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THE STATE GIVETH AND TAKETH AWAY: RACE, CLASS, AND URBAN HOSPITAL CLOSINGS

SHAUN OSSEI-OWUSU*

“The Lord gave, and the Lord hath taken away.” Job 1:21

I. INTRODUCTION

The goal of this symposium is to investigate, expand, and challenge two core ideas in Bernadette Atuahene’s remarkable book *We Want What’s Ours: Learning from South Africa’s Land Restitution Program*.¹ The concepts—dignity takings and dignity restoration—expand the boundaries of socio-legal inquiry as it relates to property loss and attendant remedies. Individuals across the scholarly and thematic spectrum have picked up the baton from Professor Atuahene and are applying these ideas in areas as diverse as slavery, education, punishment, and tax foreclosure.²

My modest contribution to this mélange of topics focuses on a part of the American economy that consumes 17.8 percent of our nation’s Gross Domestic Product: health care and health administration.³ I am specifically interested in the trend of urban hospital closings in low-income neighborhoods.⁴ This essay examines how Atuahene’s framework illuminates new

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1. BERNADETTE ATUAHENE, *WE WANT WHAT’S OURS: LEARNING FROM SOUTH AFRICA’S LAND RESTITUTION PROGRAM* (2014).

2. See, e.g., Symposium, *Dignity Takings / Dignity Restoration*, 92 CHI.-KENT L. REV. (forthcoming 2017).

3. *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> [<https://perma.cc/QU67-XTJV>].

4. A few things are worth noting at the outset. First, by urban hospital I am referring specifically to safety-net hospitals in large cities, although much of what I describe is applicable to non-profit hospitals in large cities as well. Second, public hospital closings are not a new development but something that has been unfolding for decades. See, e.g., Alan Sager, *Why Urban Voluntary Hospitals Close*, 18 HEALTH SERVS. RES. 451 (1983); Mitchell F. Rice, *Inner-City Hospital Closures/Relocations: Race, Income Status, and Legal Issues*, 24 SOC. SCI. & MED. 889 (1987); OFF. OF INSPECTOR GEN., DEP’T OF HEALTH & HUMAN SERVS., OEI-0495-0050, TRENDS IN URBAN HOSPITAL CLOSURE 1987–1993 (1995); Randall R. Bovbjerg et al., *Health Care for the Poor and Uninsured After a Public Hospital’s Closure or Conversion*, in ASSESSING THE NEW FEDERALISM (The Urban Inst., Occasional Paper No. 39, 2000); OFF. OF INSPECTOR GEN., DEP’T OF HEALTH & HUMAN SERVS., OEI 04-02-00611, TRENDS IN URBAN HOSPITAL CLOSURE 1990–2000 (2003); Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023 (2005); Michelle Ko et al., *Residential Segregation and the Survival*



and productive ways of thinking about the trend of urban hospital closings; at the same time, I show how her model is not the snuggest fit for thinking about the shuttering of these institutions. By doing the latter, I demonstrate how hospital closings help enrich and supplement her concepts by exploring the trajectory of Martin Luther King, Jr. Community Hospital, an institution that serves South Los Angeles, California.

The hospital and its educational affiliate Charles R. Drew University of Medicine and Science—colloquially known together as King/Drew Medical Center (“KDMC”)⁵—opened in the early 1970s.⁶ Local and state government believed that the institution would meet the health care needs of this majority black section of Los Angeles, as well as provide jobs for pink, blue, and white-collar workers.⁷ KDMC ebbed and flowed with the nation’s rapidly changing health care landscape in the last quarter of the twentieth century—a time where poverty and legislation put new pressures and responsibilities on public hospitals. But during this period, the problems of crack cocaine, gun violence, and sexually-transmitted diseases impacted the health of public hospitals in big cities across the country.⁸ At the turn of the century, when the government and the public were increasingly looking askance at certain parts of the welfare state and public financing of health care, safety-net hospitals received more scrutiny.⁹ In 2004, the *Los Angeles Times* produced an award-winning series of reports on KDMC’s shortcomings; a high profile instance of medical malpractice, which led to a woman’s death and was captured on camera, caused the

of U.S. Urban Public Hospitals, 71 MED. CARE RES. & REV. 243, 243–60 (2014). Finally, rural hospitals are also closing at alarming rate, although that is not the focus of this paper. For a recent take on this problem, see generally Ayla Ellison, *The Rural Hospital Closure Crisis: 15 Key Findings and Trends*, BECKER’S HOSP. REV. (Feb. 11, 2016), <http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html> [https://perma.cc/9J49-8NNA].

5. The hospital went through numerous name changes because of different affiliations and reorganizations. Some included Martin Luther King Jr. General Hospital, Martin Luther King Jr./Drew Medical Center (King/Drew), Martin Luther King Jr. Multi-Service Ambulatory Care Center, Martin Luther King Jr. Outpatient Center, Martin Luther King Jr.–Harbor Hospital. This essay generally refers to the institution as King/Drew (KDMC) and delineates between the hospital and school when necessary.

6. Charles R. Drew Postgraduate Medical School was incorporated in 1966 and opened its offices in 1970. Martin Luther King Jr. General Hospital opened in 1972. See *Drew Medical School Opens Offices in Watts*, L.A. TIMES, Jan. 24, 1970, at 17; *King Hospital to Open Doors Today*, L.A. TIMES, Mar. 27, 1972, at 31.

7. ROBERT BAUMAN, RACE AND THE WAR ON POVERTY: FROM WATTS TO EAST L.A. 76 (2008).

8. CLARENCE LUSANE, PIPE DREAM BLUES: RACISM AND THE WAR ON DRUGS 63–64 (1991); Edward E. Cornwell, III, *Violence, Guns, and Race: Health-care Professionals Must Speak Out*, 86 J. NAT’L MED. ASS’N 333 (1994); CTRS. FOR DISEASE CONTROL & PREVENTION, THE NATIONAL PLAN TO ELIMINATE SYPHILIS FROM THE UNITED STATES 54 (2006).

9. See generally INST. OF MED., AMERICA’S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED (Marion Ein Lewin & Stuart Altman eds., 2000).



federal government to monitor the hospital and subsequently close it in 2007.¹⁰ In 2015, the hospital opened as a smaller outfit in the post-Affordable Care Act environment.¹¹

KDMC's opening as an institution designed to meet the needs of a specific demographic group, its closing, and reopening provide the perfect context to explore and reimagine the concepts of dignity takings and dignity restoration. Part II focuses on the 1940s through the 1960s and discusses the circumstances that led to the creation of KDMC.¹² It weaves this context with early legislative and judicial developments that arguably helped South Los Angeles residents develop a property interest in KDMC. Part III's examination of the 1970s to the turn of the twenty-first century continues the discussion on legislative developments and ties them to KDMC's existence during this period. This part connects the institution's 2007 shuttering to Atuahene's understanding of takings and dignity takings. Part IV puts Professor Atuahene's concept of dignity restoration in conversation with the hospital's reopening in 2015.

II. THE CREATION OF KDMC AND THE DEVELOPMENT PROPERTY INTERESTS

A. A Safety-Net Hospital is Born

During the first half of the twentieth century, boosters marketed Southern California as a utopia.¹³ This was hardly true for the small group of African Americans that migrated to Los Angeles in the early 1900s¹⁴ and for the droves of people that followed in the middle of that century.¹⁵ In

10. See *The Troubles at King/Drew*, L.A. TIMES (Aug. 21, 2015, 10:45 AM), <http://www.latimes.com/nation/la-kingdrewpulitzer-sg-storygallery.html> [http://perma.cc/V8YW-K9N9] (collecting all of the 2004 KDMC investigative articles).

11. Soumya Karlamangla, *South L.A.'s MLK Hospital Will Reopen with a New Healthcare Outlook*, L.A. TIMES (Mar. 28, 2015, 2:00 PM), www.latimes.com/local/california/la-me-adv-mlk-hospital-20150329-story.html [http://perma.cc/X35L-Z98S].

12. For the most substantive treatment of the hospital, to which my own work is indebted, see Darnell Hunt & Ana-Christina Ramón, *Killing "Killer King": The Los Angeles Times and a "Troubled" Hospital in the 'Hood*, in BLACK LOS ANGELES: AMERICAN DREAMS AND RACIAL REALITIES 283–320 (Darnell Hunt & Ana-Christina Ramón eds., 2010).

13. See generally KEVIN STARR, MATERIAL DREAMS: SOUTHERN CALIFORNIA THROUGH THE 1920S (1990); BECKY M. NICOLAIDES, MY BLUE HEAVEN: LIFE AND POLITICS IN THE WORKING-CLASS SUBURBS OF LOS ANGELES, 1920–1965 (2002); TOM ZIMMERMAN, PARADISE PROMOTED: THE BOOSTER CAMPAIGN THAT CREATED LOS ANGELES, 1870–1930 (2008); A COMPANION TO LOS ANGELES (William Deverell & Greg Hise eds., 2010).

14. See generally DOUGLAS FLAMMING, BOUND FOR FREEDOM: BLACK LOS ANGELES IN JIM CROW AMERICA (2005); MARNE L. CAMPBELL, MAKING BLACK LOS ANGELES: CLASS, GENDER, AND COMMUNITY, 1850–1917 (2016).

15. See generally JOSH SIDES, L.A. CITY LIMITS: AFRICAN AMERICAN LOS ANGELES FROM THE GREAT DEPRESSION TO THE PRESENT (2006).

Los Angeles, blacks were not subject to the exact kind of vigilante violence that was prevalent in the South or the squalor of eastern and midwestern ghettos; but economic and physical safety were not givens.¹⁶ Moreover, African-American Los Angelinos were subject to garden-variety segregation.¹⁷ As the African-American population increased in the 1940s, blacks became increasingly quarantined into the southeast section of Los Angeles, particularly Watts. In *Fairchild v. Raines*, a case involving covenants in Pasadena (a city in Los Angeles County), famed jurist Roger Traynor wrote that, “it must be recognized that the steady migration of southern negroes and the influx of negroes into urban communities in response to the increasing demands of industry for labor, together with race segregation, have made it impossible for many negroes to find decent housing in large centers of population.”¹⁸

Inadequate health care was another problem for the black community in Watts. The federal government passed the Hospital Survey and Construction Act (also known as the “Hill–Burton Act”) in 1946 as a post-War attempt to assist states in the improvement of existing hospitals and the creation of new ones.¹⁹ A year after the law was passed, Dr. Vane M. Hoge, Chief of the Division of Hospital Facilities in the Public Health Service, stated that, “the act reflects the current concept that public health includes responsibility for the treatment and care of the individual. It recognizes, also, that hospitals are an integral part of our social fabric, on a par in the community with the church and the school.”²⁰ Considering the precarious health environment that racial minorities across the country faced,²¹ black residents in Los Angeles were well suited to benefit from this piece of legislation. But a few features blunted the law’s efficacy: weak enforcement mechanisms and regulatory oversight by the federal government;²² a prohi-

16. See generally KEITH E. COLLINS, *BLACK LOS ANGELES: THE MATURING OF THE GHETTO, 1940–1950* (1980); KELLY LYTLE HERNÁNDEZ, *CITY OF INMATES: CONQUEST, REBELLION, AND THE RISE OF HUMAN CAGING IN LOS ANGELES, 1771–1965* (2017).

17. RICHARD R. W. BROOKS & CAROL M. ROSE, *SAVING THE NEIGHBORHOOD: RACIALLY RESTRICTIVE COVENANTS, LAW, AND SOCIAL NORMS* 104 (2013) (“By the early 1920s, racial covenants had become sufficiently common that the developers of Los Angeles’ Palos Verdes Estates would refer to them as ‘the usual restrictions.’”).

18. *Fairchild v. Raines*, 151 P.2d 260, 268 (Cal. 1944) (citations omitted).

19. Ch. 958, 60 Stat. 1040 (codified as amended at 42 U.S.C. §§ 291–291o (2016)).

20. V. M. Hoge, *The Hospital Survey and Construction Act*, 62 PUB. HEALTH REP. 49, 54 (1947).

21. See generally NAYAN SHAH, *CONTAGIOUS DIVIDES: EPIDEMICS AND RACE IN SAN FRANCISCO’S CHINATOWN* (2001); NATALIA MOLINA, *FIT TO BE CITIZENS?: PUBLIC HEALTH AND RACE IN LOS ANGELES, 1879–1939* (2006); SAMUEL KELTON ROBERTS, JR., *INFECTIOUS FEAR: POLITICS, DISEASE, AND THE HEALTH EFFECTS OF SEGREGATION* (2009).

22. William Worthington & Laurens H. Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROBS. 305, 309 (1970); Marilyn G. Rose, *Federal Regulation*

bition on discrimination with a carved-out acceptance for separate-but-equal facilities;²³ and a requirement that proposed hospitals demonstrate their economic viability.²⁴ These weaknesses filtered into Los Angeles's health environment.

Dr. Lester Breslow, who served as former director of the California Department of Public Health, helpfully described the medical environment for African Americans in Los Angeles in the middle of the twentieth century. Reflecting on the 1960s, he provided a high-level snapshot of public health for black people in Los Angeles:

So we had a map of the state, all divided up, and each one was a hospital region. I said, 'I'd like to take a look at the hospital region of Watts because I hear terrible things about that.' So the map is brought in and we look at it and here is an oblong area in the middle of Los Angeles . . . that had no hospitals . . . There were some hospitals on the periphery, on the very edges. Very small, very poor hospitals. So small that they could be nothing other than poor. Mostly small, proprietary hospitals. Most people who got sick in Watts had to be what they called \$10 sick (that meant they would have to take a taxi cab for \$10 to get to the big county hospital, because to go on the bus would require three transfers. That was completely unfeasible for anybody who was seriously sick) so they had to be \$10 sick to get to the county hospital. I said, 'My goodness, how can that be?' Well, it was very simple. The area was all regionalized. The only trouble was that the right upper quarter of Watts was drawn into an adjacent hospital area where there were better living conditions over there, and the left upper quarter was drawn off similarly. The whole of Watts was just quartered into other areas where there were hospitals, but not to serve the people in Watts.²⁵

The absence of a hospital that could meet the needs of Los Angeles's black community was not due to a lack of effort. In 1950, black doctors and

of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls, 70 NW. U. L. REV. 168 (1975).

23. Section 622(f) of the Hospital Survey and Reconstruction Act stated:

[S]uch hospital or addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.

KAREN KRUSE THOMAS, *DELUXE JIM CROW: CIVIL RIGHTS AND AMERICAN HEALTH POLICY, 1935–1954*, at 116 (2011) (discussing the consequences of “separate but equal” segregation, and its effect on African-American health care in the early twentieth century).

24. PAUL V. DUTTON, *DIFFERENTIAL DIAGNOSES: A COMPARATIVE HISTORY OF HEALTH CARE PROBLEMS AND SOLUTIONS IN THE UNITED STATES AND FRANCE* 185 (2007).

25. Lester Breslow, *Vision and Reality in State Health Care: Medi-Cal and Other Public Programs, 1946–1975*; an Interview Conducted by Gabrielle Morris in 1984, at 71 (1985) (unpublished manuscript) (on file with the Regional Oral History Office, The Bancroft Library, University of California).

citizens tried to raise money from private sources that could be matched by state and federal government for the construction of a hospital, but they were rebuffed.²⁶ Local and state government rejected continued efforts by celebrities such as boxer Joe Louis as well as prominent black physicians.²⁷ The 1965 Watts riots changed everything and spurred government into action.

The uprising in Watts is notable for a few reasons. First, the scope and scale of the riot was exceptional.²⁸ The United States is no stranger to race riots, but historically such disturbances typically involved whites terrorizing blacks.²⁹ A few cities erupted in violence the previous summer, but Watts was unique for its unprecedented television coverage.³⁰ African Americans' destruction of property—a strategy that amplified their frustrations with racial inequality—was lodged into American living rooms.³¹ Second and relatedly, the Watts riot is notable because it occurred a mere week after the Voting Rights Act took effect and one month after Medicaid and Medicare were signed into law by President Johnson.³² The uprising challenged the narrative of racial progress and inaugurated the black power ethos that shifted racial fault lines in the United States. In hindsight, the riot occurred at an opportune time: precisely when there was still a meaningful commitment to poverty-reduction but before racial fatigue and backlash thwarted the potential for the welfare state's blossoming.

Allegations of police brutality spurred the riots, but a state commission, headed by former CIA director John A. McCone, released a report that highlighted poverty, unemployment, poor education, and poor health care as the core issues that undergirded black Los Angelinos' frustration.³³ After outlining a variety of health disparities in southeast Los Angeles vis-à-vis the rest of the County,³⁴ the Commission stated that it “believes that

26. M. Moss Humphrey, *Martin Luther King, Jr., General Hospital and Community Involvement*, 61 BULL. MED. LIBR. ASS'N 324 (1973).

27. *Id.*

28. GERALD HORNE, *FIRE THIS TIME: THE WATTS UPRISING AND THE 1960S*, at 3 (1997).

29. See generally ENCYCLOPEDIA OF AMERICAN RACE RIOTS (Walter C. Rucker, Jr. & James N. Upton eds., 2006).

30. Michael W. Flamm, Opinion, *The Original Long, Hot Summer: The Legacy of the 1964 Harlem Riot*, N.Y. TIMES (July 15, 2014), <https://www.nytimes.com/2014/07/16/opinion/16Flamm.html> [<http://perma.cc/T9CD-JSSF>].

31. JILL EDY, *TROUBLED PASTS: NEWS AND THE COLLECTIVE MEMORY OF SOCIAL UNREST* 22–58 (2006).

32. *Id.*

33. GOVERNOR'S COMM'N ON THE L. A. RIOTS, *VIOLENCE IN THE CITY—AN END OR BEGINNING?* (1965).

34. For example, the report noted that, “the number of doctors in the southeastern part of Los Angeles is grossly inadequate as compared with other parts of the city. It is reported that there are 106 physicians for some 252,000 people, whereas the county ratio is three times higher.” *Id.* at 74.

immediate and favorable consideration should be given to a new, comprehensively-equipped hospital in this area.”³⁵ Eventually, various levels of government, activists, and scholars at University of Southern California and University of California Los Angeles worked together to open Charles R. Drew University of Medicine and Science and Martin Luther King, Jr., General Hospital in 1970, and 1972, respectively.³⁶

B. Safety-Net Hospitals as Property?

Understanding the unique “property rights” involved with the creation of a hospital is important to an analysis that considers the “taking” of a public institution such as KDMC. A safety-net hospital sits somewhere between state property and communal property. Alison Clarke and Paul Kohler note that there is no consensus around the “dividing line” between the two.³⁷ For them, “if the user has the right not to be excluded from use by the state (i.e. the state cannot prohibit the use by that individual without changing the law)” then it could be considered open access communal property rather than as state property, but “if the state provides the facility and merely licenses users to use it by permission revocable by administrative action, then we can call this state property.”³⁸ Both apply to public hospitals; they are owned by the government, and individuals, particularly the indigent, have a right to use the hospital. At the same time, administrative action—e.g., guidelines for what constitutes the indigence—could delimit effectuation of those rights.

Different statutory, judicial, and administrative developments illustrate how Watts residents developed a version of property interests in what would become KDMC. Demographically, the hospital’s creation was premised on unmet health care needs of specific communities: poor blacks and Latinos. A health service area is a geographical unit of analysis that includes one or more counties that are self-contained with respect to the provision of routine hospital care.³⁹ KDMC’s health service area included a thirty-three-square-mile section of South Los Angeles that was predominantly low-income, had high unemployment, and, according to 1970 census data, was populated by approximately 340,000 people, eighty-two percent

35. *Id.*

36. Hunt & Ramón, *supra* note 12, at 289.

37. ALISON CLARKE & PAUL KOHLER, PROPERTY LAW: COMMENTARY AND MATERIALS 35 (2006).

38. *Id.*

39. Diane M. Makuc et al., *Health Service Areas for the United States*, in VITAL AND HEALTH STATISTICS (Nat’l Ctr. for Health Statistics, Ser. 2, No. 112, 1991).

of whom were black and twelve percent of whom were Latino.⁴⁰ On a state and statutory level, California imposed a legal obligation on counties to provide care for the indigent in 1937 and updated this requirement in 1965, the year the Watts riot occurred.⁴¹ Judicially, the Fourth Circuit struck down the separate-but-equal provision of the Hill-Burton Act in *Simkins v. Moses H. Cone Memorial Hospital* in 1963;⁴² the Supreme Court's denial of certiorari helped put an end to formally segregated health care. Subsequently, the Civil Rights Act of 1964 put the legislative stamp on this anti-discrimination requirement in federally funded hospitals. Ultimately, the purposeful specification of KDMC's service area, along with various legislative and judicial imperatives, arguably helped establish Watts' residence interest in the new hospital.

III. OPENINGS, CLOSINGS, AND TAKINGS

After identifying the property issues that are related to safety-net hospitals, the next question is: what is the relationship between dignity takings and safety-net hospital closings? This part explores this association by highlighting the development of KDMC after its opening, situating its trajectory against the larger post-1965 health care environment, and teasing out the nuances of Atuahene's definitions of takings and dignity takings.

A. *The Life of KDMC*

When Martin Luther King Jr. General Hospital opened in 1972, seven years after the riot, it was described as “the finest and biggest [hospital] ever built in and for a black community.”⁴³ Unfortunately for the hospital, the country looked different by the time it opened. The ideological climate—particularly in the areas of politics, law, and economics—all became increasingly conservative in ways that were not necessarily unique to KDMC, but did not create the ideal set of conditions for any new hospital to thrive, especially in California. Economically, two important things hap-

40. M. Alfred Haynes et al., *Health Problems in the Martin Luther King, Jr., Hospital Service Area: Implications for a Community Medicine Program*, CAL. MED., Apr. 1973, at 105, 106.

41. The statute states: “Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives and friends, by their own means, or by state hospitals or other state or private institutions.” CAL. WELF. & INST. CODE § 17000 (West 2017).

42. *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959 (4th Cir. 1963), cert. denied, 376 U.S. 938 (1964).

43. *Dr. King Hospital Set to Open in Health-Care-Starved Watts*, LONG BEACH INDEP., Mar. 24, 1972, at 20.

pened that are both linked to the government's scissoring of the safety-net in the 1970s. First, California helped foment a national taxpayer revolt in 1978 when the state passed Proposition 13, which imposed limits on property taxes and impacted counties' ability to generate funds for social services like public hospitals.⁴⁴ Second, the federal government became concerned about increasing health care costs and began passing legislation that emphasized market principles and cost containment—both of which are arguably in tension with prioritizing health in poor communities.⁴⁵ In short, the government and conservatives began to grow critical of the Great Society's expansion of the health safety-net.

In the 1980s, the primacy of market-based principles persisted and trickled down into South Los Angeles and other minority communities served by public hospitals. In the beginning of the decade, President Reagan saw Medicaid as a space for reduced spending.⁴⁶ For example, between 1981 and 1984, federal expenditures for Medicaid were cut by \$4 billion.⁴⁷ Tighter restrictions on eligibility, along with private hospitals' concerns about poor patients' ability to pay led hospitals to engage in "patient dumping."⁴⁸ This practice involves a hospital rejecting a patient after finding out that she has either no insurance or inadequate insurance. Since private hospitals operated under the "no duty to treat" rule, tort liability was limited and these private entities would transfer patients to public hospitals like KDMC (which often had statutory obligations to provide care to the poor).⁴⁹ Mainstream media outlets such as the *New York Times*, *Chicago Tribune*, *Los Angeles Times*, and *Washington Post*, among others, covered

44. Robert Lindsey, *Many States Moving to Limit Spending*, N.Y. TIMES, June 26, 1978, at A9. See generally DAVID O. SEARS & JACK CITRIN, TAX REVOLT: SOMETHING FOR NOTHING IN CALIFORNIA (1982); CLARENCE Y. H. LO, SMALL PROPERTY VERSUS BIG GOVERNMENT: SOCIAL ORIGINS OF THE PROPERTY TAX REVOLT (1990); ARTHUR O'SULLIVAN ET AL., PROPERTY TAXES AND TAX REVOLTS: THE LEGACY OF PROPOSITION 13 (1995); Clyde Haberman, *The California Ballot Measure That Inspired a Tax Revolt*, N.Y. TIMES (Oct. 16, 2016), <https://www.nytimes.com/2016/10/17/us/the-california-ballot-measure-that-inspired-a-tax-revolt.html> [http://perma.cc/A2MM-26JU].

45. See, e.g., Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e–300e-14a (2016); see also LAWRENCE BROWN, POLITICS AND HEALTH CARE ORGANIZATION: HMO AS FEDERAL POLICY (1983).

46. Lynn Etheredge, *Reagan, Congress, and Health Spending*, HEALTH AFF., Jan. 1983, at 14; Karen Davis, *Reagan Administration Health Policy*, 2 J. PUB. HEALTH POL'Y 312 (1981); Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U. L. REV. 1 (1983);

47. Diane Rowland et al., *Medicaid: Health Care for the Poor in the Reagan Era*, 9 ANN REV. PUB. HEALTH 427, 430 (1988).

48. Mitchell F. Rice & Woodrow Jones Jr., *The Uninsured and Patient Dumping: Recent Policy Responses in Indigent Care*, 83 J. NAT'L MED. ASS'N 874 (1991).

49. See generally Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21 (1989).

the patient dumping phenomenon.⁵⁰ The stories were jarring: a man who was transferred from one emergency room to another with a steak knife *still in his back*;⁵¹ stillbirths caused by private hospitals' shuffling of women in labor;⁵² a man who suffered second- and third-degree burns and was rejected by approximately forty hospitals because of his inability to pay.⁵³

In response, Congress passed the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which was arguably the most important federal health law passed since Medicare and Medicaid two decades earlier.⁵⁴ EMTALA required Medicare-receiving hospitals with emergency services to provide stabilizing treatment to individuals who presented themselves at a hospital irrespective of citizenship status or ability to pay.⁵⁵ Since most hospitals accept Medicare funding, the reach of the law was wide. EMTALA essentially created a limited federal right to emergency care. As one commentator rightfully observes, "the hospital emergency department is perhaps the only local institution where professional help is mandated by law, with guaranteed availability for all persons, all the time, regardless of the problem."⁵⁶

Although EMTALA was certainly a progressive development in the area of health care, it posed three problems for KDMC and public hospitals generally. First, the law was an unfunded mandate; the federal government required hospitals to provide emergency care but shifted the costs to hospitals and local governments.⁵⁷ The law was a boon to public hospitals in that

50. Ronald Sullivan, *Care of Poor Is Cut by Private Hospitals*, N.Y. TIMES (May 30, 1982), <http://www.nytimes.com/1982/05/30/nyregion/care-of-poor-is-cut-by-private-hospitals.html?pagewanted=all> [<https://perma.cc/S4P3-THE>]; Kenan Heise, *'Dumping' The Poor at County Hospital Angers Staff*, CHI. TRIB., Sept. 3, 1982 at B3; Margaret Engel, *Hospitals Refusing to Admit Poor*, WASH. POST (Oct. 15, 1984), https://www.washingtonpost.com/archive/local/1984/10/15/hospitals-refusing-to-admit-poor/c288388f-6c72-4948-9615-8b8696db22df/?utm_term=.65a6b7f2c74d [<http://perma.cc/T9HA-379F>]; Daniel S. Greenberg, *Health-Care Thrift Spurs Patient-Dumping*, L.A. TIMES, Nov. 12, 1984, at 5.

51. George J. Annas, *Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards*, 76 AM. J. PUB. HEALTH 74 (1986).

52. *Stillbirth Traced to 'Dumping'*, CHI. TRIB. (Dec. 19, 1985), http://articles.chicagotribune.com/1985-12-19/news/8503280238_1_stillbirth-obstetrician-two-private-hospitals [<https://perma.cc/DJ5T-4WTX>].

53. *Savannah Burn Victim Dies; Hospitals Barred Admission*, N.Y. TIMES (May 26, 1982), <http://www.nytimes.com/1982/05/26/us/savannah-burn-victim-dies-hospitals-barred-admission.html> [<https://perma.cc/QR9G-QN25>].

54. 42 U.S.C. § 1395dd (2016).

55. *Id.*

56. James A. Gordon, *The Hospital Emergency Department as a Social Welfare Institution*, 33 ANNALS EMERGENCY MED. 321, 324 (1999).

57. See WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 211 (2009) ("EMTALA's greatest shortcoming is that it places the ultimate safety net in the emergency room but fails to fund the care it mandates.").

it prevented private hospitals from dumping patients, but it also created incentives for private hospitals to opt out of the emergency business.⁵⁸ Private hospitals simply pulled out of local trauma networks or closed their emergency rooms in Los Angeles and across the country.⁵⁹ For example, between 1985 and 1990, more than a third of hospitals in Los Angeles County's twenty-two-hospital trauma network withdrew from participation.⁶⁰ This attrition impacted four of the county hospitals in L.A. (including KDMC).⁶¹ These four hospitals provided 55.5 percent of the uncompensated emergency care shortly after the federal government passed EMTALA, whereas fifty-one hospitals split the remaining forty-five percent of uncompensated costs.⁶² Dr. Brian Johnson, emergency director at the downtown-based White Memorial Hospital complained about this attrition: "People will literally die in the streets and in their offices . . . you'd be better off having a heart attack in Mexico City than in Los Angeles."⁶³

Increased statutory requirements on emergency care came at a time where cities—Los Angeles included—encountered an unprecedented mix of social maladies. The emergence of crack cocaine, the increase in gun violence, and the spread of new and old diseases all brought more people through emergency room doors with a federal right to emergency care behind them.⁶⁴ Dr. Xylina Bean served as an Associate Professor of Pediatrics as well as the Director of Intermediate Care Nursery and Infant

58. See Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389, 394 (1988) ("[H]ospital concern over liability exposure through emergency room treatment has resulted in a disturbing outbreak of emergency room closings in some parts of the country.")

59. Again, some of these trends precede EMTALA. See CAL. STATE AUDITOR, REPORT 2013-116, LOS ANGELES COUNTY: LACKING A COMPREHENSIVE ASSESSMENT OF ITS TRAUMA SYSTEM, IT CANNOT DEMONSTRATE THAT IT HAS USED MEASURE B FUNDS TO ADDRESS THE MOST PRESSING TRAUMA NEEDS 9 (2014).

60. *Id.*

61. Glenn A. Melnick et al., *Uncompensated Emergency Care in Hospital Markets in Los Angeles County*, 79 AM. J. PUB. HEALTH 514, 515 (1989).

62. *Id.*

63. Robert Reinhold, *Crisis in Emergency Rooms: More Symptoms than Cures*, N.Y. TIMES (July 28, 1988), <http://www.nytimes.com/1988/07/28/us/crisis-in-emergency-rooms-more-symptoms-than-cures.html?pagewanted=all> [https://perma.cc/C7CF-54RH].

64. Ellie E. Schoenbaum et al., *HIV Antibody in Persons Screened for Syphilis: Prevalence in a New York City Emergency Room and Primary Care Clinics*, 17 SEXUALLY TRANSMITTED DISEASES 190 (1990); James D. Colliver & Andrea N. Kopstein, *Trends in Cocaine Abuse Reflected in Emergency Room Episodes Reported to DAWN*, 106 PUB. HEALTH REP. 59, 61–63 (1991); H. Range Hutson et al., *Injuries and Deaths from Gang Violence: They Are Preventable*, 21 ANNALS EMERGENCY MED. 1234 (1992); Yih-Ing Hser et al., *Drug Use and Correlates Among Sexually Transmitted Disease Patients, Emergency Room Patients, and Arrestees*, 28 J. DRUG ISSUES 437 (1998); Robert M. Brackbill & Maya R. Sternberg, *Where Do People Go for Treatment of Sexually Transmitted Diseases?*, 31 FAM. PLAN. PERSP. 10, 11 (1999).

Follow-Up Programs at KDMC.⁶⁵ In 1988, she testified in front of Congress about the health problems facing young mothers at the hospital, how drug use is related to lack of prenatal care, and the scarcity of outpatient drug programs in Los Angeles for women who would want to remain drug free.⁶⁶ By 1991, she noted that KDMC saw the largest number of substance-abusing women in Los Angeles County and claimed that infants who did not receive prenatal care could cost KDMC anywhere from \$30,000 to \$1 million.⁶⁷

Gun violence, which was also not unique to Los Angeles but certainly pronounced, compounded the problem. Gang-related homicide rates for black males between the ages of fifteen and nineteen *tripled* in a decade in Los Angeles.⁶⁸ Between 1979 and 1981 the homicide rate was approximately sixty per 100,000 people.⁶⁹ Between 1989 and 1991 this number was 192.41 per 100,000.⁷⁰ Much of this violence occurred in KDMC's catchment area, which birthed the Bloods and Crips street gangs.⁷¹

Finally, the reemergence of syphilis and the proliferation of HIV/AIDS hampered public hospital emergency rooms. The syphilis rate per 100,000 increased across the country from 10.5 in 1985 to 14.7 in 1987; in South Central Los Angeles, this rate increased from eighty two in 1985 to an astounding 402.⁷² A 1994 study conducted jointly by doctors from the Centers for Disease Control and Prevention, the Los Angeles County Department of Health Sciences, and King/Drew doctors empirically demonstrated what many suspected: the hospital served a population at greater risk for HIV-1 infection.⁷³ This amalgam of problems did not bode well for KDMC and public hospitals as they hobbled into the 1990s; it was during this time period the hospital developed the undesirable nickname "Killer King Hospital."⁷⁴

65. Xylina Bean, *Meeting the Health Care Needs of Underserved Children*, 2 J. HEALTH CARE POOR & UNDERSERVED 147 (1991).

66. *Id.*

67. *Id.* at 155.

68. H. Range Hutson et al., *The Epidemic of Gang-Related Homicides in Los Angeles County from 1979 Through 1994*, 274 J. AM. MED. ASS'N 1031, 1034 (1995).

69. *Id.*

70. *Id.*

71. See Alex Alonso, *Out of the Void: Street Gangs in Black Los Angeles*, in BLACK LOS ANGELES: AMERICAN DREAMS AND RACIAL REALITIES, *supra* note 12, at 140–67.

72. Janny Scott, *Fund Cuts Cited in Outbreak of Syphilis Cases*, L.A. TIMES (May 8, 1988), http://articles.latimes.com/1988-05-08/news/mn-3815_1_infectious-syphilis-cases [<https://perma.cc/DEY9-SWVX>].

73. Tippavan Nagachinta et al., *HIV-1 Seroprevalence in an Inner-City Public Hospital*, 86 J. NAT'L MED. ASS'N 358, 359–60 (1994).

74. Hunt & Ramón, *supra*, note 12.

In the last decade of the twentieth century, the continued growth of health care costs, concurrent prioritization of market-logics, and bubbling anti-welfare sentiments put public hospitals on more fragile ground. These institutions' inability to deal with health-related social problems—partly because these issues required more than medical remedies and partly because of financial incapability—only added to many people's reservation about public health largesse. In Los Angeles, a dizzying array of proposed lay-offs, budget cuts, reductions in services, and potential closings of hospitals and clinics created an environment that was so dire that President Clinton personally visited Los Angeles in 1995 to announce a \$364 million infusion into County coffers.⁷⁵ During this time period, which was shortly after Clinton's failed attempt at national health insurance but still in the throes of welfare reform, journalists and the medical community wrestled specifically with role of the public hospital within the country's safety-net system.⁷⁶

In the meantime, mainstream media coverage of medical errors and malfeasance at KDMC weakened public support for the institution for the next decade. In 1995, a woman who came in for routine hysterectomy received HIV-positive blood and contracted the virus.⁷⁷ That same year, a psychiatrist pled guilty to grand theft of Medi-Cal funds.⁷⁸ In 1997, the hospital faced accusations of employment discrimination against Latinos

75. Seth Mydans, *With \$1 Billion Deficit, Los Angeles County Begins Facing Painful Cuts*, N.Y. TIMES (June 22, 1995), <http://www.nytimes.com/1995/06/22/us/with-1-billion-deficit-los-angeles-county-begins-facing-painful-cuts.html> [https://perma.cc/S7JB-WQCC]; Josh Meyer & Jeffrey Rabin, *County Official Warns of 5,000 Health Layoffs*, L.A. TIMES (Aug. 30 1995), http://articles.latimes.com/1995-08-30/local/me-40345_1_county-health [https://perma.cc/2FJW-FWJ6]; James Sterngold, *Budget Slashes Could Close Hospital*, N.Y. TIMES (July 17, 1995), <http://www.nytimes.com/1995/07/17/us/budget-slashes-could-close-hospital.html> [https://perma.cc/9KJP-QYK3]; Jeffrey L. Rabin, *New Layoffs Approved at 3 County Hospitals*, L.A. TIMES (Sept. 11, 1996), http://articles.latimes.com/1996-09-11/news/mn-42579_1_county-health-system [https://perma.cc/XRR8-MFWM]; B. Drummond Ayres, Jr., *Clinton Acts to Save Los Angeles Clinics*, N.Y. TIMES (Sept. 23, 1995), <http://www.nytimes.com/1995/09/23/us/clinton-acts-to-save-los-angeles-clinics.html> [https://perma.cc/4EEV-MA4V]; Josh Meyer & Jeffrey Rabin, *Layoffs in Health Dept. Postponed*, L.A. TIMES (Sept. 27, 1995), http://articles.latimes.com/1995-09-27/news/mn-50543_1_county-health [https://perma.cc/RW88-9NER]; John Wildermuth, *L.A. Has Played Budget Magic Since Prop. 13*, S.F. CHRON. (Oct. 13, 1995), <http://www.sfgate.com/news/article/L-A-Has-Played-Budget-Magic-Since-Prop-13-3022017.php> [https://perma.cc/Z6QB-HRZR].

76. Wildermuth, *supra* note 75.

77. Josh Meyer, *Blood Bank Setup Faulted In HIV-Tainted Transfusion: Health: County, Federal Reports Cited Serious Problems at King/Drew. Patient Was Infected Last Year.*, L.A. TIMES (Dec. 19, 1995), http://articles.latimes.com/1995-12-19/news/mn-15647_1_blood-bank [https://perma.cc/TB5X-D3SN].

78. Josh Meyer, *Doctor on County Payroll Despite Fraud Conviction: Health: King/Drew Psychiatrist Pleaded Guilty in August. He Was Placed on Leave Wednesday*, L.A. TIMES (Nov. 30, 1995), http://articles.latimes.com/1995-11-30/news/mn-8792_1_county-payroll [https://perma.cc/X9EW-X6QL].

and Asians.⁷⁹ Los Angeles County also found that unapproved moonlighting (i.e., having a secondary job) was a problem throughout the County's hospitals, but governmental and media scrutiny fell specifically upon a KDMC.⁸⁰ In 1998, a woman died after drinking a poisonous chemical mixture that was accidentally left near her nightstand.⁸¹ In 1999, the hospital was back in the spotlight after the California Supreme Court reduced the damages award given to a mother whose eighteen-month-old daughter died after KDMC failed to properly stabilize her pursuant to EMTALA.⁸² The early years of the twenty-first century were rife with revocations of various accreditations at the institution; by 2004, the *Los Angeles Times* dialed up the scrutiny and produced a Pulitzer Prize-winning series that further highlighted medical errors, mismanagement, and the rocky politics surrounding the institution.⁸³ By 2007, after years of federal probes and being placed on what amounted to institutional probation, King/Drew closed as a general acute care hospital and downsized into an outpatient services outfit.⁸⁴

B. Hospital Closings as Dignity Takings

With this brief history laid out, the next step is to consider whether the closing of this hospital constitutes a taking or a dignity taking. Atuahene defines the broader categories of takings as a circumstance “when a person, entity, or state confiscates, destroys, or *diminishes* rights to property without the informed consent of rights holders.”⁸⁵ Subsequently, she describes *dignity takings* as an instance when “the state directly or indirectly *destroys property or confiscates* various property rights from owners or occupiers and the intentional or unintentional outcome is *dehumanization* or *infantilization*.”⁸⁶ There are some obvious and more subtle differences between

79. Josh Meyer & Jeffrey L. Rabin, *Health Director Confronts Racial Disparity*, L.A. TIMES (Feb. 18, 1996), http://articles.latimes.com/1996-02-18/local/me-37361_1_top-health-department [<https://perma.cc/9YSD-TSAK>].

80. Josh Meyer, *Moonlighting by County Doctors Found Systemwide*, L.A. TIMES (Aug. 12, 1997), <http://articles.latimes.com/1997/aug/12/news/mn-21787> [<https://perma.cc/J9VZ-F7ZT>].

81. Josh Meyer, *Patient Killed by Poison, Tests Find*, L.A. TIMES (March 5, 1998), <http://articles.latimes.com/1998/mar/05/local/me-25653> [<https://perma.cc/2UWH-MPTS>].

82. *Barris v. County of Los Angeles*, 972 P.2d 966 (Cal. 1999); Harriet Chiang, *High Court OKs Reduced Malpractice Sum in Girl's Death / State's \$250,000 Limit Applies in Suit over Hospital 'Dumping'*, S.F. CHRON., Mar. 26, 1999, <http://www.sfgate.com/health/article/High-Court-OKs-Reduced-Malpractice-Sum-in-Girl-s-2939780.php> [<https://perma.cc/LEM8-635D>].

83. *The Troubles at King/Drew*, *supra* note 10.

84. Jennifer Steinhauer & Regan Morris, *Los Angeles Hospital to Close After Failing Tests and Losing Financing*, N.Y. TIMES (Aug. 11, 2007), <http://www.nytimes.com/2007/08/11/us/11hospital.html> [<http://perma.cc/V96K-55LX>].

85. Bernadette Atuahene, *Takings as a Sociolegal Concept: An Interdisciplinary Examination of Involuntary Property Loss*, 12 ANN. REV. L. & SOC. SCI. 171 (2016) (emphasis added).

86. *Id.* at 178 (emphasis added).

these two categories that are at the center of this subsection. First, dignity takings focus on the state (although not exclusively), whereas broader takings also entail persons and entities. Second, Atuahene's contribution is concerned primarily with destruction and confiscation, whereas takings include those actions and diminution. Third, and most substantively, dignity takings are pronouncedly different because they emphasize the role of dehumanization and infantilization that accompany state action or inaction.

1. The Role of the State and Other Private Entities

The first question that the concept of dignity takings invites is: why is there an exclusive focus on state action or inaction? The easy answer might be because of the state's power to affect its proprietary interests. Moreover, Atuahene's ground-up analysis produced the concept, which could not be unmoored from the South African state's undoubtedly outsized role in its vicious apartheid regime. The KDMC story suggests that there may be room for considering the role of private entities, such as the media, when analyzing a dignity taking.

The *Los Angeles Times* was an integral player in KDMC's closing; the hospital's failures certainly did it no favors but the *Times*'s award-winning, blunt journalism brought new kinds of regulatory scrutiny to the hospital.⁸⁷ African Americans' uneasy relationship with the mass media and the *Los Angeles Times* specifically, is noteworthy.⁸⁸ Beginning in the 1990s, and continuing into the next decade, black Los Angelinos criticized the *Times* for the perceived heightened attention that the paper gave the hospital.⁸⁹ In 1996, the newspaper itself recognized that individuals considered its commentary unduly.⁹⁰ Dr. Reed V. Tuckson, who served as president of KDMC's academic arm believed that "the coverage was unfair. Why . . . doesn't anyone investigate the other county hospitals?"⁹¹ He add-

87. *The Troubles at King/Drew*, *supra* note 10; see also Letter from Steven Chickering, W. Consortium Survey & Certification Officer, Ctrs. for Medicare & Medicaid Svcs., to Antoinette Smith Epps, Hospital Administrator, Martin Luther King, Jr./Charles R. Drew Medical Ctr. (Sept. 22, 2006), http://lahealthaction.org/library/CMS_Termination_Letter_For_KDMC.pdf [<https://perma.cc/QA6X-ZNXA>].

88. See generally Adeno Addis, "Hell Man, They Did Invent Us:" *The Mass Media, Law, and African Americans*, 41 BUFF. L. REV. 523 (1993); Regina Austin, *Beyond Black Demons & White Devils: Anti-Black Conspiracy Theorizing & the Black Public Sphere*, 22 FLA. ST. U. L. REV. 1021 (1995); PAMELA NEWKIRK, *WITHIN THE VEIL: BLACK JOURNALISTS, WHITE MEDIA* (2000).

89. Bill Boyarsky, *Far More Than Just a Hospital*, L.A. TIMES (Feb. 18, 1996), http://articles.latimes.com/1996-02-18/local/me-37363_1_general-hospital [<https://perma.cc/HJE5-WJVJ>].

90. *Id.*

91. *Id.*

ed, “we get hammered unmercifully.”⁹² In a rare letter to the editor that was a break from the laudation the *Times* received for its coverage of the hospital, one person wrote: “In your unrelenting attack on King/Drew Medical Center, you fail to address several issues. For example, how many lives have been saved, and lifetime disabilities prevented, by the existence of King/Drew? What of the overwhelming majority of employees who struggle daily to help improve the health of their community?”⁹³

Demonstrations and meetings orchestrated by leaders such as Jesse Jackson, Maxine Waters, Martin Luther King Jr.’s oldest daughter Yolanda King, actress Angela Bassett, and several politicians who represented KDMC’s catchment area show that there was extreme skepticism about the paper’s motives.⁹⁴ For example, several hospital administrators and local politicians representing South Los Angeles wrote to the *Times* and stated: “[T]here needs to be a fair and balanced response to an obviously biased series of ‘supermarket tabloid’ type articles recently published by the *Los Angeles Times* We would be the first to admit that there have been problems at this facility by certain individuals, but we are still waiting for the *Times* to mention the excellent work done by the more than 2400 employees, who strive extremely hard every day to care for very sick and traumatized patients.”⁹⁵

Ultimately, the media plays a powerful role in agenda-setting and government accountability. In a public opinion climate that has long been allergic to government altruism toward poor minorities, the media’s framing of a social welfare institution’s inefficacy is likely to make clarion calls for shuttering more audible. As one political scientist has observed:

[W]hen powerful mass media focus on a certain problem, for instance, politicians may consider themselves forces to institute public remedies of some sort, even when there are no tested or even known solutions of the problem at hand. The result is a tendency to throw intractable social problems at bureaucrats who become scapegoats when the problems are not solved.⁹⁶

92. *Id.*

93. Norman Palley, Letter to the Editor, *The Examination of King/Drew*, L.A. TIMES (Dec. 7, 2004), <http://articles.latimes.com/2004/dec/07/opinion/le-king7.1> [<https://perma.cc/Q6MK-RWPD>].

94. Charlene Muhammad, *Thousands Protest: Hands off King/Drew Trauma Unit!*, FINAL CALL (Dec. 2, 2004, 8:59 PM), http://www.finalcall.com/artman/publish/National_News_2/Thousands_protest_Hands_off_King_Drew_Trauma_Unit_1653.shtml [<https://perma.cc/HA2R-77S3>].

95. Eugene Hardin et al., Letter to the Editor, *RE: Recent Coverage of the King-Drew Medical Center*, L.A. TIMES, www.latimes.com/la-kingdrew-letters03-story.html [<http://perma.cc/49AV-FPUG>].

96. BO ROTHSTEIN, JUST INSTITUTIONS MATTER: THE MORAL AND POLITICAL LOGIC OF THE UNIVERSAL WELFARE STATE 74 (1998).

Similar observations have been made about journalists' mediating role in public school closings.⁹⁷ This pattern suggests that examinations of public bureaucracy closings or dignity takings might benefit from thinking about how media and other third-party intermediaries help expedite such events. Awareness of this relationship is especially salient as privatization and elimination become increasingly popular strategies in the area of public service provision, and as new and social media gain more persuasive power.

2. State Action?: Diminishment vs. Destruction and Confiscation

The next point in Atuahene's definition of dignity takings that is worth briefly highlighting is the role of state (in)action vis-à-vis the confiscation or destruction of property. Missing from this construction of dignity takings but present in Atuahene's general definition of takings is the verb "diminish." This inclusion raises difficult questions about funding and downsizing. First, *are rights to a hospital—or other social welfare institutions that are ultimately shuttered—diminished when the state does not adequately support it?* This is an analytically related but distinct question that should be addressed before determining whether the actual closing constitutes a dignity taking. Reasonable minds may disagree and come to different conclusions.

On one hand, being underfunded, understaffed, and under-resourced can lead any bureaucracy to underperform; these were constant complaints made by KDMC administrators over the years.⁹⁸ At the same time, such grievances can easily erode accountability through ineptitude and inefficiency. No doubt, KDMC faced some drastic circumstances: it served some of the sickest, poorest, and most uninsured patients in the County and in an area that was notorious for gang violence. What might be adequate for the average safety-net hospital (if there is one) may not have sufficed for

97. LOIS WEINER, *THE FUTURE OF OUR SCHOOLS: TEACHERS UNIONS AND SOCIAL JUSTICE* 39 (2012) (describing how campaigns protesting school closures in Los Angeles, Chicago, and Rochester use social media to counter the news in the corporate media, which seldom explains the harm done in school closings); Alexandra Allweiss et al., *Behind the Photos and the Tears: Media Images, Neoliberal Discourses, Racialized Constructions of Space and School Closings in Chicago*, 18 *RACE ETHNICITY & EDUC.* 611 (2015) ("Through a myriad of visual imagery and discourses that present students in urban spaces as violent, fearful, and out-of-control, neo-liberal education and media discourses facilitate a framework in which many people believe 'the closing of schools is a reform strategy' In Chicago, 'saving solutions' have been framed through neoliberal school reforms that have led to the closing of public schools predominantly in poor communities of color throughout the city that have been labeled as 'failing.'").

98. *But see* Opinion, *Perilous Chairs*, *L.A. TIMES* (Dec. 7, 2004), <http://articles.latimes.com/2004/dec/07/opinion/ed-kingdrew7> [<https://perma.cc/B9PE-GSTV>] (challenging the idea that KDMC was underfunded).



KDMC. But resource constraints do not explain the full picture. The comments of Danny J. Bakewell Jr., publisher of the African-American-owned newspaper *Los Angeles Sentinel*, are useful here. After the highly-publicized 2007 death of Edith Rodriguez, a woman who writhed in pain on KDMC's emergency room floor while a janitor mopped around her, Bakewell maintained:

We can debate all you want why the conditions at the hospital are not right . . . [B]asic services and human kindness are not do [sic] to budget cuts, they are do [sic] to a lack of compassion . . . When a person lays on the ground vomiting up blood and we clean up the blood but ignore the person. When we watch a person agonize in pain and just ignore them and assume they are faking, we really do have a problem.⁹⁹

Thus, an important issue that Atuahene's distinction between takings and dignity takings leaves open is: how does a lack of state support for social welfare institutions such as hospitals relate to takings? If the state's lack of funding to such institutions precipitates a closing, does the closing fall within the bounds of a *dignity taking*? A glance at Professor Atuahene's description of the term might suggest so, and I think her concept is roomy enough to accommodate such resource deprivation. Alternatively, if the underfunding narrative is unconvincing, a relevant inquiry remains: what is the relationship between closings and takings?

There is also the issue of form that may seem persnickety on its face, but is actually quite substantive: where does the *downsizing* of a public institution fall within the takings and dignity takings spectrum? This consideration is relevant because KDMC *as a whole* did not close. The school—Charles R. Drew University of Medicine and Science—separated from the hospital; the latter ceased offering inpatient services and shuttered its trauma center—its crown jewel. The hospital effectively downsized into a clinic that offered outpatient services.¹⁰⁰ This cutting of services is just one permutation of hospital downsizing; others include reduction of beds, staff outsourcing, and “rightsizing.”¹⁰¹ These various forms of hospital reorganization may eliminate access to certain kinds of services, reduce rates of admission, and render original core services non-existent. Downsizing is also a phenomenon in other sectors of the welfare state, such as

99. Danny J. Bakewell, Jr., Editorial, *King Drew Medical Center*, L.A. SENTINEL (June 21, 2007), <https://lasentinel.net/king-drew-medical-center.html> [<https://perma.cc/3VTC-5GRN>].

100. Robert Greene, Opinion, *A Fresh Start for South L.A. Healthcare*, L.A. TIMES (Dec. 18, 2009), <http://articles.latimes.com/2009/dec/18/opinion/la-oc-greene18-2009dec18> [<https://perma.cc/NJ67-VQFR>].

101. Yalda Mousazadeh et al., *Advantages and Disadvantages of Different Methods of Hospitals' Downsizing: A Narrative Systematic Review*, 3 HEALTH PROMOTION PERSP. 276, 277 (2013).

public education and public housing.¹⁰² These kinds of modifications can be animated by sincere concerns about cost and efficiency, but they also raise the specter of indifference that has been a theme in American medical history and is relevant to Atuahene's conceptualization of dehumanization.

3. The Texture of Dehumanization and Infantilization

Accordingly, there are the remaining categories of dehumanization and infantilization, which are the consequences of a dignity taking. Atuahene defines dehumanization as the "failure to recognize an individual's or group's humanity."¹⁰³ A few points become vital here, particularly the role of funding. Does the state's inadequate provision of resources for one community, particularly health services, constitute such dehumanization? Post-structuralist understandings of the state's power over human life and death might offer an affirmative response.¹⁰⁴ Sincere preferences for small government could offer a different answer, though. This then raises questions about whether dehumanization is something that can be descriptively and exclusively offered only by the individuals who suffer the dignity taking? One example might be a community of people in catchment area who feel perceived indifference to their lives because of inadequate governmental support to their local safety-net hospital. Alternatively, is dehumanization something that is analytically teased out by scholars (e.g., comparisons of funding for different kinds of hospitals or examinations of governmental rationales for disparate funding of hospitals)?

Beyond questions about state funding, there is also an inquiry about the role of the bureaucrat in dehumanization and the devaluation of life. In the case of KDMC, there was an alleged indifference to some patients' lives by the staff that predated the actual dignity taking. This indifference manifested itself in medical errors and unnecessary fatalities. An analog in

102. Lisa Snell David & David Tokofsky, Opinion, *Downsizing LAUSD*, L.A. TIMES (Feb. 15, 2008), www.latimes.com/la-op-dustup15feb15-story.html; Edward G. Goetz, *Where Have All the Towers Gone? The Dismantling of Public Housing in U.S. Cities*, 33 J. URBAN AFF. 267 (2011); JOHN ARENA, *DRIVEN FROM NEW ORLEANS: HOW NONPROFITS BETRAY PUBLIC HOUSING AND PROMOTE PRIVATIZATION* (2012); Maria Hantzopoulos & Alia R. Tyler-Mullings, *Introduction* to CRITICAL SMALL SCHOOLS: BEYOND PRIVATIZATION IN NEW YORK CITY URBAN EDUCATIONAL REFORM, at xxix (Maria Hantzopoulos & Alia R. Tyler-Mullings eds., 2012); Jaime A. Lee, *Rights at Risk in Privatized Public Housing*, 50 TULSA L. REV. 759, 760 (2014); Mireya Navarro, *New York City Housing Dept. Eases Rule Forcing Low-Income Tenants to Downsize*, N.Y. TIMES, Dec. 4, 2014 www.nytimes.com/2014/12/05/nyregion/new-york-city-housing-dept-eases-rule-forcing-low-income-tenants-to-downsize.html [<http://perma.cc/K4AR-CBU6>].

103. ATUAHENE, *supra* note 1, at 31.

104. See Achille Mbembe, *Necropolitics*, 15 PUB. CULTURE 11, 12 (2003) (arguing that "the ultimate expression of sovereignty resides, to a large degree, in the power and the capacity to dictate who may live and who must die").

another social welfare institution might be the negligent manager of public housing who lets buildings fall into disrepair. Such indolence might be the byproduct of resource constraints, occupational burnout, or actual disinterest. For Atuahene, intent may be irrelevant because she describes dignity takings as something that can be intentional or unintentional.¹⁰⁵ Again, this is one of the strengths of the definition; it is capacious enough to examine different kinds of bureaucratic neglect that might predate or lead to a dignity taking. The task for the scholar using this framework to analyze the closing of social welfare institutions is to delineate clearly and connect the kinds of dehumanization that might be part of the *process* of a dignity taking.

Infantilization, which she describes as the “restriction of an individual’s or group’s autonomy based on the failure to recognize and respect their full capacity to reason,”¹⁰⁶ is less applicable as it relates to the individuals within KDMC’s catchment area. A more persuasive argument could be made about the infantilization of the KDMC’s minority administrators, whom the media, the public, and local government understood as incapable leaders.¹⁰⁷ Such suspicion about these minority bureaucrats’ capability maps on to racialized criticisms about public administration generally, but without knowing whether these administrators lived in KDMC’s catchment area (which was a controversy for the leading public official representing the area),¹⁰⁸ it is difficult to tether such infantilization to the loss of the hospital. Moving forward, one could ask how social welfare bureaucrats, who are the same in-group as individuals who have suffered the dignity harm (because of race or residence), are associated with infantilization. Minorities’ representation in public administration, the identity anxieties that they face in such work, and increased challenges to the size of the welfare state make such an inquiry timely.¹⁰⁹

105. Atuahene, *supra* note 85.

106. ATUAHENE, *supra* note 1, at 32.

107. See generally Mandalit del Barco, *Los Angeles Waits to Learn Fate of King Drew Hospital*, NPR, (Aug. 16, 2006 6:00 AM), <http://www.npr.org/templates/story/story.php?storyId=5649811> [<https://perma.cc/VRM4-SXQE>].

108. Jack Leonard & Matt Lait, *Supervisor’s Residence Outside District Raises Legal Questions*, L.A. TIMES (July 27, 2007), <http://articles.latimes.com/2007/jul/27/local/me-burke27> [<https://perma.cc/45HV-WSTF>].

109. See generally CELESTE WATKINS-HAYES, *THE NEW WELFARE BUREAUCRATS: ENTANGLEMENTS OF RACE, CLASS, AND POLICY REFORM* (2009);

IV. MLK COMMUNITY HOSPITAL AND DIGNITY RESTORATION

Professor Atuahene argues that when there has been a dignity taking, the remedy must move from mere reparations (compensation for material things confiscated) to dignity restoration, which is a remedy that seeks to provide dispossessed individuals and communities with material compensation through processes that affirm their humanity and reinforce their agency.¹¹⁰ Again, my concern is not about the fit of this concept in the context of KDMC; instead, I'm more interested in what this concept can offer public hospital closings and vice versa.

In 2015, eight years after the government shuttered large swaths of KDMC's operations, it reopened as Martin Luther King, Jr. Community Hospital ("MLKCH").¹¹¹ The reopening itself was a feat because many hospitals end up permanently closed. But KDMC's symbolism, the demonstrated gap in services that its downsizing created, and the work of committed politicians helped resurrect the new institution.¹¹² Community members were certainly involved in the process but the substantive nature of that process is unclear. As the hospital's website notes:

Mark Ridley-Thomas [the County Supervisor for the district where MLKCH is located] held a series of community meetings in South Los Angeles in 2011 to discuss the master plan for the area, which includes the new hospital. Hundreds of residents, civic leaders, business owners and health care advocates attended the meetings, asked questions and provided input about the planned developments. The hospital will continue to conduct periodic community health needs assessments to carry on this process.¹¹³

Ridley-Thomas' office and the County publicized an English and Spanish advertisement that informed the public: "We need your ideas and insights regarding the future of the MLK, Jr. Medical Campus Master Plan, its relationship to the surrounding neighborhood, and how it can play a role in your community's overall health and wellness."¹¹⁴

110. Bernadette Atuahene, *Dignity Takings and Dignity Restoration: Creating A New Theoretical Framework for Understanding Involuntary Property Loss and the Remedies Required*, 41 LAW & SOC. INQUIRY 796 (2016)

111. Karlamangla, *supra* note 11.

112. *About Us*, MARTIN LUTHER KING JR. CMTY. HOSP., <http://www.mlkcommunityhospital.org/About-Us/Our-Story.aspx> [<https://perma.cc/79PW-6FCM>].

113. *Id.*

114. Mark Ridley-Thomas, *Supervisor Mark Ridley-Thomas Invites You to Help Discuss the Future of the MLK Jr. Medical Campus*, LA HEALTH ACTION, http://www.lahealthaction.org/library/MLK_mtg01_flyer%5B1%5D.pdf [<https://perma.cc/4GVR-LNRS>].

Notably, the new institution is smaller and does not have a trauma center. MLKCH is clear about both, and it states: “A trauma center provides medical services to patients who have injuries resulting from massive blunt trauma such as an automobile accident, gunshot wound or train or airplane crash. MLKCH does not have a trauma center.”¹¹⁵ Instead, it notes that its emergency room “treats serious, life-threatening conditions that do not result from traumatic injuries”¹¹⁶ such as stroke, loss of consciousness, chest pain, or heart attack. This was and still is a point of contention for community members in South Los Angeles who believed that such a center was absolutely necessary in that area.¹¹⁷ Accordingly, this invites an inquiry that may be unique to the closings and re-openings of public hospitals and other social welfare institutions. Assuming that there is community input that recognizes residents’ humanity but it is not fully implemented for legitimate reasons (e.g., costs constraints) is dignity restoration thwarted? Is the reopening of the institution enough?

There is also a demographic point worthy of discussion. Private property that is tethered to a person or family is different than something like a public hospital. Considering the vast demographic changes in cities, where African Americans are slowly out-migrating,¹¹⁸ how can their dignity be restored after the closing and reopening of a public hospital if they have moved or been pushed out? Or, is it simply a matter of providing newcomers with the same kind of property rights as former residents? This point is especially relevant in South Los Angeles, which is still relatively impoverished, but now consists primarily of Latinos.¹¹⁹

Finally, there is an issue of form that coincides with the earlier section’s discussion on diminishment. MLKCH transformed from a county-owned safety-net hospital to a private hospital governed by a non-profit (Martin Luther King, Jr. Los Angeles Healthcare Corporation). The privatization of hospitals, public schools, and public housing are facts of life and occur via traditional understandings (e.g., public to for-profit) as well

115. *Emergency Care*, MARTIN LUTHER KING JR. CMTY. HOSP., <http://www.mlkcommunityhospital.org/Our-Services/Emergency-Care.aspx> [https://perma.cc/GJ2F-F8KP].

116. *Id.*

117. Kalyn Norwood, *Community Reacts to New South L.A. Hospital with No Trauma Center*, NEON TOMMY (May 30, 2014, 1:05 PM), www.neontommy.com/news/2014/05/community-reacts-new-south-l.a.-hospital-no-trauma-center [https://perma.cc/GEN6-94TC].

118. WILLIAM H. FREY, BROOKINGS INST., *THE NEW GREAT MIGRATION: BLACK AMERICANS’ RETURN TO THE SOUTH, 1965–2000* (2004), https://www.brookings.edu/wp-content/uploads/2016/06/20040524_Frey.pdf [https://perma.cc/Z26C-NJDC].

119. See Dennis Romero, *Watts Riots 50th Anniversary: Latinos are 70 Percent of Watts, with No Power*, L.A. WEEKLY (Aug. 3, 2015, 6:30 AM), www.laweekly.com/news/watts-riots-50th-anniversary-latinos-are-70-percent-of-watts-with-no-power-5865339 [https://perma.cc/EQ2V-4A2B].

through subtler changes (e.g., public to non-profit). Tax-exemptions and various additions to the Affordable Care Act make non-profit hospitals accountable to the public, but non-profit hospitals are qualitatively different from safety-net hospitals in ways that could impact poor people's health. An analysis of dignity restorations in the context of privatized public services would benefit from examining this increasing shift from public to private and its implications on marginalized groups' understanding of the state's responsibilities to the public.

Ultimately, the rapidly changing composition of cities, along with the natural ebb and flow of the health care safety-net make the phenomena of public hospital closings an important policy concern for people in poverty and racial minorities. The same applies to parts of the welfare state that have been transforming in the last few decades. Professor Atuahene's conceptual model offers new ways of thinking about these problems; at the same time, these phenomena complement her model in ways that might make it portable for other points in time, institutions, and communities.