTON, *AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE: BEGINNINGS TO 1900* 355 (2000) (discussing how, from the Reconstruction era until the 1960s, white doctors viewed it acceptable to deny care to African American patients).

22. See Pittman, *supra* note 20, at 156 (stating that the facilities that provide medical care to African Americans were poorly funded, which affected the type of care they received). See also Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL'Y 45, 55–56 (2002) (same).

23. See Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 1, 10–11 (2001–2002) (explaining that people of color continue to experience a greater shortage of physicians in their neighborhoods than other populations).

24. See Sydney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203, 211–12 (describing discrimination experienced by African American physicians from hospitals that refused to provide admitting privileges to them).

25. See Pittman, *supra* note 20, at 154–55 (discussing how white doctors experimented on African slaves by performing operations on their bodies without anesthesia); Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 216–17 (1995–1996) (noting that the United States had a “long history of using genetics to subjugate African Americans”).

comes of racial and ethnic populations. Numerous studies have demonstrated the disparities in health status of people of color. One such study revealed:

[I]nfant mortality rates are 2½ times higher for African-Americans, and 1½ times higher for [Native Americans], than for Whites; the death rate from heart disease for African-Americans is higher than for Whites; 50% of all AIDS cases are among a minority population that comprises only 25% of the U.S. population; the prevalence of diabetes is 70% higher among African-Americans and twice as high among [Latinos] than it is among Whites; Asian Americans and Pacific Islanders have the highest rate of tuberculosis of any racial/ethnic group; cervical cancer is nearly five times more likely among Vietnamese-American women than among White women . . . .<sup>26</sup>

Although current discriminatory practices in health care are usually not as overt as in the past, more subtle forms of discrimination have persisted. In particular, three significant forms of discrimination in the delivery of health care services continue to perpetuate health disparities along racial and ethnic lines. These three—biases and stereotypes by medical practitioners affecting the delivery of health care services, lack of linguistically and culturally appropriate care in health settings, and high rates of uninsurance among people of color and immigrants—are examined more closely below.

#### A. *Poorer Quality of Care on the Basis of Race and Ethnicity*

Racial and ethnic minorities continue to receive poorer health care services than whites.<sup>27</sup> The Institute of Medicine highlighted this rampant discrimination in a report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (IOM Report), which stated that there are significant differences in the type and quality of medical services received by people of color,<sup>28</sup> even after accounting for other variables including insurance status, income, age, and severity of condition.<sup>29</sup>

The IOM Report identified several racial and ethnic differences in medical treatment. For example, it discussed disparities in treat-

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26. See Randall, *supra* note 22, at 51 (citing U.S. COMMISSION ON CIVIL RIGHTS, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY 11 (1999)).

27. See INSTITUTE OF MEDICINE, *supra* note 3, at 29–30. See also Lado, *supra* note 23, at 7–11 (describing how people of color continue to receive inferior care in the current health care system).

28. See INSTITUTE OF MEDICINE, *supra* note 3, at 5.

29. *Id.*

ment for cardiovascular disease, cancer, and HIV.<sup>30</sup> It reported that patients of color who were undergoing cardiovascular treatment were less likely to receive coronary angiography than white patients.<sup>31</sup> Patients of color who had cancer were less likely to receive diagnostic tests than white patients.<sup>32</sup> African-Americans with HIV were less likely to obtain antiretroviral therapy than white patients.<sup>33</sup> The report highlighted one cause of this disparate provision of care, reporting that “stereotyping, biases and uncertainty on the part of healthcare providers [contributed] to unequal treatment.”<sup>34</sup>

### *B. Language Access Barriers Result in Poorer Quality of Care*

More than forty-six million Americans speak a language other than English at home.<sup>35</sup> Although the majority of this group is bilingual, approximately twenty-one million individuals have LEP.<sup>36</sup> The number of LEP individuals in this country has profound ramifications for our health care system. Millions of LEP individuals have difficulty gaining access to health care services and, as discussed below, poorer quality of care when they do have access.

Effective communication between LEP individuals and their medical providers is necessary to ensure the receipt of appropriate care.<sup>37</sup> Without an interpreter, doctors and other health professionals have difficulty assessing the physical and psychological concerns of their LEP patients.<sup>38</sup> Further, poor communication can have dire con-

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30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.* See also Pittman, *supra* note 20, at 134–47 (discussing additional examples of differences in medical treatment afforded to people of color).

34. See INSTITUTE OF MEDICINE, *supra* note 3, at 1. In addition to poor quality of care encountered by racial and ethnic communities, these communities also continue to experience greater inaccessibility to doctors than other populations. See Lado *supra* note 23, at 10–11 (explaining that people of color are four times more likely to experience shortage of physicians in their neighborhoods than white patients).

35. See U.S. CENSUS, SUMMARY TABLES ON LANGUAGE USE AND ENGLISH ABILITY, tbl. 4, at <http://www.census.gov/population/www/cen2000/phc-t20.html> (last visited Nov. 2, 2004).

36. *Id.*

37. See Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS U. L.J. 75, 83–86 (2003) (discussing the negative effects of language barriers between doctors and patients).

38. See *id.* at 84–85 (describing the difficulty with evaluation and diagnosis when the doctor cannot communicate properly with the patient). See also Michael O. Allen, *Hospital Language Barrier?*, DAILY NEWS, Feb. 22, 2002, at Suburban Section 1 (reporting on activists’ allegation that hospitals’ failure to provide language services affects medical treatment of LEP patients); Joe Baird, *Business, Politics Urged to Adapt to Immigrant Flow*, THE SALT LAKE TRIB., Nov. 3, 2001, at B1 (discussing the

sequences to the patients' diagnosis and treatment, and ultimately affects mortality rates.<sup>39</sup>

The experiences of LEP patients are often typified by difficulty scheduling medical appointments;<sup>40</sup> undue delay in waiting rooms;<sup>41</sup> the burden of asking their minor children, spouses, relatives, friends or strangers to interpret for them;<sup>42</sup> failure to comprehend medical forms written only in English;<sup>43</sup> poor communication with doctors about their medical condition;<sup>44</sup> confusion about the level of treatment, types of medication and necessary tests involved;<sup>45</sup> and even denial of care because of their limited English proficiency.<sup>46</sup>

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difficulty physicians face in assessing LEP patients' medical conditions because of lack of language services).

39. See Yvette Cabrera, *Crossing Border for Health Care*, THE ORANGE COUNTY REG., Nov. 24, 2000 (discussing how language barriers affect the detection and treatment of breast cancer among Latinas, who die from the disease more often than non-Latinas even though the incidence is less).

40. See Rebecca Rodriguez, *Buena Salud*, STAR-TELEGRAM, Aug. 5, 2001, at Metro 1 (reporting how Latinos lack access to health care because of language barriers).

41. See Betsy Anne Wood, *Caring for a Limited English Proficient Patient*, ASS'N OF OPERATING ROOM NURSES J., Feb. 1, 2002, at 305 (explaining Latina patient's experience in obtaining emergency services at a facility).

42. See Barry Newman, *Language Gap: For Ill Immigrants, Doctors' Orders Can Get Lost in Translation*, WALL ST. J., Jan. 9, 2003, at A1 (reporting situations involving children and family members interpreting for LEP patients); M.C. Sullivan, *Lost in Translation: How Latinos View End-of-Life Care*, PLASTIC SURGICAL NURSING, June 22, 2001, at 90 (discussing how a fifteen-year-old Mexican American girl was asked to interpret for her mother during a hospital visit and had to inform her mother that she had cancer). See also Thomas Ginsberg, *Shouldering a Language Burden: Immigrant Families, Children's Roles As Interpreters Full of Pressure, Peril*, PHILA. INQUIRER, Mar. 9, 2003 (describing a thirteen-year-old interpreting for his parents when his ten-year-old brother was admitted in the emergency room of a Philadelphia hospital).

43. See Newman, *supra* note 42, at A1 (stating how LEP patients have complained about their inability to understand informed consent forms because they are only written in English).

44. See Teresa Mask, *Language Barrier in Health Care Can Be Deadly*, CHI. DAILY HERALD, Mar. 15, 2001, at 16 (reporting the frustration experienced by LEP patients because of language barriers when attempting to explain health concerns to their doctors).

45. See THE ACCESS PROJECT, WHAT A DIFFERENCE AN INTERPRETER CAN MAKE: HEALTH CARE EXPERIENCES OF UNINSURED WITH LIMITED ENGLISH PROFICIENCY 7 (2002) (reporting that in a survey conducted of LEP patients, twenty-seven percent did not understand their prescribed medications because of lack of explanation provided to them in their language), at [http://www.accessproject.org/downloads/c\\_LEPreportENG.pdf](http://www.accessproject.org/downloads/c_LEPreportENG.pdf) (last visited Nov. 2, 2004); Elaine Gaston, *Hispanics Must Leap Many Hurdles for Care*, THE SUN NEWS, Mar. 1, 2001, at C5 (reporting that one of immigrants' biggest obstacles to medical care was the inability to understand their diagnosis and treatment).

46. See Jeff Donaldson, *Language Could Be Barrier to Health Care for Immigrants*, RENO GAZETTE-J., Jan. 17, 2001 (noting that, each year, "thousands of immi-

The IOM Report also identified language barriers as a significant factor affecting access to care for immigrants, particularly Latino patients.<sup>47</sup> Other academic researchers have reached similar conclusions. For example, the American Pediatrics Journal reported that medical errors often occur in doctor-patient visits involving Spanish-speaking children, due in large part to inadequate language assistance services.<sup>48</sup>

### C. *High Numbers of Uninsured in Immigrant and Of Color Communities*

More than forty-three million people in the United States, including nine million children, do not have health insurance<sup>49</sup> and, consequently, have limited access to health care services. A closer examination of this staggering number reveals that the majority of people who are uninsured are people of color and immigrants.<sup>50</sup> According to recent data, Latinos have the highest uninsurance rate of all racial and ethnic groups.<sup>51</sup> African Americans and Asian Americans are also significantly more likely to be uninsured than whites.<sup>52</sup>

Several factors explain the disproportionate number of racial and ethnic communities that are uninsured. These factors are rooted in discriminatory actions and further perpetuate discrimination in health care. For example, historical discrimination has resulted in a racialized economy where many people of color remain deeply entrenched

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grants who are permanent residents or citizens are denied such services and medical treatment because they fail to understand English”).

47. See INSTITUTE OF MEDICINE, *supra* note 3, at 88–90.

48. See Glenn Flores, et al., *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, in PEDIATRICS, Jan. 7, 2003, at 6–14 (indicating that many errors occur in medical encounters between pediatricians and LEP parents).

49. See DIANE ROWLAND, KAISER COMM’N ON MEDICAID AND THE UNINSURED, UNINSURED IN AMERICA: HEARING BEFORE THE SUBCOMM. ON HEALTH, HOUSE COMM. ON WAYS AND MEANS 3 (2004) (statement of Diane Rowland, Executive Director, The Kaiser Commission on Medicaid and the Uninsured).

50. See LEIGHTON KU & TIMOTHY WAIMAN, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HOW RACE/ETHNICITY, IMMIGRATION, STATUS AND LANGUAGE AFFECT HEALTH INSURANCE COVERAGE, ACCESS TO CARE AND QUALITY OF CARE AMONG THE LOW-INCOME POPULATION 4, 6 (2003) at <http://www.kff.org/uninsured/kcmu4132report.cfm> (last visited Nov. 2, 2004).

51. *Id.* at 4–5. Even within the Latino population, uninsurance rates vary. Mexicans and Central Americans have the highest uninsurance rates while Cubans and Puerto Ricans have the lowest uninsurance rates. See INSTITUTE OF MEDICINE, *supra* note 3, at 88.

52. See KU & WAIMAN, *supra* note 50, at 4–5.

in poor jobs that do not provide health insurance benefits.<sup>53</sup> Anti-immigrant laws such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, a comprehensive legislation that reformed eligibility for public assistance benefits, including Medicaid,<sup>54</sup> have had the disparate effect of leaving thousands of immigrants who are not U.S. citizens without government health insurance.<sup>55</sup> In fact, at least one study reported that citizenship status plays a more significant role in coverage than either race or ethnicity.<sup>56</sup> Language barriers also play a role in the high uninsurance rates facing Latinos.<sup>57</sup> The failure of Medicaid offices to provide interpreters to LEP persons and provide them with documents translated in their language greatly limits the ability of LEP consumers to apply and participate in government health programs.<sup>58</sup>

## II.

### TITLE VI AND LITIGATION CHALLENGES

Congress enacted Title VI of the Civil Rights Act of 1964 to prohibit discrimination in many areas of society.<sup>59</sup> In the context of

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53. See Randall, *supra* note 22, at 54 (stating that “racial stratification of the economy due to other forms of discrimination has resulted in a concentration of racial minorities in low wage jobs,” which generally do not provide health insurance benefits); Lado, *supra* note 23, at 16 (stating that “historic patterns of job discrimination and poor levels of training and education combined to concentrate African American workers in unhealthy industries and hazardous jobs”).

54. See Pub. L. No. 104-193, 110 Stat. 2105 (1996). See also *Welfare Reform – Treatment of Legal Immigrants – Congress Authorizes States to Deny Public Benefits to Noncitizens and Excludes Legal Immigrants from Federal Aid Programs*, 110 HARV. L. REV. 1191, 1191 (1997) (describing Personal Responsibility and Work Opportunity Reconciliation Act of 1996 as an “assault on legal immigrants”).

55. See LEIGHTON KU, SHAWN FREMSTAD & MATTHEW BROADDUS, CENTER ON BUDGET AND POLICY PRIORITIES, *NonCitizens’ Use of Public Benefits Has Declined Since 1996: Recent Report Paints Misleading Picture of Impact of Eligibility Restrictions on Immigrant Families 2* (2003) (last visited June 8, 2004) (contending that analysis of 2000 Census Bureau demonstrates heavy decline in Medicaid participation by immigrant families since 1996), available at <http://www.cbpp.org/4-14-03wel.pdf>. See also Joel Ferber & Theresa Steed, *The Impact of Welfare Reform on Access to Medicaid: Curing Systemic Violations of Medicaid De-Linking Requirements*, 45 ST. LOUIS U. L.J. 145, 146 (2001) (describing effects of Personal Responsibility and Work Opportunity Reconciliation Act of 1996 on individuals’ eligibility and participation in Medicaid program).

56. See KU & WAIDMAN, *supra* note 50, at 6.

57. *Id.* at 9.

58. See Lisa Axelrod, *The Trend Toward Medicaid Managed Care: Is the Government Selling Out the Medicaid Poor?*, 7 B.U. PUB. INT. L.J. 251, 263–64 (1998) (explaining that many consumers who do not speak English experience difficulty in applying for Medicaid).

59. See 42 U.S.C. § 2000d (1964) (stating that no person shall be discriminated against in a federally-funded program on the basis of his race, color or national ori-

health care, Title VI was meant to desegregate our racialized health care system.<sup>60</sup> Title VI and the regulations implementing Title VI<sup>61</sup> are designed to deny entities federal funds should they discriminate against individuals on the basis of race, color, or national origin.<sup>62</sup> Under these federal laws, prohibited conduct includes intentional discrimination<sup>63</sup> and actions that have the effect of discrimination, even though the latter may be unintentional.<sup>64</sup>

For years, plaintiffs utilized Title VI's disparate impact regulations to fight unequal access to health care services for people of color by filing administrative complaints or lawsuits in court.<sup>65</sup> Individuals enforced Title VI primarily by filing administrative complaints with the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services, which enforces Title VI in the context of health care.<sup>66</sup> One such complaint was filed against a hospital located near the U.S.-Mexican border in Texas, which required security personnel to dress up in uniforms similar to those worn by the U.S. Border Patrol

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gin). For a comprehensive discussion of the legislative history of Title VI of the Civil Rights Act, see DAVID BARTON SMITH, *HEALTH CARE DIVIDED, RACE AND HEALING A NATION* 96–108 (1999).

60. See Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Health Care System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 *YALE J. HEALTH POL'Y L. & ETHICS* 215, 220 (2003) (explaining that one primary goal of Congress in enacting Title VI was to address discrimination in health care); SMITH, *supra* note 59, 96–108.

61. Under Title VI, federal agencies are authorized to promulgate regulations to implement the mandate of the statute. See 42 U.S.C. § 2000d (2004). Consequently, several federal agencies have created regulations implementing Title VI. See, e.g., 28 C.F.R. § 42.101, *et. seq.* (2004); 29 C.F.R. § 31.145, *et. seq.* (2004); 45 C.F.R. § 80.1, *et. seq.* (2003). See also 28 C.F.R. § 42.108 (2004); 29 C.F.R. § 31.8 (2004); 45 C.F.R. § 80.8 (2004).

62. See 42 U.S.C. § 2000d-1 (2004).

63. See 42 U.S.C. § 2000d (2004).

64. See 28 C.F.R. § 104 (2004) (prohibiting conduct that has effect of discriminating against persons on account of race, color, or national origin). See also 29 C.F.R. § 31.3 (2004) (prohibiting discrimination caused by disparate impact); 45 C.F.R. § 80.3 (2003) (prohibiting conduct which results in discrimination).

65. See SMITH, *supra* note 59, at 91–95 (discussing civil rights litigation in the health care context); Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 *FORDHAM L. REV.* 939, 939–47 (1990) (documenting cases of discrimination in health care and use of Title VI to stop such discrimination).

66. See 42 U.S.C. § 2000d-1 (2004) (providing that federal agencies with authority to issue federal funds have authority to carry out provisions of Section 601 of Title VI); 45 C.F.R. § 80.3(b)(2) (2003). For additional information about the Office for Civil Rights of the U.S. Department of Health and Human Services, see <http://www.hhs.gov/ocr/index.html>.

in order to discourage Latinos from using the hospital.<sup>67</sup> Complaints have also been filed against hospitals for failing to provide linguistically appropriate care to LEP patients.<sup>68</sup>

Plaintiffs also enforced Title VI by filing lawsuits in court to enjoin providers from engaging in conduct that had a disparate effect on racial and ethnic minorities.<sup>69</sup> For example, suits were filed to stop hospital closures<sup>70</sup> and hospital relocations<sup>71</sup> that would disproportionately impact communities of color and hospital policies that resulted in denying LEP patients appropriate care.<sup>72</sup> Although some of these lawsuits did not result in outright victories,<sup>73</sup> circumstances surrounding the suits have led to equitable outcomes for the communities of color involved.<sup>74</sup> There is no doubt that litigation has played a

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67. See THOMAS E. PEREZ, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, in INSTITUTE OF MEDICINE, *supra* note 3, at 639 (discussing discrimination cases filed and settled with OCR). Other complaints mentioned included one against a national pharmacy chain that repeatedly refused to fill prescription of an African American Medicaid recipient and one against a hospital that had a de facto segregated maternity ward. The filing of an administrative complaint with OCR does not prevent the filing of a lawsuit in federal court even though OCR has not completed its investigation. See Office for Civil Rights, *Frequently Asked Questions and Answers* (discussing ability to file lawsuit in conjunction with filing an administrative complaint), at <http://www.hhs.gov/ocr/newfaq.html> (last visited Nov. 2, 2004).

68. See Perez, *supra* note 67, at 639–42.

69. See, e.g., NAACP v. Med. Ctr., 657 F.2d 1322 (3d Cir. 1981) (plaintiffs sued medical center for proposed relocation of a hospital from inner city to a suburban location); Bryan v. Koch, 627 F.2d 612 (2d Cir. 1980) (plaintiffs sued City of New York for proposed closure of a hospital that served a population that was ninety-eight percent African American and Latino); Linton v. Comm’r of Health and Env’t, 779 F. Supp. 925 (M.D. Tenn. 1990) (plaintiffs challenged State of Tennessee’s limited bed certification policy for nursing homes requiring only a portion of the beds in Medicaid participating nursing homes to be certifiably available for Medicaid patients).

70. See, e.g., Bryan, 627 F.2d at 614.

71. See, e.g., Med. Ctr., 657 F.2d at 1324.

72. See Aghazadeh v. Maine Med. Ctr., No. 98-421-P-C, 1999 WL 33117182, at \*1 (D. Me. Jun. 8, 1999). Some of these Title VI litigation cases have been successful and have prevented discriminatory conduct in the delivery of health care services. See, e.g., Linton, 779 F. Supp. at 932 (holding that state program which allowed nursing homes to decertify beds previously available to patients with Medicaid in order to make room for patients with private insurance had disparate impact on minorities). See also Latimore v. County of Contra Costa, 77 F.3d 489 (9th Cir. 1996) (unpublished disposition) (stating that district court initially granted preliminary injunction to stop construction of hospital that would have furthered unequal access for people of color).

73. See Rosenbaum & Teitelbaum, *supra* note 60, at 226 (noting that Title VI health care discrimination cases “have never been particularly common, nor particularly successful”).

74. See Marianne Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239, 253 (1994).

critical role in ensuring that providers comply with Title VI's anti-discrimination mandates.<sup>75</sup>

The effectiveness of litigation strategies based on Title VI, however, has been diminished significantly by the Supreme Court's opinion in *Alexander v. Sandoval*.<sup>76</sup> *Sandoval* involved a Spanish-speaking woman who challenged Alabama's English-only policy requiring the state driver's license tests to be administered solely in English.<sup>77</sup> Mrs. Sandoval argued that the policy had a disproportionate consequence on applicants for driver's licenses who had limited proficiency in English.<sup>78</sup> The Court acknowledged that Title VI and its regulations proscribe both intentional discrimination<sup>79</sup> and conduct that had the disparate effect of discriminating on the basis of race, color, or national origin.<sup>80</sup> The Court noted, however, that there is a private right of action only for intentional discrimination claims.<sup>81</sup> For disparate impact claims such as Mrs. Sandoval's, no private right of action exists under Title VI.<sup>82</sup>

The *Sandoval* opinion delivered a devastating blow to the civil rights community.<sup>83</sup> Without the ability to litigate a disparate impact case, the only available recourse to enforce Title VI under this theory is to file an administrative complaint with OCR.<sup>84</sup> However, OCR is severely under-funded and its limited resources make it an ineffective governmental enforcement agency, not only for enforcing Title VI and other federal health laws but also for regulating our huge health care system.<sup>85</sup>

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75. See Rosenbaum & Teitelbaum, *supra* note 60, at 243 (explaining that litigation and the threat of litigation have been important in securing settlements for plaintiffs); Lado, *supra* note 74, at 253 (“[L]itigation can play a critical role in challenging practices that result in an unjust distribution of health services.”).

76. 532 U.S. 275 (2001).

77. *Id.* at 278–79.

78. *Id.* at 279.

79. *Id.* at 280.

80. *Id.* at 281.

81. *Id.* at 285–93.

82. See *id.* at 284.

83. See Rosenbaum & Teitelbaum, *supra* note 60, at 238–39 (stating that the *Sandoval* opinion “sent shockwaves through the civil rights community” and “effectively wiped out two decades of Title VI litigation”).

84. See *Sandoval*, 532 U.S. at 289 (stating that Title VI creates a limited private remedy). For a discussion of strategies of filing a civil rights complaint with OCR post-*Sandoval*, see Randal S. Jeffrey, Elisabeth Ryden Benjamin & Constance P. Carden, *Drafting an Administrative Complaint to Be Filed with the U.S. Department of Health and Human Services' Office for Civil Rights*, CLEARINGHOUSE REV.: J. POVERTY L. & POL'Y 276, 276–78 (Sept.–Oct. 2001).

85. See 1 U.S. Comm'n on Civil Rights, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY

In light of *Sandoval*, health and civil rights advocates need to re-examine their strategies for dismantling racial and ethnic barriers in access to care, and utilize innovative approaches for challenging policies and practices that have a disparate effect on immigrants and people of color. In particular, it is incumbent upon civil rights advocates to engage in non-traditional forms of lawyering and advocacy.<sup>86</sup> One such strategy is community lawyering.

### III.

#### COMMUNITY LAWYERING ADDRESSES INEQUALITIES IN HEALTH CARE

For years, scholars, practitioners and activists have proposed that public interest and poverty lawyers should rely less on traditional approaches of solving their clients' legal problems that view litigation as the primary means of enforcing clients' rights.<sup>87</sup> They have argued

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1, 189–200 (1999) (reporting that OCR had failed to effectively enforce Title VI); Jane Perkins, *Race Discrimination in America's Health Care System*, 27 CLEARINGHOUSE REV. 371, 380 (Special Issue 1993) (questioning efficiency of OCR complaint process). See also Rosenbaum & Teitelbaum, *supra* note 60, at 230–32 (explaining OCR's ineffective enforcement of Title VI, OCR's funding difficulties, and its inadequate complaint process); Lado, *supra* note 23, at 28 (describing OCR as an agency that is "underfunded, inadequately staffed, and largely ineffectual").

86. This Article does not contend that lawyers and advocates should automatically forgo litigation. Rather, it views litigation as one strategy within the ambit of community lawyering. There is no question that litigation remains a powerful tool for enforcing civil rights. See Rosenbaum & Teitelbaum, *supra* note 60, at 243 (stating that litigation and the threat of litigation play an important role in bringing about change); Lado, *supra* note 23, at 33–34 (discussing importance of litigation in dismantling discrimination in health care). Moreover, there remain alternative litigation strategies to challenge discriminatory barriers to health care services. State and city laws, for example, provide potential bases for filing a health discrimination case. See, e.g., Rose Cuisson Villazor, *Reversing the Rollback of Language Rights Post-Sandoval*, in AWAKENING FROM THE DREAM: PURSUING CIVIL RIGHTS IN A CONSERVATIVE ERA (Denise Morgan et al. eds.) (forthcoming 2005) (discussing state and city laws and ordinances that provide bases for removing language barriers in the health care context). International laws may also provide adequate causes of action for breaking down discriminatory barriers to health care. See Randall, *supra* note 22, at 46 (arguing that racial disparities in the United States constitute serious human rights violations under the International Convention on the Elimination of All Forms of Racial Discrimination).

87. See, e.g., Gerald P. Lopez, REBELLIOUS LAWYERING: ONE CHICANO'S VIEW OF PROGRESSIVE LAW PRACTICE 24, 70–82 (1992) (analyzing the problems with traditional litigation techniques and discussing the reorientation of lawyers' work); Jennifer Gordon, *We Make the Road by Walking: Immigrant Workers, The Workplace Project, and the Struggle for Social Change*, 30 HARV. C.R.-C.L. L. REV. 407, 437–41 (1995) (discussing problems of relying on legal services as a long-term solution); Lucie E. White, *To Learn and Teach: Lessons from Driefontein on Lawyering and Power*, 1998 WISC. L. REV. 699, 757 (1988) (discussing limitations of the litigation-centered approach to public interest lawyering). For a comprehensive discussion

that litigation-centered strategies do not improve the conditions of their poor clients because they do not address the root of a client's problems.<sup>88</sup> They contend that such conventional lawyering approaches tend to suppress clients' voices and narratives, particularly when lawyers argue over facts and the substantive law affecting them.<sup>89</sup> Moreover, a conventional attorney-client relationship merely perpetuates the dependency of clients on their lawyers<sup>90</sup> and does not equip clients with sufficient knowledge to enforce their own rights. Thus, under a typical strategy grounded in litigation, the lawyer and the litigation process itself become agents of client subordination.<sup>91</sup>

Instead of the conventional "regnant lawyering" approach,<sup>92</sup> scholars and activists have proposed an alternative form of social justice advocacy that places less importance on traditional litigation-based strategies and more importance on organizing, mobilizing and empowering individuals and community groups.<sup>93</sup> While this Article

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of the various factors that have influenced the development of community lawyering, see Scott L. Cummings & Ingrid V. Eagly, *A Critical Reflection on Law and Organizing*, 48 U.C.L.A. L. REV. 443, 465–66 (2001) (providing historical overview of factors that led to the progressive lawyering movement in poverty and public interest law referred to in their Article as "law and organizing").

88. See, e.g., Lopez, *supra* note 87, at 24 (discussing the relationship between traditional lawyers and subordinated people); White, *supra* note 87, at 757 (discussing limitations in the litigation-centered approach to public interest lawyering).

89. See, e.g., Binny Miller, *Telling Stories About Cases and Clients: The Ethics of Narrative*, 14 GEO. LEGAL ETHICS 1, 20 (2000) (noting that critics of traditional lawyering practices view lawyers as "narrators who too often subordinate their clients—their stories and their lives—by telling stories that misrepresent or exclude client experience"); Anthony V. Alfieri, *The Antinomies of Poverty Law and a Theory of Dialogic Empowerment*, 16 N.Y.U. REV. L. & SOC. CHANGE 659, 665 (1987–88) (contending that conventional lawyering methods silence clients' voices).

90. See Miller, *supra* note 89, at 20; Gordon, *supra* note 87, at 438 (explaining that providing legal services for individual clients undermined organizing and community building because the clients were not interested in addressing systemic issues causing their legal problems).

91. See, e.g., Richard D. Marsico, *Working for Social Change and Preserving Client Autonomy: Is There a Role for "Facilitative" Lawyering?*, 1 CLINICAL L. REV. 639, 649–50 (1995) (noting that in a traditional attorney-client relationship, client voices are suppressed and dependency on lawyers is encouraged, which only further leads to their subordination).

92. See Janine Sisak, *If the Shoe Doesn't Fit . . . Reformulating Rebellious Lawyering to Encompass Community Group Representation*, 25 FORDHAM URB. L.J. 873, 876 (1998) (stating that "[r]egnant lawyering is simply the standard conception of poverty lawyering" where lawyers bring lawsuits on behalf of clients to obtain remedies on their behalf). See also Lopez, *supra* note 87, at 25–53 (criticizing traditional lawyering strategies).

93. See, e.g., Lopez, *supra* note 87, at 17–22 (stating that litigation often leads to short-term victories and fails to address the systemic problems of clients); Paul R. Tremblay, *Rebellious Lawyering: Regnant Lawyering, and Street-Level Bureaucracy*, 43 HASTINGS L.J. 947, 952 (1991–92) (commenting that litigation ignores, if not sac-

uses the term “community lawyering” to refer to this social justice form of advocacy, it acknowledges that this type of progressive lawyering has also been referred to as rebellious lawyering,<sup>94</sup> law and organizing,<sup>95</sup> social change lawyering,<sup>96</sup> critical lawyering<sup>97</sup> and empowerment lawyering.<sup>98</sup> While there may be distinctions among these different community-based types of lawyering,<sup>99</sup> all share the general premise that litigation is merely one—perhaps subordinate—potential form of advocacy.<sup>100</sup>

Advocacy strategies affiliated with community lawyering include organizing, community education, media outreach, petition drives, public demonstrations, lobbying, and shaming campaigns.<sup>101</sup> Under a community lawyering approach, individuals and members of community-based organizations actively work alongside organizers and lawyers in the day-to-day strategic planning of their case or campaign.<sup>102</sup>

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rifices, “long-term rewards”); White, *supra* note 87, at 757 (contending that litigation perpetuates the status quo).

94. See Lopez, *supra* note 87, at 37–38 (recommending that progressive lawyers collaborate with professional and non-professional individuals in finding solutions to their community clients’ legal and non-legal problems).

95. See Cummings & Eagly, *supra* note 87, at 447 (referring to new progressive legal practice that emerged during post-welfare, post-civil rights era as the “law and organizing” movement).

96. See Louise G. Trubek, *Reinvigorating Poverty Law Practice: Sites, Skills and Collaborations*, 25 *FORDHAM URB. L.J.* 801, 804 (1997–98) (discussing three public interest organizations funded by the government or private contributions that work for poor people as models of social change lawyering).

97. See Kevin R. Johnson, *Lawyering for Social Change: What’s A Lawyer To Do?*, 5 *MICH. J. RACE & L.* 201, 222 (1999) (stating that critical lawyering grew out of concern for client disempowerment caused by impact litigation and aims to provide subordinated people with greater access to legal representation).

98. See William P. Quigley, *Reflections of Community Organizers: Lawyering for Empowerment of Community Organizations*, 21 *OHIO N.U. L. REV.* 455, 455–56 (1994) (defining empowerment lawyering as lawyering for community groups with community organizing as its essential element).

99. See Cummings & Eagly, *supra* note 87, at 466 (noting that there are different descriptions of what it means to engage in law and organizing).

100. See *id.* at 447 (describing the law and organizing movement as a type of legal advocacy that is “subordinate” to “grassroots organizing campaigns”); Jennifer Gordon, *supra* note 87, at 438 (discussing the pitfalls of relying primarily on litigation to solve clients’ problems).

101. See Andrea M. Seielstad, *Unwritten Laws and Customs, Local Legal Cultures, and Clinical Legal Education*, 6 *CLINICAL L. REV.* 127, 127 n.2 (1999) (providing various examples of law and organizing actions).

102. See Cummings & Eagly, *supra* note 87, at 447–48 (stating that “[L]awyers seeking to improve the conditions of poor clients are encouraged to supplement conventional litigation strategies with community education programs, link the provision of legal services with membership in organizing groups, and become directly involved in organizing campaigns.”). Indeed, many have criticized how lawyers who use traditional modes of lawyering often fail to engage their clients in the decision-making

Proposed solutions—litigation or non-litigation based—are informed by the clients' knowledge and experience of the issue. Ultimately, the role of a lawyer under this model is to help facilitate community empowerment and activism.<sup>103</sup>

Community lawyering as a social justice strategy has been primarily associated with workers' rights, the environmental justice movement, and community and economic development.<sup>104</sup> Through community lawyering, poor, of color and immigrant communities have achieved tremendous successes in improving wage and hour conditions,<sup>105</sup> dismantling discriminatory sitings of power plants<sup>106</sup> and developing the economic needs of poor communities.<sup>107</sup> The potential to mount successful campaigns and obtain similar victories in the health context provides enormous incentives for engaging in community lawyering where access to health care is concerned.

#### A. *Why Use Community Lawyering in Health Care?*

Several factors provide support for the utilization of community lawyering in the health care context. First, as already discussed, litigation opportunities in dismantling discrimination in access to and delivery of health care services have been undermined severely by the U.S. Supreme Court in *Sandoval*.<sup>108</sup> The lack of a private right of action to pursue a Title VI disparate impact case makes filing a law-

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process of solving their legal problems. See Ingrid V. Eagly, *Community Education: Creating A New Vision of Legal Services Practice*, 4 CLINICAL L. REV. 433, 441 (contending, for example, that Legal Aid attorneys do not have sufficient time to spend with their clients to strategize with them on their legal options); Ann Southworth, *Lawyer-Client Decisionmaking in Civil Rights and Poverty Practice: An Empirical Study of Lawyers' Norms*, 9 GEO. J. LEGAL ETHICS 1101, 1105 (1996) (discussing conclusion of many Legal Services attorneys in Chicago that their clients are better served when the lawyers make the decisions on their behalf).

103. See Cummings & Eagly, *supra* note 87, at 460–61 (noting that “community building” is primary goal in a law and organizing campaign).

104. See *id.* at 470–79 (stating that three distinct practices identified with law and organizing are workers' rights issues, environmental justice, and community development).

105. See *id.* at 470–73 (discussing community organizing efforts done by the Workplace Project in Hempstead, NY, which was instrumental in obtaining wages for exploited workers).

106. See *id.* at 473–76 (highlighting community advocacy work of Golden Gate Law and Justice Clinic in San Francisco, CA, which worked with community-based organizations in stopping development of power plant in primarily African American neighborhood).

107. See *id.* at 476–79 (describing organizing and coalitional work done by Greater Boston Legal Services in collaborating with labor, clergy, and community activists to secure passage of living wage ordinance).

108. See discussion *supra* Part II.

suit daunting.<sup>109</sup> Potential challenges in enforcing other health laws, such as the Medicaid Act,<sup>110</sup> also raise concerns about the effectiveness of a litigation-based strategy.

Administrative advocacy strategies are limited as well. OCR's inadequate resources and enforcement capabilities make the reality of forcing medical providers to comply with Title VI challenging.<sup>111</sup> Thus, strategies centered on non-litigation and non-administrative approaches are necessary to supplement, if not overcome, the tremendous barriers lawyers and advocates face when using Title VI to obtain equal access to care for marginalized communities.

Second, most health care problems are generally tied to issues of geography.<sup>112</sup> For example, when people complain about inadequate health care services from a medical provider, they are mainly referring to hospitals, clinics, and doctors located in their neighborhoods.<sup>113</sup> Specific issues that have riled communities in different parts of the country include hospital closures<sup>114</sup> and the transfer of medical ser-

109. See Rosenbaum & Teitelbaum, *supra* note 60, at 243–45 (discussing tremendously negative impact of *Alexander v. Sandoval* on Title VI health care discrimination cases). Although individuals retain the right to file a Title VI lawsuit under disparate treatment theory, it should be noted that proving a case under this theory is very difficult. See *id.* at 227 (stating that “‘smoking gun’ evidence of discriminatory motive is rare . . . [and thus] proving motive (and therefore prevailing as plaintiff) is extremely difficult”).

110. See, e.g., *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50 (1st Cir. 2004) (holding that there is no private right of action to enforce provisions of the Medicaid Act).

111. See Lado, *supra* note 23, at 28 (discussing OCR's ineffectiveness in enforcing Title VI). In order for OCR to be a more effective agency, however, it would need additional funding and resources. See Rosenbaum & Teitelbaum, *supra* note 60, at 247–48 (recommending better funding sources for OCR to improve the agency's ability to enforce Title VI). Regardless of OCR's inadequacies in monitoring Title VI compliance, it should be noted that filing complaints with OCR remains a vital part of Title VI enforcement. In particular, complaints with OCR provide a record of the types of discrimination that continue to occur in the marketplace.

112. In fact, the issue of inadequate health care services is inextricably tied to historical and de facto segregation that have affected the placement of communities in which people of color reside. See, e.g., Robyn Whipple Diaz, *Unequal Access: The Crisis of Health Care Inequality for Low-Income African-American Residents of the District of Columbia*, 7 J. HEALTH CARE L. & POL'Y 120 (2004) (discussing how racial and economic segregation led to inadequate health care services for African Americans in the southeast district of Washington, DC).

113. See, e.g., *Mussington v. St. Luke's-Roosevelt Hosp. Ctr.*, 824 F. Supp. 427, 429 (S.D.N.Y. 1993) (involving Harlem residents' complaints against local hospital's proposed relocation of obstetrics, neonatal intensive care and general medical surgical beds to location not easily accessible to residents).

114. See, e.g., *Bryan v. Koch*, 492 F. Supp. 212, 215 (S.D.N.Y. 1980) (involving proposed closures of public hospitals).

vices from one hospital<sup>115</sup>—usually in a poor neighborhood—to a hospital in a more affluent one,<sup>116</sup> both of which address unequal access to medical services.

In addition, some diseases are concentrated by geography as well.<sup>117</sup> For instance, in 1999 the rate of childhood asthma in the Bronx was 1,000 percent higher than the rest of New York State.<sup>118</sup> Hospitalization rates for asthma among people in the South Bronx were as high as 17.3 for every 1,000 people, and death rates from asthma were eleven per 100,000 people.<sup>119</sup> At the time, both rates were eight times the national average.<sup>120</sup> The high incidence diseases in specific neighborhoods make it an ideal issue for community groups and lawyers to address collectively.

Third, and perhaps most importantly, by being a catalyst for empowering community members, community lawyering is particularly useful in the health context. More specifically, as communities become empowered, they gain the confidence that they need to demand services to which they are entitled and force health providers to be more accountable to them.<sup>121</sup> Providers, whether fearful of negative publicity or potential lawsuits, would in turn want to meet the needs of the community.<sup>122</sup>

In sum, community lawyering offers a rich alternative to community members and medical providers by creating space for dialogue

115. See, e.g., *Mussington*, 824 F. Supp. at 429 (involving allegations that shifting medical services to another site would constitute discrimination against low-income African Americans and Latinos).

116. See, e.g., *NAACP v. Wilmington Med. Ctr.*, 491 F. Supp. 290, 291 (D. Del. 1980) (addressing relocation of hospital facilities from urban location to suburban area).

117. See, e.g., Neil L. Albert, *A Right to Treatment for AIDS Patients?*, 92 *DICK. L. REV.* 743, 758 (1987) (discussing geographical concentration of individuals with HIV).

118. See Wendy C. Perdue, Lawrence O. Gostin & Lesley A. Stone, *Public Health and The Built Environment: Historical, Empirical, and Theoretical Foundations for an Expanded Role*, 31 *J. L. MED. & ETHICS* 557, 559 (2003) (stating that rate of childhood asthma in the Bronx is 1,000 percent higher than the rest of New York State). The rate of asthma among children in the South Bronx is also twice the national average. See *SOUTH BRONX CLEAN AIR COALITION, OUR CHILDREN OUR SCHOOLS* (1999), at <http://www.crp.cornell.edu/projects/southbronx/gis/schools.html> (last visited June 1, 2004).

119. *SOUTH BRONX CLEAN AIR COALITION*, *supra* note 118.

120. *Id.*

121. See Quigley, *supra* note 98, at 455–56 (explaining that purpose of empowering community groups is to give them greater control over forces that affect their lives).

122. See, e.g., Shauna I. Marshall, *Mission Impossible?: Ethical Community Lawyering*, 7 *CLINICAL L. REV.* 147, 170 (2000) (describing case in which community residents of color utilized direct action, negative publicity, and political support to stop redevelopment plan in their neighborhood, which they felt would displace them).

among stakeholders within a community on access to health care issues.

*B. Community Lawyering—Forcing Hospitals to Improve Services to People in the Community*

Galvanizing community members to address a hospital's failure to provide quality care services is an ideal example of how community lawyering strategies could help meet the needs of the community.<sup>123</sup> Lawyers, organizers, and community members could strategize regarding a number of actions to attract and encourage hospital administrators and employees to address their needs. These actions could include community surveys, releasing findings to the public and the media, public demonstrations, administrative advocacy, and lobbying. One example of successful community lawyering collaboration is the partnership between Make the Road and NYLPI. Both groups engaged in varied legal and non-legal actions to force hospitals in Bushwick, Brooklyn to provide equal access to health services for people with limited English proficiency.

The partnership between Make the Road and NYLPI began in August 2001 after the two groups met to discuss the issue of lack of adequate services for LEP patients at Woodhull Hospital and Wyckoff Hospital.<sup>124</sup> Members of Make the Road had been patients at one or both hospitals and had experienced poor services at the hospitals be-

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123. It should be noted that community lawyering in the health context is not a new concept, and has been used successfully in the past. In the early 1970s and early 1980s for example, communities in New York City organized campaigns to prevent the closure of hospitals in their neighborhoods. Specifically, in *Bryan v. Koch*, 492 F. Supp. 212 (S.D.N.Y.), *aff'd*, 627 F.2d 612 (2d Cir. 1980), the communities involved filed a lawsuit in federal court under Title VI, and also used community activism to ensure that the hospitals remained opened. See Lado, *supra* note 23, at 22 & nn.111 & 113 (noting that creative legal advocacy coupled with community organizing helped prevent loss of hospitals in communities of color). Although the court ultimately dismissed the lawsuit against the plaintiffs, the campaign generated sufficient community outcry and participation in the issue, which ultimately helped to obtain racially equitable results. *Id.* In particular, although the court dismissed plaintiffs' Title VI complaint against the City of New York for its proposed closure of Sydenham Hospital in Central Harlem that served a primarily African American and Latino patient population, see *Bryan*, 627 F.2d at 614, the City agreed to keep open Metropolitan Hospital, another public hospital located in Harlem, that the city had originally planned to close as well. See Lado, *supra* note 23, at 22 n.113.

124. Telephone Conversation with Marianne Engelman Lado, General Counsel, NYLPI (Oct. 25, 2004) (explaining that NYLPI lawyers and organizers met with members of Make the Road by Walking in August 2001 to confer about the language access problems in the two Bushwick hospitals).

cause of the lack of adequate language services for LEP persons.<sup>125</sup> While the groups had formed a lawyer-client relationship, the union that emerged over time was a more collaborative relationship.

Over the next six months, the groups engaged in a number of actions to strengthen their language access campaign. NYLPI focused its efforts on providing legal advice and information to Make the Road members. For example, NYLPI lawyers and organizers conducted community education workshops for Make the Road members and other Bushwick residents to inform them about their legal right to get interpreters at hospitals.<sup>126</sup> Make the Road members concentrated more on obtaining additional information and support from the Bushwick immigrant community, particularly individuals who were patients at either hospital.<sup>127</sup>

In January 2002 the two groups met to determine the next step in their campaign; by then Make the Road members had interviewed more than seventy patients at Woodhull Hospital and seventy-five patients at Wyckoff Hospital.<sup>128</sup> During these interviews, the patients reported that between seventy-nine and eighty-one percent of the patients were not able to communicate with their doctors because of the

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125. See Katie Worth, *For English Speakers Only? Emergency Room Help*, VILLAGE VOICE, May 1–7, 2002, available at <http://www.villagevoice.com/issues/0218/worth.php> (last visited June 8, 2004) (discussing one of the Make the Road members' experience with language barriers at Woodhull Hospital).

126. Providing legal information to the community serves the purpose of not only educating community members about their legal rights but also informing them of the process of how to enforce their rights. See generally Eagly, *supra* note 102 (discussing how community education provides critical information to community clients). NYLPI also distributed bilingual "I Need an Interpreter" or "Know-Your-Rights" cards to Make the Road members, which they could show to hospital employees if they need language services. These cards are particularly helpful in providing basic legal information to community members as well as equipping them with something tangible that they could use to defend their rights. See generally Michael Fleishman, *Reciprocity Unmasked: The Role of the Mexican Government In Defense of Its Foreign Nationals in United States Death Penalty Cases*, 20 ARIZ. J. INT'L & COMP. L. 359, 379 (2003) (discussing distribution and use of "Know-Your-Rights" cards to inform Mexican-Americans about their legal rights).

127. Using forms prepared by NYLPI, Make the Road members conducted facility surveys to determine whether the hospitals had posted signs in Spanish and other languages that informed patients of their right to language access services. Make the Road members also conducted patient surveys and interviewed Spanish-speaking individuals who were patients at either Woodhull or Wyckoff Hospitals. Patients interested in complaining about the hospitals' failure to provide language access services to them were invited to join Make the Road's meetings. Their names were also submitted to NYLPI, who contacted them to ask specific information about their experiences.

128. See MAKE THE ROAD BY WALKING, UNEQUAL TREATMENT: CIVIL RIGHTS VIOLATIONS AT WOODHULL HOSPITAL AND WYCKOFF HOSPITAL AGAINST PEOPLE WITH LIMITED ENGLISH PROFICIENCY (LEP) (2003) (on file with author).

lack of interpreters at the hospitals.<sup>129</sup> Between sixty-eight and seventy-four percent of patients did not receive or see hospital documents translated into Spanish, and between eighty-three and eighty-seven percent of patients were never told of their right to have an interpreter.<sup>130</sup> NYLPI had also interviewed about twenty members of Make the Road and Bushwick residents who received poor medical services at either Woodhull or Wyckoff Hospital because of the language barriers at the hospital.<sup>131</sup>

At the meeting, the groups decided to take legal action by filing civil rights complaints against the hospitals with the New York State Attorney General's Office (AGO)<sup>132</sup> and taking direct community action through a public demonstration in front of one of the hospitals. For the next few weeks, NYLPI and Make the Road worked on putting together affidavits in support of the complaints. Make the Road compiled their survey results and collated them into report form. Both groups sent media advisories several days before the complaints' filing date and media releases on the day the complaints were filed.<sup>133</sup>

On February 28, 2002, NYLPI filed two civil rights complaints on behalf of Make the Road, one against Woodhull Hospital and one against Wyckoff Hospital.<sup>134</sup> That same day, both Make the Road and NYLPI engaged in a peaceful demonstration outside of Wyckoff Hospital and subsequently held a press conference.<sup>135</sup> They distributed copies of the complaints as well as the results of the surveys con-

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129. *Id.*

130. *Id.*

131. Telephone Conversation with Marianne Engelman Lado, General Counsel, NYLPI (Oct. 25, 2004).

132. The New York State Attorney General's Office (AGO) had the general authority to enforce violations of state and federal law. *See generally* N.Y. EXEC. LAW § 63 (2004) (explaining duties of the Attorney General of New York).

133. *See* Press Release, *supra* note 4.

134. *See* Discrimination Complaint, *supra* note 7.

135. *See* Pat Sisson, *Translation Needed*, CITY LIMITS, Feb. 25, 2002, available at <http://www.citylimits.org/content/articles/weeklyView.cfm?articlenumber=743> (reporting on Make the Road members' filing a civil rights complaint regarding the hospital's lack of language access services).

ducted by Make the Road.<sup>136</sup> Mainstream and Spanish-speaking media attended the press conference and interviewed both groups.<sup>137</sup>

The filing of the complaints with the AGO meant that the two groups had very little control over the AGO's investigation.<sup>138</sup> In February 2003, the AGO completed its investigation and secured resolution agreements from the hospitals. Among other things, the agreements required the hospitals to assign a Language Access Coordinator, identify bilingual employees who would be designated full-time staff interpreters, provide bilingual employees with training on medical interpreting, assess the language needs of their patients, and translate important hospital documents into Spanish and other languages if necessary.<sup>139</sup> Moreover, under the resolution agreements, the AGO would monitor the hospitals' compliance with the agreements.<sup>140</sup>

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136. See Ana Ledo, *Lack of Interpreters Harms Immigrant Patients, Community Organization Charges*, VOICES THAT MUST BE HEARD, Feb. 22, 2002, available at <http://www.indypressny.org/article.php3?ArticleID=25> (last visited Oct. 23, 2004) (discussing report by Make the Road by Walking on unavailability of interpreters at local hospitals). See also Seth Kugel, *Some Say Hospitals Lack Vital Procedure: Translation*, N.Y. TIMES, Apr. 7, 2002, at 4 (discussing Make the Road by Walking report, which concluded that "Spanish speakers could not communicate with staff members at Woodhull and Wyckoff hospitals").

137. See Michael O. Allen, *Hospital Language Barrier?*, DAILY NEWS, Feb. 22, 2002, at Suburban Section 1 (reporting about Make the Road by Walking's demonstration outside of Wyckoff Heights Medical Center); Jose L. Llanes, *Demandan a Hospitales in Brooklyn*, HOY, Feb. 22, 2002, at 4 (same); Ana Ledo, *Denuncian Falta de Interpretes, No Hay Comunicacion Entre Pacientes Hispanos y Medicos en Hospitales*, EL DIARIO, Feb. 22, 2002, at 3 (same). See also Alan Mozes, *NYC Hospitals Sued for Lack of Spanish Services*, REUTERS HEALTH, Feb. 22, 2002, available at [http://www.interpreterschia.org/news\\_info.htm](http://www.interpreterschia.org/news_info.htm) (last visited Oct. 23, 2004).

138. About a month after the filing of the complaints, the AGO went to Make the Road's offices to interview the members who submitted affidavits in support of the complaints. NYLPI prepared the members for these interviews and also sat with them during their conversation with the AGO lawyers.

139. See Letter from Lynda D. Curtis, Senior Vice President, North Brooklyn Health Network, to Natalie R. Williams, Deputy Bureau Chief, Civil Rights Bureau, Office of the New York State Attorney General 1-4 (Feb. 27, 2003), available at <http://stage.nylpi.org/pub/wooddoc.pdf> (discussing language access policies adopted by Woodhull Hospital after the Attorney General's investigation of the hospital's practices); Resolution Agreement between the Office of the Attorney General of the State of New York and Wyckoff Heights Medical Center 1-22 (Feb. 27, 2003), available at <http://stage.nylpi.org/pub/wyckoffres.pdf> (explaining the language access policies adopted by Wyckoff Hospital).

140. See Letter from Lynda D. Curtis, Senior Vice President, North Brooklyn Health Network, to Natalie R. Williams, Deputy Bureau Chief, Civil Rights Bureau, Office of the New York State Attorney General 1-4 (Feb. 27, 2003), available at <http://stage.nylpi.org/pub/wooddoc.pdf> (explaining monitoring reports to be filed with the AGO as required by the resolution agreements); Resolution Agreement between the Office of the Attorney General of the State of New York and Wyckoff Heights Medical Center 1-22 (Feb. 27, 2003), available at <http://stage.nylpi.org/pub/wyckoffres.pdf> (same).

Clearly, the collaborative efforts of Make the Road and NYLPI successfully led to the improved language access services for LEP patients in the Bushwick community.<sup>141</sup> Despite the limitations of *Sandoval*, the groups found alternative strategies for improving access to care for marginalized populations.

#### IV.

##### ADVANTAGES AND DISADVANTAGES OF COMMUNITY LAWYERING IN HEALTH CARE

As a social change strategy, community lawyering offers several advantages to lawyers, organizers and activists working on access to health care issues. Through its participatory and democratic process, community lawyering presents poor, of color and immigrant persons and communities the opportunities to share their personal experiences, actively fight for their rights and voice their opinions with providers and other persons who often marginalize them. In addition, community lawyering helps to avoid the high costs associated with litigation.

Community lawyering, however, does have its limitations. The biggest drawback is that victories secured by communities are limited in scope. Secondly, successes obtained outside of litigation may be difficult to enforce.

##### A. *Advantages*

The ability of clients to actively participate in the strategic development of a campaign is perhaps one of the biggest advantages of community lawyering.<sup>142</sup> Providing clients some space to air their concerns, such as a public demonstration or media event, is an inviting

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141. In the spring of 2004, Make the Road conducted new surveys of patients at Woodhull and Wyckoff Hospitals. LEP patients reported that services at the hospitals had improved. Make the Road interviewed forty patients at Woodhull and twenty-eight patients at Wyckoff and found that, overall, services for LEP patients had improved by about fifty percent since the filing of the agreements. Make the Road and NYLPI scheduled meetings with administrators of Woodhull and Wyckoff and shared with them the results of the surveys. See MAKE THE ROAD BY WALKING, ONE YEAR LATER: WOODHULL AND WYCKOFF HOSPITALS IMPROVE SERVICES TO LEP PATIENTS BUT LANGUAGE ACCESS BARRIERS PERSIST (2004) (on file with author). The hospitals agreed to continue working on improving their services and engaging in a dialogue with Make the Road and other members in the community about language access services.

142. See Ascanio Piomelli, *Appreciating Collaborative Lawyering*, 6 CLINICAL L. REV. 427, 440–41 (2000) (stating that most significant theme of law and organizing scholarship is its emphasis on active client participation). See also Binny Miller, *Give Them Back Their Lives: Recognizing Client Narrative in Case Theory*, 93 MICH. L. REV. 485, 503–06 (1994) (explaining client-centered strategies and importance of clients' decision-making powers).

participatory process that is often amiss in a litigation-structured campaign, wherein clients' stories are usually told by lawyers in court documents or before a judge.<sup>143</sup> In the context of health care, the client's opportunity to participate proactively in a case or campaign is even more important because many who are discriminated against by health care providers do not have the resources to engage in litigation. Most undocumented immigrants, for example, are excluded from obtaining assistance from federally funded legal services organizations.<sup>144</sup>

In addition, encouraging clients to participate actively in developing strategies and solutions to their legal problems helps empower the clients individually and collectively, and promotes community building and independence. This is another advantage of community lawyering.<sup>145</sup> The community members' investment in enforcing their own health care rights would consequently provide them with skills, knowledge and other resources to continue fighting health inequities in their neighborhood.<sup>146</sup> The campaign's sustainability would therefore strengthen their ability to continue negotiating with medical providers in their neighborhood, and may also encourage them to engage in other campaigns that would address other inequalities in their community.<sup>147</sup>

Finally, community lawyering avoids much of what makes litigation unappealing. In addition to what was earlier described as disempowering clients,<sup>148</sup> litigation can be tremendously costly, and one always risks losing and creating unfavorable precedent.<sup>149</sup> Through community lawyering, on the other hand, one might obtain the gains that would arguably have been reached through a successful litigation

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143. See Miller, *supra* note 89, at 20; Alfieri, *supra* note 89, at 665.

144. See 45 C.F.R. § 1626.5-.6 (2003) (relating to public welfare barring Legal Services Corporation from representing undocumented immigrants).

145. See Tremblay, *supra* note 93, at 951-53 (describing how rebellious lawyering and law and organizing strategies "seek[] to empower subordinated clients" by encouraging use of client narratives and promoting client political activism); Lopez, *supra* note 87, at 74-82 (explaining that rebellious lawyering promotes self-help and community empowerment).

146. See Tremblay, *supra* note 93, at 951-53; Lopez, *supra* note 87, at 74-82.

147. See, e.g., Luke W. Cole, *Empowerment As the Key to Environmental Protection: The Need for Environmental Poverty Law*, 19 *ECOLOGY L.Q.* 619, 668-69 (1992) (stating that "[b]y increasing the community's knowledge, and others' knowledge of the community's problems, the community's persuasive power is necessarily strengthened").

148. See discussion *supra* Part III.

149. See Bonnie Kae Grover, Essay, *Left-Right Critiques of the American Judicial System: Resetting the Social Agenda*, 3 *V.A. J. SOC. POL'Y & L.* 371, 377 (1996) (noting criticism of litigation as having high economic cost with inconsistent results).

approach in the first place. In another Make the Road and NYLPI campaign, for example, the groups were able to get Brooklyn Hospital, another hospital that community members have complained about for poor services provided to LEP patients, to sit down and negotiate a language access policy that they wanted the hospital to adopt.<sup>150</sup> Because of the work that Make the Road and NYLPI did in Woodhull and Wyckoff hospitals, Brooklyn Hospital administrators were willing to have a dialogue with the two groups in order to avoid negative publicity.

The above highlights the reasons that make community lawyering an attractive strategy for improving access to health care services. As discussed below, however, community lawyering does have its limitations. Understanding these limitations is necessary for ensuring successful advocacy for marginalized communities facing unequal access to care.

### *B. Limitations of Community Lawyering in Health Care*

The primary drawback to engaging in community lawyering is that the victories achieved are limited to that particular community. As an approach that is a locally or geographically-based strategy, community lawyering would generally not have the goal of obtaining a broader and far-reaching effect, such as might be obtained through litigation (specifically impact litigation).<sup>151</sup> Instead, the main goal would be to address and improve specific communities' issues. Thus, as a primarily locally-based strategy, community lawyering has limited abilities to create systemic change.<sup>152</sup>

The Make the Road and NYLPI's hospital language access campaign demonstrates this point clearly. Acquiring appropriate language assistance services policies in three hospitals secured better health care services for people who either live in or go to those hospitals. If lawyers, advocates and organizers continue this hospital-by-hospital ap-

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150. See Agreement Among Make the Road by Walking, Inc., Fort Greene Strategic Neighborhood Action Partnership and The Brooklyn Hospital Center, Sept. 14, 2004 (on file with the New York University Journal of Legislation and Public Policy).

151. See Cummings & Eagly, *supra* note 87, at 485–86 (discussing how law and organizing, as a political strategy, “fails to offer a coherent challenge to the larger institutional structures that produce poverty and inequality”); John Foster-Bey, *Bridging Communities: Making the Link Between Regional Economies and Local Community Economic Development*, 8 STAN. L. & POL'Y REV. 25, 32–34 (1997) (stating that locally-based strategies cannot address adequately the broader regional factors that perpetuate racism and poverty).

152. See Cummings & Eagly, *supra* note 87, at 485–86; Foster-Bey, *supra* note 151, at 32–34.

proach (particularly in New York City, where there are more than sixty hospitals), many people who face unequal access to care will continue to be discriminated against for many years. In addition, much of the systemic discrimination in the health care system is tied to the distribution—or, perhaps more accurate, the lack—of funds from federal and private foundations. The unequal allocation of funds to hospitals and clinics that serve medically underserved communities would be difficult to challenge using a community lawyering approach.

A second drawback of community lawyering in health care is that some community-based organizations are funded by hospitals, clinics and other health organizations to provide services to people in the community.<sup>153</sup> As such, their ability to participate and support a campaign against medical providers in the community is severely limited by the inherent conflict of interest.

Finally, there is the potential difficulty of enforcing agreements or policies that hospitals, clinics or doctors have voluntarily adopted in the face of community pressure. Most parties tend to comply with agreements they entered into when a court has jurisdiction over the matter, as they may be found in contempt for failing to comply with a consent decree. When there is no judicial involvement, however, the possibility of minimal or no compliance is high.<sup>154</sup> Thus, vigorous monitoring of the providers' compliance with agreements or new policies will usually become the responsibility of community residents. Efforts at monitoring compliance with agreements or adopted policies may take resources away from other campaigns in which a community group might want to participate.

#### CONCLUSION

More than 40 years since Title VI of the Civil Rights Act of 1964 was enacted, people of color, ethnic and language minorities, immigrants and poor people continue to face unequal access to health care. As the availability of litigation and administrative strategies to improve access to care for these people becomes more and more limited, lawyers, advocates, and activists need to engage in more creative and

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153. See Lewis D. Solomon & Tricia Asaro, *Community-Based Health Care: A Legal and Policy Analysis*, 24 *FORDHAM URB. L.J.* 235, 266–67 (1997) (discussing how many community-based health care clinics are funded by hospitals and private foundations and are run by community members).

154. See Arthur R. Block, *Enforcement of Title VI Compliance Agreements by Third Party Beneficiaries*, 18 *HARV. C.R.-C.L. L. REV.* 1, 51 (1983) (noting that thousands of voluntary compliance agreements have remained unimplemented).

proactive approaches. Community lawyering offers one such strategy that has tremendous potential for breaking down discriminatory barriers and ensuring equal access to marginalized communities.

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