Health Care, Title VI, and Racism's New Normal

Dayna Bowen Matthew

University of Colorado Law School

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ARTICLE

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DAYNA BOWEN MATTHEW*

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* Professor of Law, University of Colorado Law School; J.D., University of Virginia Law School; A.B. Harvard-Radcliffe College. My thanks to Professors Fred Bloom, Hal Bruff, Kristen Carpenter, Helen Norton, Nestor Davidson, Aya Gruber, Eric Gerding, Chris Guzelian, and Angela Onwuachi-Willig for comments on earlier drafts. Special thanks to Professors Irene Blair, Richard Jessor, and Jeff Luftig for sharing your immense wisdom and experience as social scientists. I thank Zachary Ahmed, Jon Hoisted, Michelle Brown, and Alex White, as well as Jillian Mariani, for excellent research and administrative assistance. Errors that remain are my own. © 2014, Dayna Bowen Matthew.
Title VI closes the gap between our purposes as a democracy and our prejudices as individuals. The cuts of prejudice need healing. The costs of prejudice need understanding. Title VI offers a place for the meeting of our minds as to federal money. It can recognize no prejudice. It affords a place for the meeting of our hearts, as prejudice must yield to our common purposes, our common progress and the common perfection of these United States.

Senator John O. Pastore
March 3, 1964

INTRODUCTION

An estimated 84,570 minority patients die annually due to health care disparities that result, in no small part, from the unconscious racism that pervades the American health care system. The fact that black and brown patients consistently receive inferior medical treatment than their white counterparts has been documented beyond dispute. These health care disparities persist even after controlling for income, education, geography, socioeconomic status, insurance coverage, and every meaningful comorbidity. Moreover, health care disparities produce disparate health outcomes so that minorities die quicker and sicker in America than whites, solely

3. See generally COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTHCARE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003) [hereinafter Disparities in Healthcare].
5. Id. at 81-82 (Table 20).
because of their race or ethnicity. This Article outlines the considerable progress the scientific community has made in understanding physician bias, and argues that changes to law and policy now must follow.

Studies have confirmed that physicians, like most Americans, generally demonstrate pro-white implicit biases against Latinos and African-Americans. These biases are unintentional and arise unconsciously. However, they have been shown to adversely affect physicians' clinical decision-making to the severe detriment of minority patients. For example, in one study, as physicians' anti-black implicit bias levels increased, their likelihood of prescribing the optimal treatment for coronary artery disease to black patients decreased while the frequency with which they prescribed optimal treatment to whites increased. Another pair of studies examined pediatricians' clinical decision-making and found that physicians with greater pro-white implicit biases more readily prescribed pain medication to white children than to African-American children. Other research has suggested that doctors misinterpret population data in their patient assessments, allowing racial stereotypes to influence their perceptions, leading them to automatically associate diseases arising from behavioral choices—such as drug abuse and obesity—with blacks, while being less prompt in accurately identifying these conditions in white patients. Physician implicit biases have been associated with poorer communication between doctors and their minority patients, as physicians hold shorter clinical encounters with minority patients, make less frequent eye contact, verbally dominate exchanges that allow for few questions or comments from minority patients, and share less information with minority patients than with white patients. Certainly, there is little evidence in case law or elsewhere to suggest that bigotry, overt racism, or explicit prejudice are the primary sources of the racial and ethnic discrimination that occurs in medicine. But the fact that these differences are not due to bigotry is very much beside the most important point. Patients from minority racial and ethnic backgrounds are discriminated against in health care, and the outcome of this discrimination is poorer health and shorter lifespans than whites suffer in almost every category. Therefore, the emerging body of literature that points to the influence of providers' implicit biases to explain the regular patterns of disparate medical treatment cannot be ignored.

I argue in this Article that this empirical evidence of physician bias is not only a likely explanation for the stagnant persistence of inequality in health care, but also contributes substantially to the higher morbidity and mortality rates that minority

6. Irene V. Blair et al., Assessment of Biases Against Latinos and African Americans Among Primary Care Providers and Community Members, 103 AM. J. PUB. HEALTH 92 (2012) [hereinafter Blair et al., Assessment].
8. Id. at 1231.
Americans suffer as compared to whites. Moreover, I argue that the available scientific evidence now compels legal scholars and jurists to examine the role that civil rights law should play in addressing the deadly impact of racial discrimination due to physician bias. This Article confronts unconscious racism as a significant cause of health and health care disparities, and argues that the law and policy should meaningfully account for the resulting harms. Just as the Supreme Court has noted in the employment context, in health care, physicians’ “undisciplined system of subjective [i.e., unintentional] decision-making can have precisely the same effects as a system pervaded by impermissible intentional discrimination.” Civil rights law was intended to provide redress for precisely such injurious discrimination. Thus, numerous legal scholars have argued fervently for the reform of anti-discrimination laws that fail to reflect that unconscious rather than intentional racism has become the new normal. Sadly, legislators and courts have not responded. I challenge lawmakers’ apparent indifference to implicit bias discrimination, and intend to move the somewhat stalled conversation in the legal literature forward, not only by adding health care to the list of environments where implicit biases operate perniciously, but also by adding new scientific findings and new legal solutions to the discourse.

First, I focus specifically on Title VI of the Civil Rights Act of 1964, one of the broadest of the civil rights era statutes, because that law has been almost entirely overlooked in the conversation among scholars about how to address implicit bias discrimination. Title VI has a rich history of being used as an effective tool to eliminate segregation and overt racism in health care and reaches broadly beyond health care to prohibit discrimination by any recipient of federal funds. Next, this Article adds a comprehensive review of the social science literature on malleability: the insight that unconscious prejudices can be altered. I introduce a body of social science literature collected over the past twenty-five years, which shows that unintentional and unconscious biases are neither inevitable nor impenetrable but instead may be intentionally controlled through interventions such as stereotype-negation, exposure to counter-stereotypes, and social norm-shifting in order to reduce the discriminatory effects of implicit biases on physician’s clinical judgments and conduct. I propose that this malleability evidence provides a basis for crafting a legal response to unconscious racism; in light of this evidence, physicians and others may be held to a negligence standard of care in Title VI disparate treatment claims—notwithstanding the Supreme Court’s current fetish with what Professor Ian Haney-
López has called “malicious” rather than “contextual” intent as a requirement to prove and recover for actionable discrimination. Moreover, malleability evidence provides the moral basis for Congress to amend Title VI and restore private enforcement of disparate impact claims.

In 1987, when Charles Lawrence famously identified the false dichotomy between unconstitutional intentional discrimination and constitutionally acceptable unintentional discrimination, cognitive psychologists had barely scratched the surface of the implicit bias field. Today, a massive evidentiary record is available to show how powerfully unintentional bias informs discriminatory judgments and conduct, and relating that science to anti-discrimination law. Linda Krieger began advocating a cognitive bias approach to equal employment opportunity in 1995. Since then, the implicit bias discourse has focused primarily on employment discrimination and the importance of addressing this form of prejudice under Title VII as well as the Equal Protection clause. Beyond employment, Professors Antony Page and Michael Pitts identified implicit bias as an affront to voting integrity at polling places. Others have considered the limitations of anti-discrimination law that fails to affect the phenomenological realities of implicit bias in criminal justice, media and broadcast policy, jury selection, litigation advocacy, and in judicial selection. Professor Kimani Paul-Emile has thoughtfully asserted that civil rights laws should accommodate patients’ racial preferences and Professor Rene Bowser has linked physicians’ implicit bias to institutional patterns of racial profiling in health care.

27. See Haney-Lopez, supra note 23.
31. Rene Bowser, Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities,
this Article offers a systematic and comprehensive review of the evidence that individual physicians’ unconscious racism has become the new normal form of racial and ethnic discrimination in medicine, which current law completely ignores. This is the first article to present an in-depth treatment of the role that physician implicit bias plays in producing inequality in the health care system; the first article in the legal literature to comprehensively review the social science evidence that implicit biases are malleable; and the first article to examine how this knowledge must change our approach to Title VI anti-discrimination jurisprudence.

In this Article, I make three arguments. First, I argue that the deadly connection between physicians’ implicit racial bias and health care disparities in the United States compels legal attention. Second, I argue the scientific evidence collected over more than two decades contradicts the assumption that unconscious racism is inevitable, impenetrable, and inaccessible to human control. In fact, the evidence of malleability demonstrates that unconscious racism is within the intentional control of actors and institutions whose discriminatory judgments and conduct unintentionally harm minority patients. I assert that this evidence of malleability is a legal “game-changer,” as malleability evidence provides the scientific leverage that has been missing from the debate about personal and legal accountability for discriminatory harms that result from unintentional and subconscious racism. Third, I apply the science of implicit bias to advocate reform of Title VI of the Civil Rights Act of 1964. I argue that discrimination due to implicit bias reaches and therefore should be penalized more broadly than courts and legislatures have acknowledged to date. Based on the social science record, Title VI can be restored to an effective legal weapon against lethal discrimination in health care delivery, and wherever the discriminators are recipients of federal funds, whether the racial bias is deliberate and intentional, or subtle and subconsciously motivated.

Part I describes the two shortcomings of current Title VI jurisprudence. This section explains the need for a legislative correction of the courts’ shambolic analysis of disparate impact claims, and lays the foundation for a new rule of judicial construction to replace current Title VI jurisprudence, which is sadly out of step with modern forms of discrimination. Part II turns to the evidence of implicit bias in the American health care system as an exemplar of the un-checked harm caused by an ineffective Title VI. Part III introduces the scientific evidence that implicit biases are malleable. Because the data in these sections has heretofore been absent from the legal literature—and, as such, supports a fundamental shift in the discourse regarding implicit bias, intentionality, and causation in anti-discrimination law—I carefully review a broad sample of experiments and their results. Part IV puts the malleability evidence to work, providing an evidence-based reconceptualization of Title VI that accounts for reality of contemporary discrimination and the historical goals of the Civil Rights

Act of 1964. After responding to the objections to my analysis that are sure to arise, I conclude with a discussion of the restorative impact that reforming Title VI will have beyond the health care context.

I. THE NEED FOR REFORM

Congress has changed neither the plain language nor their legislative intent for Title VI since its enactment. The statute prohibits racial and ethnic discrimination in all sectors of the American economy where federal funds are expended, including in health care delivery. Section 601 of the Act declares that “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal assistance.” Section 602 goes on to state that “[e]ach Federal department and agency . . . is authorized and directed to effectuate the provisions of section 2000d [Section 601 of this title . . . [,]]” thus giving administrative agencies the authority to promulgate regulations consistent with the aims of the law. Although the statute’s provisions have endured, its effectiveness to control discrimination has not. Federal courts have systematically eviscerated the protection against discrimination Title VI was intended to provide.

Judicial interpretations continue to permit recovery against programs and institutions that “deliberately” and “intentionally” discriminate against minorities. A plaintiff wishing to recover for disparate treatment must first establish a prima facie case by producing evidence to show the defendant intentionally treated a person who is a member of a protected class less favorably than similarly situated non-minorities. If a plaintiff’s disparate treatment case does not include direct evidence of intentional discrimination, the plaintiff may alternatively prove intent indirectly using the burden-shifting framework of *McDonnell Douglas Corp. v. Green*. To

33. Although Title VI broadly prohibits discrimination by any recipient of federal assistance, see *id.* at § 2000d, I focus in this Article on the law’s application to the health-care delivery system as the chosen example for analytical purposes, for reasons described earlier. The analysis here extends beyond the health care sector.
34. *Id.*
35. *Id.* at § 2000d-1.
37. See, e.g., *Maislin v. Tennessee State University*, 665 F. Supp. 2d 922, 928 (M.D. Tenn. 2009) (holding that deliberate indifference to a hostile work environment is actionable under Title VI); see also *White v. Engler*, 188 F. Supp. 2d 730 (E.D. Mich. 2001) (denying a motion to dismiss a class action filed against a state board of education and state employees, alleging that a state-sponsored award program discriminated against students of color), a suit alleging intentional discrimination in violation of Title VI).
prevail under either approach, the Title VI plaintiff must finally demonstrate evidence of intent. Despite copious evidence that overt and intentional discrimination has long been out of vogue in America, courts have struggled for a principled way to extend Title VI prohibitions beyond merely intentional discrimination, unable to distinguish, much less penalize, unintentional or unconscious discrimination. Title VI ostensibly prohibits facially neutral programs and policies that nonetheless have a disparately discriminatory impact on minorities.

Although private parties may no longer assert these claims of unintentional harm, the government may make a prima facie showing of disparate impact by presenting statistical evidence that a practice or program has an adverse impact on a protected group, thus creating a presumption of discrimination. If the defendant is able to show a legitimate, non-discriminatory purpose for the challenged practice, then the burden shifts to the plaintiff to overcome this showing by demonstrating a less discriminatory alternative was available but was not implemented.

The Supreme Court’s flip-flop on this Title VI doctrine has been whiplash inducing. In Lau v. Nichols, the Court held that disparate impact actions were colorable under Section 601, but in University of California v. Bakke, the Court held the opposite, only to reverse itself once again in Guardians Ass’n v. Civil Service Commission of New York, and then later to change the statutory basis for disparate impact claims in Alexander v. Choate. In Alexander v. Sandoval, of course, the Supreme Court sounded the death knell to private causes of action alleging disparate impact, but left open the possibility of administrative enforcement for these claims. The result is a hopeless tangle of confusing Title VI jurisprudence, and worse, a law that is
virtually meaningless as a measure to protect racial and ethnic minorities in America against modern forms of discrimination.

The lower courts currently reach outcomes in both disparate treatment and disparate impact cases that are incongruous with the language and purpose of Title VI. For example, in a Pennsylvania case, the court dismissed allegations of racial discrimination by a class of minority students who showed the defendant school district systematically removed black students from the mainstream educational curriculum by misidentifying them as disabled and unfairly assigning them to special needs classes.\(^{53}\) The plaintiffs presented statistical data sufficient to make out a *prima facie* case on disparate impact grounds,\(^{54}\) but due to *Sandoval*, these private litigants were forced to allege a disparate treatment case.\(^{55}\) Consequently, their claims were denied when the court concluded the school did not act with “discriminatory purpose” to segregate minority students into inferior educational programs.\(^{56}\) The litigants’ claims in this Pennsylvania case were essentially disparate impact allegations that fell victim to disparate treatment analysis based on motive and intent. In another instance, a New York court simply ignored a plaintiff’s evidence that the state’s Department of Labor policies and procedures systematically disadvantaged Hispanic customers because her complaints “focused on disparate impact on Hispanic LEP customers, not intentional discrimination.”\(^{57}\).

The focus of Title VI litigation must be clarified. First, the disparate impact cause of action must be returned to private enforcers as originally intended by the statute’s framers, and as supported by nearly 40 years of common law tradition. Second, the courts must move beyond outdated notions of intentionality to allow Title VI cases to proceed under theories of recovery that reflect the way discriminators behave in reality. For years, scholars have pointed to the dissonance between anti-discrimination law and the behavior it seeks to regulate. Nowhere is the disconnect between Congress’ intent underlying Title VI and the role to which courts have demoted this cause of action become more apparent than in the field of health care. The American health care system is a fitting focus for antidiscrimination law because the problem of racial inequality in health care remains one of the most pervasive, unsolved racial and ethnic injustices in America. The evidence of the devastating impact of implicit bias on health and health care disparities continues to mount, despite the fact that the problem is a top priority for American lawmakers, policymakers, health providers, and patients. Although the social science literature is bursting with scientific evidence that shows the power of implicit bias to cause health inequity, that evidence has not been translated into information that law- and policy-makers can use. If Title VI can be revived to fight discrimination due to implicit bias in health care, then the health


\(^{54}\) These data concerned disproportionate representation of blacks in disabled classes, evidence of individual misdiagnoses, the school district’s procedural irregularities in testing, evidence of disparate learning opportunities, and the underrepresentation of minority administrators throughout the school district. *Id.* at 761.

\(^{55}\) See *id.* at 752.

\(^{56}\) *Id.* at 764.

\(^{57}\) Morales v. N.Y. St. Dep’t of Labor, 865 F. Supp. 2d 220 (N.D.N.Y. 2012).
care example may extend to many settings, including education, employment, and, civil, as well as criminal, law enforcement.

A. Title VI and Health Care Equity

From its inception, health care equity has been at the core of the legislative purpose for Title VI.58 The record of the floor debate as the Senate considered this landmark civil rights act reveals that proponents repeatedly cited and quoted a watershed hospital desegregation case as part of their pleas for the bill's passage.59 The case, Simkins v. Moses H. Cone Memorial Hospital, was brought by black physicians, dentists, and patients to challenge racial segregation in a publically financed hospital.60 The defendant hospital had received funds under the Hill-Burton Act, by which Congress had exercised its spending power to distribute federal grants for construction and renovation of racially segregated hospitals since 1946.61 The Fourth Circuit held in Simkins that the separate-but-equal language contained in the Hill-Burton Act was unconstitutional.62 On March 2, 1964, the United States Supreme Court announced its decision to deny certiorari in Simkins.63 On March 30, 1964, just after the Supreme Court declined to disturb this holding, the bill proposing Title VI came before the full Senate for debate.64 Senators regarded the Supreme Court’s decision not to hear Simkins as a clear signal that the Court had concluded that the “separate but equal” doctrine, as applied to hospitals, violated the Equal Protection Clause.65 Moreover, the Supreme Court’s decision was seen as validation of the important anti-discrimination goals set out in Title VI, and as recognition that

58. This historical fact makes the law’s impotence in the face of persistent and pervasive health care disparities particularly ironic. Shamefully, the most recent Title VI case that in any way addresses health care inequities was an action brought by physicians and an organization “dedicated to the preservation and promotion of a common language—English—in American political and governmental life,” alleging that requiring medical providers to provide translation services to non-English speaking patients violated Title VI. See Colwell v. Dep’t of Health & Hum. Servs., 558 F.3d 1112 (9th Cir. 2009) (dismissing the action as unripe).

59. I refer here to the views of the majority that prevailed in enacting this legislation, but I do not mean to imply that Congress displayed unanimity of thought and mind in passing this law. The Congressional coalitions that reached compromise to enact Title VI were not homogeneous. In their account, Professors Rodriguez and Weingast explain that there were ardent supporters (mostly northern Democrats), ardent opponents (mostly southern Republicans) and a number of moderates who eventually passed Title VI. Daniel B. Rodriguez & Barry R. Weingast, The Positive Political Theory of Legislative History: New Perspectives on the 1964 Civil Rights Act and its Interpretation, 151 U. PA. L. REV. 1417 (2003).


62. Simkins, 323 F.2d at 969-70.


64. For discussion of legislative history and implementation of Title VI see Comment, Civil Rights Act of 1964—Implementation and Impact, 36 GEO. WASH. L. REV., 824, 828-829 (1968); see also 110 CONG. REC. 6561 (1964) (remarks of Sen. Kuchel, relying on Simkins as evidence of judicial support for the conclusion that public funding of separate-but-equal services is unconstitutional).

65. For a legislative history and discussion of the impact that the Simkins case had on Title VI floor debate, see DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 101-05 (1999).
piecemeal litigation was insufficient to dismantle discrimination in the nation’s hospitals. Senator John Pastore of Rhode Island famously declared as follows:

The Supreme Court declined to review that decision; so it is the law of our land. Yet despite the effort of the Court of Appeals to strike down discrimination in the Simkins case, the same court was forced last week to rule again in a Wilmington, N.C., suit that a private hospital operated with public funds must desist from barring Negro physicians from staff membership. That is why we need title VI of the Civil Rights Act, H.R. 7152—to prevent such discrimination where Federal funds are involved. Title VI intends to insure once and for all that the financial resources of the Federal Government—the commonwealth of Negro and white alike—will no longer subsidize racial discrimination.66

Congress clearly read the decision not to disturb the Fourth Circuit’s condemnation of the “massive use of public funds and extensive state-funding” to support hospital segregation as both a prelude to and an impetus for the enactment of Title VI.67

Today, the statute’s language stands unchanged and continues to cover all health care providers who receive federal assistance from Medicare, Medicaid, and other federally funded health insurance programs.68 Indeed, Congress recently reiterated its intent to use Title VI to address health care inequity in the Patient Protection and Affordable Care Act of 2010 (PPACA).69 Yet PPACA’s nondiscrimination provision that expressly incorporates Title VI will mean absolutely nothing without meaningful reform to Title VI. Today, nearly 50 years after Title VI became law, the judicial interpretations of the law make it nearly irrelevant to modern day discrimination generally, and particularly ineffective at combating the deadly race and ethnic disparities in health care.

B. The Shocking Inhumanity of Unjust Health Care

Martin Luther King, Jr. is traditionally credited with declaring, “of all the forms of inequality, injustice in health care is the most shocking and inhumane” in a speech to

66. 110 CONG. REC. 2481, 4183 (1964).
67. “But we emphasize that this is not merely a controversy over a sum of money. Viewed from the plaintiffs’ standpoint it is an effort by a group of citizens to escape the consequences of discrimination in a concern touching health and life itself. . . . Such involvement in discriminatory action ‘it was the design of the Fourteenth Amendment to condemn.’” Simkins, 323 F.2d at 967-68 (quoting Burton v. Wilmington Parking Auth., 365 U.S. 715, 724 (1961)).
68. In 2009, this funding totaled $715 billion, and last year, the United States government paid 36.4% of the nation’s national health care expenditures. See National Center for Health Statistics, Health, United States, 2011: With Special Feature on Socioeconomic Status and Health, CENTERS FOR DISEASE CONTROL AND PREVENTION 376 (May 2012), http://www.cdc.gov/nchs/data/hus/hus11.pdf.
69. 42 U.S.C. § 18116(a) (2006) (“Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, . . . shall apply for purposes of violations of this subsection.”).
the Medical Committee for Human Rights in 1966. This declaration remains true today. No individual can participate fully in society, or compete effectively for its resources and rewards, without good health. Thus, any person or group unjustly denied an equal opportunity to be healthy also ignominiously suffers exclusion from all other opportunities including the chance to successfully meet their most basic needs such as housing, food security, education, and employment. This section of this Article samples the overwhelming scientific evidence that shows that minorities in America are unjustly denied an equal opportunity to be healthy. Moreover, it supports the conclusion that physician prejudice, bias, and stereotypes are substantial contributors to racial and ethnic health disparities. Three examples from the medical literature are instructive.

1. Disparate Treatment Leads To Disparate Outcomes for Heart Disease Patients

African Americans are three times as likely as whites to develop cardiovascular disease and are twice as likely to die from it. Nevertheless, after controlling for genetic differences in risk factors, socioeconomic status, health behaviors, and access to care, race and ethnicity have been well-documented determinants of the quality of treatment that minorities receive for heart and vascular diseases.

Minority patients receive less education and counseling about life-saving preventative behaviors. Physicians are less likely to counsel black patients to modify risk factors for heart disease such as smoking cessation, diet modification, and increasing exercise. Once African-Americans fall ill, they are more likely to receive poor quality care than are white patients. Blacks are less likely than whites to be admitted

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73. Pamela Sankar et al., Genetic Research and Health Disparities, 291 JAMA 2985 (2004) (cautioning against overemphasizing genetic over social and environmental influences on health disparities).

74. David R. Williams, Race, Socioeconomic Status, and Health the Added Effects of Racism and Discrimination, 896 ANN. N.Y. ACADEMY SCI. 173 (1999) (Disentangling effect of racism and discrimination from socioeconomic status on health disparities).

75. William W. Dressler et al., Race and Ethnicity in Public Health Research: Models to Explain Health Disparities, 34 ANN. REV. ANTHROPOLOGY 231 (2005) (finding little evidence to support the conclusion that that health behaviors or genetic differences can explain racial and ethnic health disparities).

76. Kevin Fiscella et al., Disparities in Health Care by Race, Ethnicity, and Language among the Insured: Findings from a National Sample, 40 MED. CARE 52 (2002) (finding that differences in access to health care do not explain racial and ethnic health disparities).

77. See, e.g., Kevin A. Schulman et al., The Effect of Race and Sex on Physicians’ Recommendations for Cardiac Catheterization, 340 NEW ENG. J. MED. 618 (1999).

for coronary artery bypass surgery\textsuperscript{79} and less likely to be triaged for coronary heart
disease.\textsuperscript{80} One study showed that African-Americans were less ready for discharge
than other coronary heart disease patients, based on a cross-sectional sample of
10,000 Medicare patients discharged from 297 hospitals in five states.\textsuperscript{81} Over a
dozens studies have demonstrated persistent “underuse” of invasive procedures that
are effective in treating coronary disease such as angiography and bypass graft surgery
in African-Americans as compared with white patients.\textsuperscript{82} With respect to medical
instead of invasive treatments, the data is more mixed. Studies generally show no
difference in physicians’ use of aspirin or beta-blockers to treat heart disease in black
and white patients; however, blacks are less likely to receive thrombolysis when it is
clinically indicated, and one study showed that African-American women are the
least likely demographic group to receive cardiac catheterization treatments for heart
disease.\textsuperscript{83}

In addition to the evidence of clinical disparities, providers show bias in their
social judgments and expectations about treating black and white patients with
coronary complaints, even before the clinical encounter begins. For example, one
group of researchers found that race significantly influenced physicians’ perceptions
of minority patients’ education and physical activity preferences and for minority
male patients.\textsuperscript{84} For the male patients in the study, these perceptions were a signifi-
cant predictor of the doctors’ clinical recommendations.\textsuperscript{85} In other words, negative
racial perceptions significantly influenced doctors’ clinical recommendations to mi-
nority male patients even after controlling for clinical appropriateness and the pa-
tient’s ability to pay.\textsuperscript{86} Several studies demonstrate that physicians perceive blacks
and low-income patients more negatively than white and higher income patients.\textsuperscript{87}

The decision to diagnose, treat, and monitor a patient’s illness depends not only
on the technical assessment of objective data, but also on physician interpretations of
that data and social information as it pertains to particular patients. Whether the
providers are medical students, private doctors, public hospital physicians, public
health workers, nurses, or staff, researchers are beginning to find multiple pathways

\textsuperscript{79} Edward L Hannan et al., Access to Coronary Artery Bypass Surgery by Race/Ethnicity and Gender among Patients Who are Appropriate for Surgery, 37 MED. CARE 68 (1999).
\textsuperscript{80} Stuart E. Sheifer et al., Race and Sex Differences in the Management of Coronary Artery Disease, 139 AM. HEART J. 848 (2000).
\textsuperscript{81} Katherine L. Kahn et al., Health Care for Black and Poor Hospitalized Medicare Patients, 271 JAMA 1169 (1994).
\textsuperscript{82} See, e.g., David M. Carlisle et al., Racial and Ethnic Differences in the Use of Invasive Cardiac Procedures among Cardiac Patients in Los Angeles County, 1986 through 1988, 85 AM. J. PUB. HEALTH 352 (1995); Steven P. Sedlis et al., Racial Differences in Performance of Invasive Cardiac Procedures in a Department of Veterans Affairs Medical Center, 50 J. CLINICAL EPIDEMIOLOGY 899 (1997).
\textsuperscript{83} Schulman et al., supra note 77, at 623-25.
\textsuperscript{84} Michelle van Ryn et al., Physicians’ Perceptions of Patients’ Social and Behavioral Characteristics and Race Disparities in Treatment Recommendations for Men with Coronary Artery Disease, 96 AM. J. PUB. HEALTH 351, 353-56 (2006).
\textsuperscript{85} Id.
\textsuperscript{86} Id.
\textsuperscript{87} Michelle van Ryn & Jane Burke, The Effect of Patient Race and Socio-Economic Status on Physicians’ Perceptions of Patients, 50 SOC. SCI. & MED. 813 (2000).
through which these providers bring negative, prior beliefs about minority patients’ intelligence, proclivity to engage in risky behavior, likelihood of medical cooperativeness, and adherence to treatment recommendations—unlike their positive expectations of white patients. Even more important, the evidence shows that these disparate perceptions can have a disparately detrimental impact on health outcomes.

2. Disparate Treatment Leads To Disparate Outcomes for Renal Patients

Despite the fact that black Americans represent a disproportionate number of patients with end-stage renal disease (ESRD), they are far less likely to receive aggressive or high quality care for this treatable disease. For patients with ESRD, there are only two treatment possibilities: dialysis therapy or kidney transplant. Transplants are the treatment of choice, offering longer life expectancy, especially if the transplant occurs before dialysis. Younger patients live even longer, though older adults—even at age seventy-five—gain an average of four or more years of longevity from transplant than if they remained on dialysis.

Therefore, the extensive documentation of race and ethnicity disparities in the evaluation for, placement, and rate of transplants between blacks and whites describes a lethal injustice.

Disparate treatment for minority renal patients runs through the entire scope of their clinical experience, beginning with the inferior education and information sharing that they are offered when compared with whites. One study, in which 1,500 black and white renal patients were interviewed and 300 nephrologists were surveyed, found “African-American patients were less likely than white patients to have a complete evaluation to determine whether they were clinically appropriate for transplantation.” However, researchers have demonstrated that differences in black

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90. See, Nat’l Kidney & Urologic Diseases Info. Clearinghouse, Kidney Disease Statistics for the United States, NAT’L INST. OF HEALTH (June 2012), http://kidney.niddk.nih.gov/kiddiseases/pubs/kustats/KU_Diseases_Stats_508.pdf [hereinafter Clearinghouse, Statistics]. Black Americans are at substantially greater risk for end-stage renal disease (ESRD) than white Americans; they represent one third of all ESRD patients, but only 13% of the total U.S. population. Andy I. Choi et al., White/Black Racial Differences in Risk of End-Stage Renal Disease and Death, 122 AM. J. MED. 622, 623 (2009). ESRD incident rates are more than three times higher for African Americans than for whites, though since 2000, the incident rates for all races has stabilized and since 2001, the incidence rate for Native Americans for ESRD from all causes has been declining. Clearinghouse, Statistics, supra, at 3. Nevertheless, rates of prevalent ESRD remains greatest among blacks and Native American populations. See id.; see also Précis: An Introduction to End-Stage Renal Disease in the United States, 58 AM. J. KIDNEY DISEASES e17 (2011).


93. Beth Israel Deaconess Med. Center, supra note 91.

94. Ayanian, supra note 92, at 512.
and white patient preferences explain only a small fraction of these treatment differences. In the same study, among patients who reported they were certain they wanted a transplant, black patients were less likely than whites to be referred for transplant evaluation, and less likely to be placed on a transplant waiting list. Predictably, numerous studies show that black patients receive transplants at a significantly lower rate than white patients, even adjusting for patient preferences, expectations, type of treatment facility, socio-demographics, health status, comorbidities, and the cause of renal conditions.

3. Disparate Treatment Leads To Disparate Outcomes for Cancer Patients

Racial disparities in cancer treatment have been directly linked to disparities in long-term survival. For example, a research group from the University of Texas demonstrated that in 31% of the black patient cases reviewed, patients with potentially resectable pancreatic cancers never received a surgical evaluation, as compared to 23% of whites. Once seen by a surgeon, blacks were still significantly less likely to receive surgical resection. The unadjusted data showed a worse overall survival rate for blacks than for whites, but when the data were adjusted for receiving surgical resection, racial disparities in long-term survival disappeared.

Despite this research, conjecture that such survival disparities are due to biological differences in patients has persisted. Dr. Peter Bach sought to challenge this conjecture. Dr. Bach’s research team sought to determine whether the racial disparities in survival between blacks and whites persisted where the patients all received the same treatments for similar stages of cancer, regardless of their race. In their systematic review of the literature, Dr. Bach’s research team evaluated eighty-nine cohorts of patients who received comparable treatment for similar stage cancers. Across the 89 cohorts, which involved analyses of survival rates for over 32,000 black patients and 189,000 white patients, Dr. Bach found that blacks who received comparable treatment for similar stage cancers, after adjusting for differences in population mortality, suffered only 107% of the mortality rate experienced by...

96. Ayanian, supra note 92, at 512.
99. *Id*.
100. *Id* at 935-36.
101. *Id* at 936.
102. For example, in a study sponsored by the National Cancer Institute, survival rates for blacks and whites with colon, breast, uterus, and bladder cancer found that lower survival rates persisted for blacks with all four types of cancer, and persisted even after adjusting for clinical and socioeconomic characteristics. Peter B. Bach et al., *Survival of Blacks and Whites after a Cancer Diagnosis*, 287 JAMA 2106, 2106 (2002).
103. *Id*.
104. *Id* at 2108.
whites.105 Moreover, for three of the four most common cancers—lung, colorectal, and prostate—there was no evidence of excess cancer mortality in blacks.106 Dr. Bach concluded that differences in cancer biology between racial groups are unlikely to be responsible for a substantial portion of survival disparities.107 Instead, disparities are more likely the result of disparate cancer treatment.108 Dr. Bach’s conclusion not only replicates numerous studies that have demonstrated that African-Americans are less likely to receive optimal care for cancer,109 but also provides a basis for the conclusion that differences in treatment by race also result in differences in survival rates among white and minority cancer patients.110 The fact that blacks and whites enjoy similar survival rates when treated comparably for similar stage cancers must be regarded with alarm, because it confirms that discrimination in health care is deadly.

The three examples from heart, cancer, and renal disease data summarized here are illustrative but far from exhaustive. The Institute of Medicine (IOM) gathered evidence that disparate treatment of disease and injury in the United States are pervasive across a broad variety of medical conditions and settings.111 Following the publication of the IOM’s report, a maelstrom of debate erupted, because the IOM posited that physicians might significantly contribute to health disparities, due to their biases, prejudices, and stereotypes.112 Critics asserted the whole disparities problem is a “myth,” apparently imagining away the “veritable mountain of empirical studies” that even detractors admit confirms pervasive racial and ethnic disparities in Americans’ health, health care access, and health care quality.113 A small but stolid group of scientists offered a biological explanation for health disparities, arguing the discredited view that racial groups in the United States are genetically similar to their

105. Id. at 2110.
106. Id. at 2111.
107. Id. at 2111-12.
108. Id.
110. See Bach, supra note 102, at 2110-12.
111. For a comprehensive literature review of scientific studies showing health disparities, see generally Unequal Treatment, supra note 3.
114. Epstein, supra note 112, at S27.
pre-historic human ancestors and these genetic similarities determine biologically meaningful distinctions among American racial groups. More thoughtful researchers, including historical epidemiologists, sociologists, philosophers, and hosts of physicians have cited social determinants, reasoning that racial disparities in health derive from interplay between complex social forces such as economic disadvantage; institutional and interpersonal discrimination; structural barriers to healthy life choices, including unequal access to healthy food, education, work, and housing environments; and disparate access to water and sanitation. However, the most controversial and perhaps most important contribution to racial and ethnic health disparities that remains unexplored is the contribution that physicians’ implicit biases make to disproportionately poorer health outcomes for minority patients. The salient point to take away from the three examples discussed here is how commonplace, pervasive, and disastrously harmful inequality in health care has become. The next section examines the role that physicians’ implicit biases play in creating this shocking injustice.

II. IMPLICIT BIAS AND HEALTH CARE DISPARITIES

Modern health care delivery involves a complex network of actors. Physicians and patients lie at the core of that network and have been the most closely studied to understand their cognitive attitudes, prejudices, and biases. The first section of Part II reviews the social science of implicit bias generally and the second section reviews the evidence that physicians’ implicit bias is a significant contributor to health inequality. Both sections contribute information about implicit bias not previously reported in the legal literature, but important to the task of identifying the type and timing of interventions most likely to effectively control discrimination due to implicit biases.

115. See, e.g., Neil Risch et al., Categorization of Humans in Biomedical Research: Genes, Race, and Disease, 3 GENOME BIOL. 1 (2002). A myriad of scientific research discredits this view, which fatally rests on the mistaken notion that phenotype is equivalent to genotype. For a lucid exposition of the arguments against this genetic determinist view, see generally Nancy Krieger, Stormy Weather: Race, Gene Expression, and the Science of Health Disparities, 95 AM. J. PUB. HEALTH 2155 (2005) (explaining that (1) self-reported racial categories describe racial and ethnic features that arise out of gene expression, rather than heritable or innate biological traits, and (2) the notion that genetic variability accounts for medically important differences in disease outcomes among racial and ethnic groups depends on the generalized frequency of genetic variants or alleles underlying the susceptibility of diseases, which occur in fewer than two percent of all diseases).


A. An Updated Understanding of Implicit Bias

Consensus has emerged based on twenty-five years of social science research that implicit biases are pervasive among Americans. A bias in this context is a negative attitude held about one group of people relative to another group. An implicit bias is a negative association that operates unintentionally or unconsciously to inform judgments and behavior. Implicit biases differ from explicit biases, which are deliberately held evaluations that operate with conscious awareness, choice, and intentionality. Importantly, implicit and explicit biases differ dramatically in the extent to which they influence behavior. One of the most important revelations about implicit bias is the extent to which unconscious, implicit attitudes have the power to override an individual’s consciously held, explicit preferences and beliefs.

Researchers have repeatedly shown that a person is much more likely to act in accord with implicit attitudes and prejudices than in alignment with expressly held viewpoints or personal values. In other words, unconsciously held racial attitudes have greater influence over decisions and behavior than consciously held, race-neutral preferences. No matter how unequivocally and sincerely egalitarian a person intends to behave, hundreds of thousands of Americans tested have empirically demonstrated that we are a nation of people who hold strong implicit biases against members of ethnic and racial minority groups.

In the case of health care disparities, this fact has powerful explanatory implications. For example, Dr. Alexander Green demonstrated that even physicians who expressed virtually no explicit preferences for white or black patients were nevertheless more likely to give superior treatment to white patients based on their pro-white implicit biases.

Figure 1 below provides a schematic description of how implicit biases form and inform our perceptions, judgments, and conduct towards people that we identify as belonging to ethnic and racial minority groups. I will use this diagram to provide a basic explanation of how implicit biases work. My explanation is based upon the work of leading social psychologists that study automatic thought, stereotypes, and implicit attitudes.

120. Richard R. Banks et al., Discrimination and Implicit Bias in a Racially Unequal Society, 94 CALIF. L. REV. 1169 (2006); Greenwald & Krieger, supra note 20, at 959.
121. Greenwald & Krieger, supra note 20, at 951.
122. See, e.g., Andrew Karpinski & James Hilton, Attitudes and the Implicit Association Test, 81 J. PERSONALITY & SOC. PSYCHOL. 774 (2001) (explaining that implicit and explicit attitudes are independent and differentially predict behavior); id. at 966 (explaining that implicit bias measures significantly better in predicting discrimination than explicit bias measures).
124. Greenwald & Krieger, supra note 20, at 945.
125. Green et al., supra note 7, at 1231.
Implicit biases form based on information subconsciously gathered and stored during the course of a lifetime. The first step—storing social knowledge—is a process that takes place wholly outside a person’s conscious awareness.\(^{127}\) The Environmental Association Model of implicit bias explains that we all store social knowledge in memory from everything we see, feel, and experience in the world around us; our implicit biases reflect the environment and culture that surrounds us, rather than views we personally endorse.\(^{128}\) This explains why an individual may espouse no overt personal preference for one racial group over another, and yet may hold implicit biases that cause the person to discriminate. I will call the second step in the implicit bias process “identification.” Identification occurs the moment two people meet. Immediately upon encounter, our minds subconsciously begin to perform a sorting and contextualizing exercise to make sense of the information received.\(^{129}\) The task is to find categories from our stored memories to match or fit the newly encountered individual or situation. When we have found a match, we have identified the group to which the person we encounter belongs, as well as the category of stored information that applies to them.\(^{130}\) Importantly, the identification process occurs involuntarily and can result in positive or negative associations, depending on the content of the categories we have stored from the first step. In this second step, we might categorize a person as male or female, short or tall, fat or skinny, and so on, without attaching any value judgments whatsoever. In fact, each person and situation evokes multiple categories during identification. However, studies show that because Americans live in a race-conscious society, our environment conditions us to instinctively identify a person’s racial or ethnic group as a dominant informational cue for further processing.\(^{131}\)

Once we identify the stored categories to which new information belongs, the process of shaping and responding to our implicit biases begins. Very quickly—fewer than 500 milliseconds from the moment of identification—\(^{132}\) we begin the third step, called “retrieval.”\(^{133}\) During retrieval, we subconsciously access the most prominent associations we have stored in memory about that relevant racial or ethnic

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127. Id. at 139.
129. Andersen et al., *supra* note 126, at 142.
130. Id. at 141.
131. See, e.g., *id.* at 152.
133. Andersen et al., *supra* note 126, at 147.
group. This process happens without any intentional awareness on our part. Thus, accessing stored memories happens with "automaticity."134 Again, these categorical associations can be value neutral, such as the ones required to help us live daily in a complex society. For example, when we cross a street, we automatically retrieve associations about cars and trucks—that they are fast and dangerous—in order to cross safely. However, the information we retrieve may also be positive or negative, and may differ from one person to the next even when we receive the same input or stimuli. For example, the appearance of a police officer may summons associations of safety and protection for someone who is a wealthy, white American, but may evoke associations of danger and fear for a black or Latino male American, regardless of whether he is wealthy, middle-class, or poor.

The categorical associations we retrieve are called "stereotypes."135 While stereotypes are attributes about groups that can be held at a conscious or sub-conscious level, it is the unconsciously held stereotypes that are activated in the next step towards forming implicit biases. The activation step simply moves a stereotype from stored memory to a subconscious place where it becomes accessible for further use.136 The stereotype becomes available to use in shaping our understanding of the situation at hand. When negative stereotypes are shaped into a system of beliefs that we automatically associate with a people group, they form attitudes we call "prejudices." In the fourth step, automatically activated attitudes become dominant and overwhelming, displacing even our intentional attitudes and preferences, unless these subconsciously activated views are deliberately contradicted.137 This is the stage at which we unconsciously form implicit biases. Finally, in the fifth step, implicit biases work to influence the way we choose to judge and interact with people and situations.138 Implicit biases may cause people who believe in equality to act discriminatorily.139 And although implicit biases operate at an unconscious level, it does not necessarily follow that implicit racial biases cannot be influenced or controlled by the individual or the external environment. Indeed, the best evidence, as we shall see in Part III, infra, is quite to the contrary.

The tool of choice that both neuroscientists and social psychologists use to measure unconscious attitudes is called the Implicit Association Test (IAT).140 The IAT is a computer based test that works from the straightforward premise that when people are asked to associate photographs with words that are consistent with their

134. Blair & Banaji, supra note 132, at 1142.
135. Andersen et al., supra note 126, at 148; Greenwald & Krieger, supra note 20, at 949.
136. Andersen et al., supra note 126, at 148.
137. Greenwald & Krieger, supra note 20, at 951; see generally Bertram Gawronski et al., Implicit Bias in Impression Formation: Associations Influence the Construal of Individuating Information, 33 EUR. J. SOC. PSYCHOL. 573 (2003).
139. Id.
140. The IAT is the most widely accepted, but not the only, tool available to measure implicit bias. Other methods, including the Go/No-Go Association Task (GNAT), the Lexical Decision Task (LDT), and selective priming, are discussed later in the Article. See Laurie A. Rudman, The Validity of the Implicit Association Test is a Scientific Certainty, 1 INDUS. & ORG. PSYCHOL. 426 (2008).
implicitly held beliefs, they will make those associations quickly.141 When people are asked to connect photographs with words they would not naturally or automatically associate with those photographs, their response times will be slower, to allow them to override their automatic instincts.142 The IAT measures the time a person takes to associate selected pairs of positive and negative words with pairs of pictures.143

The IAT has been used extensively to measure implicit attitudes about race using a version of the test called the Race-Attitude IAT.144 It measures the time a person takes to quickly sort photographs of African- and European-American faces, and combinations of those facial shots with positive and negative adjectives.145 The closer a subject’s IAT score is to zero, the more neutral their preferences are between blacks and whites.146 A zero score indicates the person taking the test took no more or less time to associate words with black or white faces.147 A high positive IAT score signals strong, automatic, implicit biases in favor of whites over blacks—a “pro-white” or “anti-black” bias, whereas a very low or negative IAT score denotes a strong bias in favor of blacks over whites—a “pro-black” or “anti-white” bias.148 Over one million people have completed the publicly available Race-Attitude IAT to date, and over seventy percent of them show preference for white Americans over black Americans, even when their explicit, self-reported values are egalitarian.149

The IAT specifically, and implicit cognitive psychology generally, have been criticized by some for failing to “satisfy key scientific tests of validity”—internally, statistically, and externally.150 Critics have further asserted the focus on implicit bias is wrongly placed, both because the IAT itself is ambiguous and because it more likely measures intentional but covert racial bias rather than unconscious racism.151 Other critics claim that the emphasis on subconscious racism distracts civil rights advocates from addressing the entrenched and substantively more important sources of inequality such poverty, poor housing, and inferior education systems.152 Indeed, some of the most progressive critics have decried the exceptionalism they suspect underlies implicit bias scholarship.153 However, the majority of social scientists have discrep-

143. See generally Brian A. Nosek et al., The Implicit Association Test at Age 7: A Methodological and Conceptual Review, in AUTOMATIC PROCESSES IN SOCIAL THINKING AND BEHAVIOR 265 (J.A. Bargh ed., 2007).
144. Janice Sabin et al., Physicians’ Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender, 20 J. Health Care for the Poor & Underserved 896, 899 (2009).
145. Id.
146. See id. at 899-900.
147. See id.
148. See id.
149. Id. at 897.
150. Mitchell & Tetlock, supra note 13, at 1023.
151. See, e.g., id. at 1096 n.236.
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ited the critiques of the IAT itself, some likening detractors to an island of dissent within a sea of consensus based on “a solid empirical bedrock for understanding the occurrence of implicit bias.” Moreover, once unpacked, the leading substantive critiques rest principally on normative disagreements about whether or not the law should concern itself with bias that is unconscious and unintentional.

I rely principally upon studies that use the IAT to measure implicit attitudes for four reasons. First, the IAT is the most widely accepted and broadly applied scientific measure of implicit attitudes available. Both the volume and variety of contexts in which social scientists have employed the IAT to measure implicit biases are large and impressive. Second, the IAT has survived rigorous peer review, critique, and refinements since its introduction in 1998. Greenwald et al., for example, confirmed the IAT’s predictive validity for measures of interracial behavior in a meta-analysis of 122 reports that included 184 independent samples. Notably, the meta-analysis showed the IAT effect measures demonstrated particular strength for socially sensitive topics such as racial and intergroup behavior. Third, an emerging neuroscience literature showing the correlation between IAT measures and psychophysiological reactions to interracial interactions adds scientific support to the usefulness and construct validity of this test. Fourth, legal scholars, as well as social scientists, studying bias in health care have broadly embraced the IAT as a method to measure unconscious racial and ethnic bias; making the IAT the most appropriate measure for my discussion of health and health care disparities.

In 1998, Anthony Greenwald and Linda Krieger introduced the idea that antidiscrimination law should be reformed to reflect information about unconscious

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154. The IAT has been the subject of over 450 peer-reviewed publications; its scientific acceptance and validity is by now, unassailable. See Sabin et al., supra note 144, at 899 (“The IAT has become widely accepted as a measure of implicit social cognition because it achieves good reliability in comparison to other implicit measures, is relatively robust with repeated assessment for pre-post evaluation, captures evaluations that are related, but distinct from self-report, and has predictive validity.”).


156. See id. at 42 (“[I]t is rare... for the huge preponderance of scientists within a well-established discipline to be utterly and spectacularly wrong. This seems to be what Tetlock and Mitchell are suggesting—that the near-consensus among social psychologists concerning the discovery of implicit bias reflects some kind of collective folly or perhaps a hoax or in any case the regrettable result of a blinding ideological commitment to the doctrine of ‘statist interventionism.’”).

157. Id. at 45-46.

158. Id.; see generally Nosek et al., supra note 143.


161. Id. at 32.

162. Stanley Damian et al., The Neural Basis of Implicit Attitudes, 17 CURRENT DIRECTIONS IN PSYCHOL. SCI. 164 (2008).
behavior obtained through widespread use of the Race-Attitude IAT. They asserted that because the IAT had proved reliable as a scientific measure of unconscious mental processes and thus provided sufficient basis to alert discriminators of their conduct, civil rights law should employ the evidence gathered from the test to more accurately and effectively control prejudice and discrimination. The IAT and its evidence of implicit bias have formed the basis of the academic movement called Behavioral Realism, an analytical school of thought unified by its insistence that the law must reckon with the new, more accurate model of human thought, decision-making and action that the science of implicit bias reveals. However, it is fair to say that despite the prominence of its proponents, this movement has not received the traction legal scholars had hoped from courts and legislatures, which continue to lag behind in addressing implicit bias discrimination through the law. In this Article, I aim to highlight new empirical evidence that will compel scholars and jurists to recognize that the law must become cognizant of discrimination due to implicit racial and ethnic bias in health care.

B. Physician Implicit Bias: Racism’s New Normal

Racial and ethnic discrimination arising from implicit biases have become the new normal in American health care. This section reviews the small but powerful body of empirical literature that demonstrates the impact that implicit biases have throughout the health care delivery system. I begin with evidence confirming that the majority of American physicians tested show strong pro-white implicit biases. Next, I review a representative sample of the groundbreaking evidence that reveal how implicit biases travel from physicians’ unintended attitudes to cause racial and ethnic discrimination to the detriment of minority patients’ morbidity and mortality. I conclude with a word about the causal link between physician implicit bias and the disparate health outcomes that minority patients suffer.

1. Widespread Physician Bias

Physicians introduce implicit bias into every phase of health care delivery. Using the IAT data collected from hundreds of thousands of voluntary visitors to Harvard University’s Project Implicit interactive website, one study analyzed data

163. See Greenwald & Krieger, supra note 20, at 946 (stating that current anti-discrimination law is naïve in assuming that humans act solely in accordance with explicit and conscious intentions).

164. See id.


166. See Sabin et al., supra note 144, at 906-08. Physicians are not likely to only actors in the health care industry who hold significant implicit racial and ethnic biases. However, one limitation of the current social science literature is the dearth of research concerning the impact of bias through other health care providers including nurses, technical assistants, staff, and health administrators.
from over 2500 test-takers who self-identified as “MDs.” They then compared the physicians’ IAT data to their self-reported explicit biases, gathered from a questionnaire. The study revealed that the physicians tested exhibited the same preferences for whites over blacks as are seen in the general population. This study of volunteer test-takers may not be representative of all physicians; those who took the IAT for this study are a self-selected group, and the physicians tested were older and more racially homogenous than the American population generally. Nevertheless, the study is revealing because of the size and diversity of the sample group.

This study made two additional noteworthy findings. First, white male physicians displayed the strongest pro-white preferences. African-American physicians on average did not show implicit preference for either white or black Americans, but the broad standard deviation reported for black MDs indicates that some of these doctors had strong implicit preferences for whites and others had strong implicit preferences for blacks. The second revelation from this study relates to the weak correlation between physicians’ explicitly reported racial preferences and their measured implicit biases. Hispanic and white female physicians reported relatively weak preferences for whites over blacks, though white male physicians showed slightly stronger explicit pro-white attitudes. Both male and female African-Americans reported explicit attitudes favoring blacks. Female Hispanic MDs, on average, reported no explicit race bias whatsoever. However, it is the relationship—or lack thereof—between implicit and explicit measures that is most counterintuitive. Although implicit and explicit measures for all those tested were statistically significant, the two measures were only modestly related. This disconnect confirms other data and supports the understanding that cognitive processes that govern explicit and implicit attitudes are separate and independent. This finding suggests that a person may explicitly hold egalitarian beliefs while simultaneously holding implicitly biased racial views, or vice-versa. These results become particularly important when viewed in the context of medical decision-making and health care delivery.

2. Physician Bias Taints Treatment Decisions

In 1999, Dr. Kevin Schulman reported the first, path-breaking study of how patients’ race and gender influences physicians’ treatment decision-making, leading to treatment disparities for cardiovascular disease. This study fundamentally

167. Id. at 899.
168. Id. at 899-902.
169. Id. at 906.
170. Id. at 908.
171. Id. at 902.
172. Id.
173. Id.
174. Id.
175. Id.
176. Id.
177. See, e.g., Karpinski & Hilton, supra note 122; see also the discussion supra, Part II.A.
178. Schulman et al., supra note 77.
changed the conversation about disparities, providing the first concrete evidence that
doctors clinically discriminate against minority patients and therefore may contrib-
ute directly to disparate health outcomes. Dr. Schulman studied 720 primary care
physicians, using a computerized survey to show the doctors videotaped vignettes of
hypothetical patient interviews. The patients were actually scripted actors who
were selected to appear similar in age and affect. The eight actors—two each of
white women, white men, black women, and black men—presented identical scripts
and diagnostic data—in each vignette, the patients differed only by race and gen-
der. After reviewing the vignettes and data, the physicians were asked to make
treatment recommendations. Dr. Schulman analyzed the physician responses by
using a multivariate regression model and found that the patients’ race and gender
independently influenced how physicians managed chest pain.

Dr. Schulman reported that his data showed that white, male patients were signifi-
cantly more likely to receive a recommendation for cardiac catheterization than black
and female patients, with a black-white odds ratio of 0.6. However, in response to
criticism of his methodology, Dr. Schulman clarified that black female patients were
13% less likely than white males to receive catheterization, and black males were 7% less likely.

Taking this correction into account, Schulman concluded “we doubt that lower utilization rates observed consistently among black patients reflect an
effort to provide more appropriate care to these patients,” aptly dismissing those
critics who missed the core message of the study. Dr. Schulman’s essential finding
remained disturbingly unshaken: doctors provided black and female patients with
different and inferior medical treatment than they provided to white and male
patients. However, although Dr. Schulman’s study linked considerations of race
and gender to physicians’ treatment decisions, it did not attribute those consider-
ations to the physicians’ implicitly held biases.

In 2007, Dr. Alexander Green took the next step in a study that examined what
influenced physicians’ decisions to recommend thrombolysis for cardiac patients.
The Green study strongly linked physicians’ implicit biases to their racially disparate
treatment decisions. Dr. Green’s research team measured physicians’ levels of
implicit and explicit race bias by asking them to complete two Implicit Association
Tests and a questionnaire. Next, the doctors were randomly assigned to view a
photograph of either a black or a white actor, while reading a clinical vignette that

179. Id. at 619.
180. Id.
181. Id.
182. Id.
183. Id. at 622-23.
184. Id. at 624.
186. Id. at 287.
187. See id.
188. See generally Schulman et al., supra note 77.
189. Green et al., supra note 7, at 1231.
190. Id. at 1232-33.
described symptoms potentially linked to coronary artery disease (CAD). The doctors were then asked to rate the likelihood that the patient’s chest pain was due to CAD and to state whether they would prescribe thrombolysis. The findings were remarkable. Dr. Green found an inverse relationship between the level of physicians’ implicit bias and the quality of treatment they gave to minority patients; that is, as physicians’ levels of unconscious race bias increased, the likelihood they would refer black patients for thrombolysis decreased, while the likelihood they would refer white patients for thrombolysis increased.

Green’s study replicated the finding that physicians demonstrated anti-black implicit biases at approximately the same level as the general American population. Moreover, Dr. Green’s findings demonstrated that white physicians tend to hold implicit racial biases against African-Americans, associating their black patients with negative attributes, such as being generally uncooperative and medically non-compliant, even though the physicians show no explicit association between black patients and negative attributes. The study showed a statistical interaction between physicians’ willingness to prescribe thrombolysis and their implicit biases against blacks generally, and against black patients specifically. Importantly, the physicians in this study expressed absolutely no explicit racial bias on questionnaires asking their preferences between black and white patients. In fact, this study showed no explicit bias in favor of white patients whatsoever. Thus, the Green study lends further support to the conclusion that physicians’ unconscious beliefs are a more important determinant of the quality of patient care they give, than what they profess about their race or ethnicity preferences explicitly.

In another part of this study, Dr. Green and his researchers made a crucial finding that could prove helpful to policymakers. They separately tested 67 of the physicians who were made aware that the study’s purpose was to evaluate racial bias in medical decision-making. This group of physicians showed entirely different treatment recommendation patterns than those who were unaware of the study’s objective. The informed group of doctors showed an increasing willingness to prescribe thrombolysis to blacks, even as their IAT scores evincing anti-black, implicit bias, increased. This outcome may reflect a “novelty effect”—evidence that the study participants self-corrected their biases to improve their outcomes once they were made aware of the study’s focus. However, I propose an alternate view of the difference between physicians who knew Dr. Green’s purpose and those who did not. These findings

191. Id.
192. Id.
193. Id. at 1235.
194. See id. at 1234.
195. Id.
196. Id.
197. Id. at 1235.
198. See also Diana Jill Burgess et al., Patient Race and Physicians’ Decisions to Prescribe Opioids for Chronic Low Back Pain, 67 SOC. SCI. & MED. 1852, 1853 (2008).
199. Green et al., supra note 7, at 1235.
200. Id.
reasonably suggest that physicians can recognize, modulate, and even counteract the effect of their implicit race bias on treatment decisions, at least when they are being studied. Therefore, it is also reasonable to view this self-correction as positive and hopeful evidence that physicians generally are willing and able to reverse the impact of their unconscious racial biases if they are made aware that they have them. In fact, the majority of physicians studied admitted they thought it likely that implicit racial biases affect their medical decisions, and their self-awareness increased as the study went on. Before taking the IATs, 60.5% of physicians agreed with the statement: “Subconscious biases about patients based on their race may affect the way I make decisions about their care without my realizing it.” After taking the IATs, that number increased to 71.6%. Moreover, 74.8% of physicians felt the IATs were worthwhile, and 76% “felt that learning more about unconscious biases could improve their care of patients.” It is reasonable to conclude from this data that the majority of physicians tested would also be responsive to interventions aimed at reducing their implicit biases.

The Green study is not without critics. A group of researchers working with both British and American primary care doctors were unable to replicate Green’s finding with respect to race bias, but did find that patient gender significantly influenced physicians’ diagnostic decisions. This same group also made the counterintuitive claim that social class and patient age had no impact on physician decision-making; if true, this extraordinary finding would contradict the extensively supported evidence of a social gradient in health first identified by Sir Michael Marmot in his famous Whitehall Studies begun in 1967.

Others have alleged that because the physicians in Green’s study who showed lower IAT scores treated black and white patients differently, while physicians with higher IAT scores treated black and white patients similarly, Green should have concluded the IAT does not measure true racial bias. This criticism misapprehends Dr. Green’s data. His most striking finding is the predictive relationship between increasing physician bias and treatment decisions. The Green study findings are remarkable because of the interactive relationship between physicians’ clinical choices and measured implicit bias. A physician’s likelihood of recommending treatment for black patients is inversely related to the IAT.

201. Id.
202. Id.
203. Id.
206. See Hal R. Arkes, Prof., Ohio St. U., & Neal V. Dawson, Staff Physician, MetroHealth Medical Center, Presentation at the Society for Judgment and Decision Making: Race-Based Bias in Physician Decision Making (Nov. 16, 2008). However, another criticism raised by Arkes and Dawson is legitimate. These researchers point out that Dr. Green failed to describe criteria for the appropriateness of thrombolysis as a treatment for African-American patients, especially since racial differences between patients may represent real epidemiological or clinical differences. Id. Indeed, Dr. Green did not examine the reasons behind physicians’ decisions. Id. Yet this omission has little bearing on the relationship between bias and treatment that Dr. Green did examine and find. See id.
score but positively related to IAT scores for white patients. Said another way, the stronger a physician’s pro-white implicit bias, the less likely black patients are to receive helpful treatment, but the more likely white patients are to get optimal care. Dr. Green’s findings are also remarkable for the lack of correlation between physicians’ neutral explicit racial preferences and their treatment decisions, and, in contrast, the direct relationship between their implicit racial biases and their treatment judgments. Taken together, the Schulman and Green studies represent a turning point in the understanding of whether and how physicians contribute to racial and ethnic health disparities.

Another pair of studies, conducted by Dr. Janice Sabin and focusing on pediatricians, refined our understanding of how physicians’ implicit biases adversely affect minority patient health outcomes. In the first study, Sabin’s group recruited pediatric faculty, fellows and residents from an urban, research university and administered three computer based IAT surveys. Dr. Sabin found that pediatricians generally showed lower implicit preferences for whites over blacks than most IAT test-takers, and then most other physicians. Moreover, even these lower implicit bias measures were not associated with any statistically significant differences in the doctors’ treatment recommendations between black and white patients with UTI, ADHD, or asthma. The study did find a “moderate implicit association between the concept of ‘compliant patient’ and European Americans rather than African Americans, but another racial finding was counterintuitive, as the physicians studied were more likely to recommend the recognized treatment of choice—outpatient care—for African-American patients than for white patients. These conflicting findings add complexity to the
understanding that implicit biases affect physicians differently based on their specialties and the illnesses they are treating.

Drs. Sabin and Greenwald next used an online survey of 86 academic pediatricians to conduct a second inquiry to determine the correlation between pediatricians’ implicit race biases and their diagnostic decisions for the same four pediatric conditions.\(^{217}\) In the 2012 study, Sabin and Greenwald did find an association between the doctors’ implicit attitudes about race and the treatment recommendations for their black and white patients, particularly for pain treatment.\(^{218}\) Specifically, the researchers “found a significant correlation between physician female gender and the willingness to prescribe a narcotic pain medication for the White patient, but not for the African American patient.”\(^{219}\) In both studies, the researchers were able to confirm that pediatricians tested have significantly lower implicit biases than other physicians, and that these biases had differing effects on medical decisions depending on the patient, the condition being treated, and the socio-demographic factors of the treating physician.

A group led by Dr. Gordon Moskowitz published a study in 2012 that continued to explore the connection between physicians’ implicit attitudes and their diagnostic decisions.\(^{220}\) Moskowitz tested physicians’ ability to identify medical terms quickly from a group of randomly generated words appearing on a computer screen.\(^{221}\) However, immediately before the selected words appeared, physicians were subliminally “primed” with a photograph of either an African-or European-American face.\(^{222}\) The photograph flashed quickly in the physician’s peripheral field of vision so that it could not be consciously perceived.\(^{223}\) The researchers found that physicians were fastest at identifying medical words for diseases stereotypically associated with African-Americans after subliminally seeing a black face, but slower identifying the same medical words after being primed with a white face.\(^{224}\) Moreover, physicians responded fastest to terms for conditions that were perceived as arising from behavioral choices, such as HIV, drug abuse, and obesity, after being primed with black faces.\(^{225}\) In contrast, physicians were slower to identify terms for medical conditions that were genetic in origin such as hypertension, stroke, sickle cell anemia, and coronary artery disease, even though the study showed these diseases are also stereotypically identified with blacks.\(^{226}\) Thus, physicians in Moskowitz’s study implicitly associated certain diseases with African-Americans, without being aware they were doing so.\(^{227}\)


\(^{218}\) Id. at 991-92.

\(^{219}\) Id.

\(^{220}\) Moskowitz et al., supra note 10.

\(^{221}\) Id. at 997-98.

\(^{222}\) Id.

\(^{223}\) Id. at 998.

\(^{224}\) Id. at 999.

\(^{225}\) Id.

\(^{226}\) Id.

\(^{227}\) See id.
Moreover, they were quick to implicitly associate diseases arising from anti-social behavior with African-Americans. Moskowitz explains the significance of this finding:

This is important because (1) it occurred without the doctors realizing they were invoking stereotypes (or even that they were thinking about African Americans), suggesting that stereotypes influenced them in ways and at times they did not consciously intend, and (2) these implicit associations were apparent for both conditions associated with lifestyle choices and diseases associated with genetic predisposition. Implicit stereotypical beliefs about African Americans may be accurate and medically justifiable, and they may equally have no basis in medical evidence. Our aim was to examine whether implicit stereotyping exists among medical doctors, because it may bias diagnosis of and treatment recommended to African American patients even in the absence of intent or awareness by the practitioner.

By showing the sub-conscious operation of the disease associations, Moskowitz has pointed out a serious concern. A physician’s recollection of stereotype information associated with a patient’s racial or ethnic group, may crowd out the physician’s unbiased assessment and objective treatment decisions about the individual minority patient in her care. Even if the stereotype is accurate, the individual’s symptoms may not be best explained by the stereotypical diagnosis . . . [or] implicit assumptions may lead to an exaggerated sense of the severity of the symptoms. This type of stereotyping, called “statistical discrimination,” is particularly dangerous to minority patients’ health outcomes because it gives doctors the comfortable illusion that their practice decisions are evidence-based, when in fact they are based on unconsciously racist presumptions.

3. Implicit Bias Affects Other Health Providers

In 2011, a group led by Adil Haider published a study involving first-year medical students at Johns Hopkins Medical School. Haider found that the majority of doctors-in-training hold similar implicit preferences for whites as compared to blacks, and for wealthier individuals as compared to those from lower socio-economic groups. These results are consistent with those found among their more senior physician colleagues and among Americans overall. However, Haider generally found no association between the medical students’ IAT scores and their clinical
assessments based on patient vignettes. Students viewed three patient vignettes and then took a multiple-choice questionnaire to test their medical judgment across four scenarios. The scenarios required a pain assessment, a determination of the appropriateness of informed consent, and assessments of patient reliability and trust. The vignettes were selected to randomly show students patients of different races—black and white—and patients of different socioeconomic classes. In two of the three vignettes, there was no connection between medical student implicit biases and their medical judgments. The students’ racial biases correlated with differences in their assessments of patients only in the vignette involved in assessing a patient’s informed consent. In all other scenarios, the students’ responses did not vary with the patient’s race or socio-economic status, notwithstanding evidence these students held similar implicit biases to more senior physicians and residents in other studies.

One commenter explained the difference between student biases and patient care by pointing to the focused attention they were able to give the patient assessment task as compared to the practice settings where older physicians are tired, anxious, stressed, and carrying high cognitive loads. However, this explanation does not accommodate the laboratory studies in which more senior physicians’ implicit biases affected their patient judgments even when they responded in controlled, focused, low-cognitive load, research environments. In fact, Haider’s study more plausibly raises important questions about whether some aspect of American medical training contributes to the increased likelihood that younger physicians’ biases will influence their medical decision-making. Another study provides empirical evidence to shed light on this possibility.

Dr. Shelley White-Means studied implicit and explicit race and skin-tone bias among pre-professional medical, nursing, and pharmacy students at southern U.S. colleges. This longitudinal study followed students over three years, but the same students were not followed through the entire study. Researchers administered two IATs—the Race-Attitude IAT, and an IAT measuring skin tone preferences—annually during the study. Four findings are noteworthy. First, pre-professional students exhibited significantly higher levels of pro-white bias than test takers in the nation as a whole. Remarkably, 94% of non-Hispanic Whites, 100% of Hispanics, 76% of Asians, and 64% of black students tested revealed statistically significant

236. Haider et al., supra note 233, at 945.
237. Id. at 943-44.
238. Id.
239. Id. at 945-946.
240. Id. at 946.
241. Id. at 947.
244. Id. at 439-40. Technically, because this study did not follow the same students over the three-year period, it is a cross-sectional, rather than longitudinal, study.
245. Id. at 440-41.
246. Id. at 447.
unconscious preferences for whites over blacks. Interestingly, some mean race IAT scores varied by professional school and race of the respondents. For example, third- and fourth-year black pharmacy students indicated an implicit preference for blacks, and Asian medical students exhibited the strongest preference for light over dark skin tones. Second, the students’ implicit bias scores were negatively correlated with their self-reported levels of cultural competency. Thus, these health profession students confidently believed themselves to be effective communicators in cross-cultural situations, despite their IAT scores to the contrary. Third, students’ race bias did not change significantly across the three graduate years; however, a slight increase in pro-white bias among older medical students may have reached statistical significance if more third- and fourth-year medical students had participated in the study. Finally, the study found a correlation between students’ socio-economic status and their implicit bias scores. The participants’ implicit race bias scores were significantly lower when students reported their backgrounds included personal experience with economic deprivation. In summary, the White-Means study lays the foundation for further exploration of the differences in racial and ethnic and racial bias across the health professions, and of the impact that medical education has on health providers’ implicit attitudes.

4. Physician Biases Affect Patient Communication and Post-Clinical Adherence

Implicit bias has an impact beyond the physician’s clinical decisions. Bias also affects the interaction and communication physicians have with their patients, as well as their patients’ responses to these clinical encounters. Dr. Lisa Cooper studied 40 primary care physicians and over 260 of their patients to determine the influence that physicians’ implicit biases may have on patients. After audio-taping clinical office visits, Dr. Cooper administered a survey to patients following the doctor’s meeting, and two IATs, to the physicians. Using linear and logistic regression analysis, Dr. Cooper identified two important influences. First, Dr. Cooper found that greater physician bias was associated disparate communication styles and content. Physicians with higher IAT (pro-white) scores had longer, slower conversations with black patients, in which the doctors were more verbally dominant. Physicians with higher IAT scores had shorter, more rapid dialogue with white patients, in which the physician was less verbally dominant and presented a more...
positive affect. Higher IAT scores were also associated with less patient-centered communication content with black patients than with white. Dr. Cooper’s second finding confirmed an association between high physician IAT levels and negative patient ratings of trust and confidence in the clinician for black patients, but largely positive patient ratings for white patients. While the communication differences these researchers observed may be subject to different interpretations, the patient responses to implicitly biased physicians were clearly negative for black patients, and generally positive for whites. Dr. Cooper points out that greater patient trust is empirically associated with patient adherence and continuity of care, underscoring the harm that poor physician-patient communication will likely have on minority patients’ health outcomes.

In 2010, a group of social psychologists led by Dr. Louis Penner further examined the responses that minority patients may have to implicit biased physicians. These researchers used the term “aversive racism” to explore how implicit and explicit racial bias interact during the communication exchange between physicians and their minority patients. An aversive racist describes the individual whose implicit and explicit bias measures present a contradiction; they score very low on explicit bias measures, but very high on implicit bias tests. Not only does the aversive racist deny expressly racist views—in fact, this person explicitly and perhaps even emphatically disapproves of racial bias in others. At the same time, this person also unconsciously holds attitudes informed by racial prejudice and stereotypes.

Penner’s group examined the effects of implicit and explicit bias on physician-patient relationships in a study of fifteen primary care physicians and one-hundred fifty of their African-American patients at an inner city clinic. The study evaluated the level of teamwork and cooperation black patients felt with doctors who demonstrated high anti-black implicit bias on their IATs. Penner’s findings are troubling. African-American patients in this study reacted most negatively towards physicians who met the criteria for an aversive racist, relative to all other combinations of implicit and explicit physician bias. According to Penner, African-Americans trust these physicians least of all physicians, perceiving a lack of trust,

258. Id. at 981.
259. Id.
260. Id. at 983.
261. Id.
262. Id.
264. Id. at 436.
265. Id. at 437.
266. Id. The physicians Dr. Penner studied were almost all non-black, foreign trained doctors, a typical demographic profile for inner city providers who serve poor communities of color. Id. This lack of diversity among physicians was a limitation of the study. See id. Also, because the participants in Penner’s study were volunteers, not randomly selected, they were not a representative sample of the health care provider or patient community. Id.
267. Id. at 436-37.
268. Id. at 439.
friendliness, and teamwork in their relationships. Together, the Cooper and Penner studies reasonably point to the disconcerting expectation that black patients are unlikely to accept medical advice, adhere to treatment regimes, or schedule and attend follow-up visits with implicitly biased physicians, especially if those doctors profess low explicit racial and ethnic biases.

The Schulman, Green, and Sabin studies lay a strong foundation for understanding how physicians’ implicit racial biases lead to disparate medical treatment and health outcomes. Dr. Schulman identified race and gender as influences that affect physicians’ treatment decisions, while Dr. Green provided evidence showing the correlation between doctors’ unconscious racial biases and their treatment decisions. Notwithstanding the cautionary note sounded by Dr. Arber’s non-findings, the link between unconscious racism and disparate treatment cannot be ignored. Dr. Sabin’s study refines this correlation, showing that biases and their impacts will vary with different types of physicians, maladies, and patient groups. The Haider and White-Means studies add another nuance to suggest the strong influences that biases have over communication as well as medical decision making during the course of medical training, and Drs. Cooper and Penner point to the substantial impact that doctors’ aversive racism may have on minority patients’ trust, confidence, and adherence to treatment regimens during and after the clinical visit. The results from Dr. Moskowitz’s study show how bias can lead to erroneous statistical judgments and compromise the quality of care a doctor provides to an individual minority patient who does not fit the generalizable data. The picture of harm that emerges from these data is serious and has been tolerated for far too long. The data that follow provide the necessary basis for principled application of anti-discrimination law to radically shift the paradigm that, to date, has tolerated disparities due to unconscious discrimination in health care.

5. Physician Implicit Biases Contribute To Health Disparities

The evidentiary record reviewed in this section demonstrates that physicians’ implicit biases cause inferior health outcomes, and thereby contribute to racial and ethnic health disparities. Physicians’ implicit biases enter the examination room, clinical office, and even the operating room. Implicit biases distort physicians’ interpretation of objective patient data and information. As a result, physicians unintentionally provide inferior treatment to minority patients, and minority patients consequently suffer inferior health outcomes. Moreover, implicit biases influence physicians to provide inferior health information to minority patients, exacerbating those disparate health outcomes. Finally, physicians who hold high pro-white biases communicate less effectively with minority patients, and minority patients respond in kind. Especially where the physicians are characterized by high measures of implicit bias accompanied by low explicit bias, minority patients perceive unintentional racism, which inhibits their adherence and care seeking. Dr. John Dovidio explains that taken together, these disparities in diagnosis, treatment, and patient communica-
tion affect “patient recall of medical information, treatment adherence, patient satisfaction, and health outcomes.” Together with some of the nation’s leading health and health care social scientists, Dovidio plainly asserted a the causal link between physician implicit bias and health disparities stating:

We believe, however, that sufficient data do exist to conclude that subtle racism is a significant contributor to health care disparities . . . . We acknowledge that health care disparities may be caused by a variety of factors, including system level factors, outside of medical interactions. Nevertheless, we contend that efforts to reduce the impact of prejudice and stereotyping in patient-provider interactions can help to reduce racial disparities in health by improving the quality of care for racial and ethnic minority groups. Indeed, studies have shown that when treatment disparities are eliminated, disparities in health outcomes are substantially attenuated or absent.

Having established the causal connection between physicians’ implicit bias and minority patients’ poor health outcomes, the next step is to determine what can be done to eliminate diagnosis, treatment and communication disparities. The next section introduces a crucial body of social science research that has garnered very little attention in the legal literature. I believe the evidence that physician implicit biases are malleable—subject to deliberate control and influence—is the essential missing piece of the puzzle that will allow law- and policy-makers to act to eradicate the ubiquitous influence of unconscious discrimination in health care.

III. Malleability

Over the past quarter century, social scientists have amassed a copious body of empirical research documenting the evidence that Americans overwhelmingly and subconsciously hold negative stereotypes about blacks and other minorities. The empirical evidence moreover confirms that though these implicit attitudes are unconsciously held, they powerfully direct judgments and conduct so that most Americans act in accord with their implicit biases, even if these attitudes are directly contrary to their expressly egalitarian views on race. The evidence that implicit biases are associated with harmful discrimination is overwhelming. Yet, convincing calls for legal reform to address modern forms of racial discrimination have gone largely unheeded. I believe this lack of legal uptake is because most legal literature assumes that discrimination due to implicit biases operates automatically, and that without intent or conscious awareness, such bias is also unavoidable, intractable, and beyond conscious control. None of these assumptions are correct.

271. Id. at 481-82.
272. See, e.g., Sabin et al., supra note 144, at 896-97.
273. Id.
The prevailing narrative about unconscious racism wrongly assumes its inevitability. Thus, when confronted with academic proposals to make law responsive to serious harms caused by implicit bias, jurists have stumbled over their understanding that the discrimination, no matter how deadly or unjust, is outside the control of the discriminators; they have struggled with the idea of holding one responsible for actions they do not intend to commit or injuries they did not intend to cause. Perhaps the truth concerning implicit biases’ susceptibility to intentional external and internal influences has been ignored because it challenges a comfortable absolutist narrative that permits courts and others to wink at the fact that implicit biases produce the most virulent and complex forms of racial discrimination. The scientific evidence of malleability should result in no less than an upheaval in this complacency. The next section of this Article introduces the empirical evidence that unconscious racism, though ubiquitous, is neither inaccessible nor uncontrollable, and its influences are not inescapable.

A. Empirical Evidence of Malleability

Social scientists have been developing the body of empirical evidence that shows implicit biases are malleable for more than two decades.275 The empirical record now offers strong evidence that implicit attitudes are neither inaccessible nor inescapable; they are not impossible to control, and they are not out of reach. Implicit associations can be influenced both by the individual who unconsciously holds these stereotypes and prejudices, and by external influences. Researchers have reported and reviewed between forty276 and fifty277 studies that demonstrate unconscious implicit attitudes are responsive to deliberate individual choices, to external changes in environment, and to the general social acceptability of the stereotype or prejudice. Although implicit biases evolve from social knowledge acquired slowly and over a lifetime, they are not impervious to change. The evidence reveals that learning can continue to take place and alter social knowledge even after initial attitudes and associations are formed. Just as one may have subconsciously incorporated bad habits into driving behavior over many years, yet alter those driving habits later on, so one may alter his or her implicit biases. Driving may improve when a person chooses to pay attention, either of their own accord or because of external influences—say, new rules of the road, prosecution for reckless driving, or attending a driver’s education class. Implicit biases can change for similar reasons. Thus, malleability describes an ongoing learning process in which people with old, objectionable implicit biases can learn to


277. Blair, supra note 14, at 244.
respond to newer, more appropriate attitudes and beliefs. Put another way, longstanding and unconscious thinking and behavior can change.

This understanding of malleability is called the “connectionist” model of implicit bias. Unlike the prior notion that implicit associations were static and inaccessibly fixed “things,” the empirical record reveals that stereotypes and prejudicial beliefs to which we may adhere at any given time are “states” of thinking that form based on past experiences and inputs, but that may be revised depending upon current informational inputs gathered and weighed with each new encounter. This flexible view of stereotyping replaces an outdated, rigid view, and allows for the evidence that individuals can constantly update the stored knowledge that produces implicit biases. Psychologists explain that “stereotypes are quite elastic and, thus, any individual could hold an infinite number of representations of social category’s members, when viewed across time and place.”

In other words, “a stereotype is a pattern of activation that, at a given point in time, is jointly determined by current input (i.e., the context) and the ... weight[]” of the new information’s connection to existing and underlying beliefs.

Early demonstrations of implicit biases focused on their automaticity—the fact that individuals made associations from stored knowledge to present day people and situations without any awareness that these associations were being made, much less that the associations were responsible for directing their conscious conduct and choices. Researchers formerly concluded that automaticity meant inevitability, reporting that “[a] crucial component of automatic processes is their inescapability; they occur despite deliberate attempts to bypass or ignore them.” However, for more than two decades, researchers have collected a strong record to contradict the early understanding. These views have been replaced by what one social scientist has called “the now-bountiful evidence that automatic attitudes—like self-reported attitudes—are sensitive to personal, social, and situational pressures.” Further, “[t]he conclusion that automatic stereotypes and prejudice are not as inflexible as previously assumed is strengthened by the number and variety of demonstrations (nearly 50 in all), the fact that the tests were conducted in the service of many different goals, and by the similarity of findings across different measures.”

The importance of this understanding of malleability to anti-discrimination efforts cannot be overstated. First, it demonstrates that interventions may be strategically introduced to alter implicit biases, and we can now say that implicit biases and their resulting discrimination may be reduced. When referring to the ability to “reduce” implicit biases or stereotypes, I mean that current inputs can be adjusted so that the resulting stereotype patterns no longer conform to traditional discriminatory

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278. Andersen et al., supra note 126, at 142.
280. See id.
282. Blair, supra note 14, at 256.
283. Id. at 254.
or inequitable stereotypes, but instead lead to more equitable judgments and conduct. Furthermore, the research underlying the connectionist model has also provided important insights concerning several intervention methods available to individuals and institutions wishing to mediate the discriminatory impact of decisions and conduct informed by implicit biases. Finally, by demonstrating that even automatic and subconscious biases are within reach and control, researchers have provided a sound basis for holding individuals and institutions responsible for reducing the discriminatory impact of implicit biases.

B. Evidence that Interventions Reduce Implicit Biases

The social science literature includes several studies of a wide variety of intervention strategies that have been tested for their efficacy in reducing implicit biases. Borrowing from the work of sociologists, I organize the interventions shown to be most effective and that have the clearest practical application into three categories that I call “Type A,” “Type B,” and “Type C” interventions, based on the timing of each intervention. Figure 2 demonstrates when each intervention occurs during the cognitive process.

![Figure 2. Three Types of Interventions to Reduce the Impact of Implicit Bias](image)

<table>
<thead>
<tr>
<th>Store</th>
<th>Identify</th>
<th>Retrieve</th>
<th>Activate</th>
<th>Form</th>
<th>Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Group</td>
<td>Membership</td>
<td>Stereotypes</td>
<td>Triggered</td>
<td>Implicit</td>
<td>Judgments, Decisions, and Conduct</td>
</tr>
</tbody>
</table>

Type A methods reduce implicit biases by intervening before stereotypes are subconsciously activated. This category includes distraction methods aimed at increasing the cognitive busyness a person experiences so that the encounter with stimuli that invokes automatic negative stereotypes is less direct and prolonged. Type A also includes a priori training that seeks to negate stereotype activation. This is the most effective of the Type A interventions discussed in the social science literature. Type B interventions are introduced after stereotypes are activated, but before implicit biases are formed. This second method depends on heterogeneity within the activated automatic stereotype in order to contradict the older learned patterns of categorization, with newer, contradictory examples. Type C interventions describe methods introduced after implicit biases are formed but before the biases influence judgments and behavior. Suppression campaigns, such as a “Just Say No” approach, fall into this category, and are notoriously ineffective. However, other Type C methods that alter individual and social motivations do work to reduce the discriminatory impact of

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284. See supra Part II.A.
implicit biases. I next review sample experiments that demonstrate how each type of intervention works.

1. Type A Intervention: Stereotype Negation Training

Researchers have demonstrated that stereotype negation training can significantly reduce the automatic activation of stereotypes. As early as 1989, psychologist Patricia Devine performed a series of three studies that demonstrated that automatic racial stereotypes and prejudices against blacks could be controlled and ultimately changed by an individual’s willingness to invest the “intention, attention, and time.” Dr. Devine demonstrated that negation training could effectively inhibit automatically activated attitudes and beliefs, and replace them with non-prejudiced ideas and responses. Her explanation of the change process succinctly describes the premise underlying stereotype negation training:

Inhibiting stereotype-congruent or prejudice-like responses and intentionally replacing them with non-prejudiced responses can be likened to the breaking of a bad habit. That is, automatic stereotype activation functions in much the same way as a bad habit. Its consequences are spontaneous and undesirable, at least for the low-prejudice person . . . . Elimination of a bad habit requires essentially the same steps as the formation of a habit. The individual must (a) initially decide to stop the old behavior, (b) remember the resolution, and (c) try repeatedly and decide repeatedly to eliminate the habit before the habit can be eliminated. In addition, the individual must develop a new cognitive (attitudinal and belief) structure that is consistent with the newly determined pattern of responses.

Devine’s description of the methodological principles that make stereotype negation training effective distinguishes this training from cultural competency programs currently in use throughout the American health care system. Cultural Competency programs typically provide episodic exposure to factual information about health disparities and minority communities. These curricula encourage “colorblindness” or suppression of anti-group attitudes in order to achieve equality of care, and often can have a disappointing “rebound” effect, making prejudice more,

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285. Devine, supra note 15, at 16 (finding that low-prejudice individuals chose non-prejudiced thoughts to record, in contradiction to a list of stereotypes about Blacks they had earlier generated).
286. See id.
287. Id. at 15.
289. See, e.g., Office of Minority Health, A Physician’s Practical Guide to Culturally Competent Care, U.S. DEP’T OF HEALTH & HUMAN SERVS., https://cccm.thinkculturalhealth.hhs.gov/ (last visited Feb. 14, 2013). This is a website that offers several certificate courses for health care providers to learn cultural competency. It provides an interactive online course that took me approximately 2 hours to complete. It contained important and accurate data about health disparities, case studies followed by “self-exploration” questions that ask the responder’s feelings, and aspirational goals for “respectful” and “equitable” care. See id. The training includes no mention or address of implicit biases or automatic stereotypes, prejudices, beliefs, or attitudes of any kind. See id.
rather than less, likely. Such methods are aimed primarily at affecting explicit, rather than implicit, biases and prejudices. As a result, the effectiveness of cultural competency programs has been mixed, at best. Stereotype negation aims instead to remove and replace automatic, implicit, subconscious attitudes and beliefs through repeated exposure to new structural models of association. Studies show this method works to reduce and replace implicit biases. One group of social scientists conducted a series of experiments in which participants were asked to associate stereotype words with images of skinheads and African-Americans before and after negation training. These researchers theorized that just as negative stereotypes are learned through repeated exposure, introducing repeated training to denounce stereotypes and replace old automatic attitudes with newly learned ones could reduce automatic activation of negative stereotype traits. It worked: participants in their studies who received extensive stereotype negation training were able to reduce stereotype activation and the reduced effect was still clearly visible 24 hours following the training session. "[T]hese findings provide support for the assumption that with instruction and repetition, individuals can become adept at responding negatively to stereotypes. In short, practice does make perfect—or at least very good—stereotype negotors."

A later study demonstrated similarly effective outcomes using live student participants. This study involved two quasi-experiments that followed college students enrolled in a prejudice and conflict seminar. Control group students were enrolled in a research methods class. The researchers used the IAT to measure implicit preferences, as well as the Lexical Decision Task (LDT) test, to measure automatic stereotypes. The researchers measured students’ implicit biases twice: at the begin-
ning of the semester and at the end of the semester.\textsuperscript{301} During the semester, the students underwent stereotype negation training, including: (1) journaling exercises that required students to document and discuss their own biases, motivations for bias, and ways to counteract their biases, (2) pro-social contact with members of other racial and ethnic groups, including an African-American male professor, and (3) discussion that focused on personal views and experiences, which sometimes resulted in heated exchanges among students, but allowed them to encounter, share, and process personalized experiences, as well as information about prejudice.\textsuperscript{302} The researchers found that training significantly reduced both implicit and explicit anti-black biases—at the end of the two experiments, students in the prejudice and conflict seminar showed significantly lower implicit and explicit anti-black biases, as compared to control group students.\textsuperscript{303} Although this sample of the leading studies on stereotype negation training is admittedly not exhaustive, it does demonstrate that social science research supports the conclusion that individuals who exhibit “automatic,” implicit racial biases and prejudices can be trained to think and behave differently.

2. Type B Intervention: Promoting Counter-Stereotypes

Increasing the accessibility of counter-stereotypes decreases automatic negative stereotype associations.\textsuperscript{304} In one study, researchers repeatedly showed participants photographic images of famous and admired blacks such as Martin Luther King or Denzel Washington, and photographs of infamous and disliked Whites, such as Charles Manson, to achieve significant reductions in automatic preferences.\textsuperscript{305} The researchers in this study concluded with the observation that while exposure to admired and disliked group member produced substantial changes in automatic, implicit attitudes, the evidence suggested little change in explicit biases.\textsuperscript{306} These are useful findings that have been replicated by other scientists studying race,\textsuperscript{307} gender,\textsuperscript{308} and age\textsuperscript{309} implicit biases. Although the application for the studies discussed in this Article relates to race and ethnicity bias, the evidence that Type B interventions work to counter other stereotypes is instructive. Indeed, the practical importance of this counter-stereotype research becomes most plainly apparent when
the experiments move from controlled laboratory settings, into actual “real life” field settings.

In a longitudinal study of the impact that counter-stereotypes have on gender biases, researchers tested whether exposure to women in positions of leadership on a college campus changed female students’ implicit gender biases. One of the two experiments in this series was conducted in a laboratory, while the other took place on the campuses of coeducational and women’s colleges. In the first study, female participants were exposed to biographies and photographs of high profile women in leadership positions. Women in a control group were shown descriptions and pictures of a variety of flowers. The participants then completed gender-IATs to measure their implicit biases. The study showed that exposure to admired members of a disadvantaged group—women—positively affected automatic attitudes and beliefs about members of that social group. In the second study, fifty-two college students from two campuses were asked to complete identical gender-IAT studies. These participants were also asked to describe their course load, extracurricular activities, and role models on campus. In contrast to the group in the first study, the researchers sought to discover the effects of exposure to counter-stereotypes in the students’ everyday lives. Women occupied leadership and counter-stereotypical positions—such as deans, math and science professors, and college presidents—at the all-women’s college more frequently than they did at the co-educational school. The students were followed a year after their initial study to see how their stereotypes and prejudices had changed. At the end of both studies, the scientists concluded: “Both the laboratory study and the field study reported in this paper converge on the same message—women’s automatic stereotypic beliefs about their ingroup can be undermined if they inhabit local environments in which women frequently occupy counter-stereotypic leadership roles.” The findings with respect to environmental cues were especially important, as the researchers found that academic environments that exposed students to female leaders not only reduced automatic stereotype beliefs about women, but also showed a long term, positive effect that increased over time, “underscor[ing] the power of local environments in shaping women’s nonconscious beliefs about their ingroup.” In addition, these gender-bias studies replicate results
seen in other controlled laboratory settings demonstrating the malleability of implicit race-bias. 323

In another approach to presenting counter-stereotypes, researchers have found that both still and video images work to reduce implicit biases. 324 Photographs of an admired black, elderly, or female subject or videos showing counter-stereotypic conditions can effectively reduce automatic stereotyping. 325 In one study, some participants watched a short video of African-Americans enjoying a family barbecue or attending church, while other participants saw videos of blacks in gang-violence scenes. 326 Participants who had watched the first videos demonstrated significantly lower implicit preferences for whites when compared to participants who had watched a video of blacks engaged in anti-social stereotypical activities. 327 Researchers concluded these experiments demonstrated that automatic group biases and stereotypes, “commonly thought to be fixed and invariant, are in fact sensitive to changes in the situational context.” 328

The next series of experiments are remarkable, because they show that individuals can reduce their implicit biases by what they choose to think. “Imagining” is a variant on the use of counter-stereotypes based on an individual’s ability to think up their own counter-stereotype images. 329 Dr. Irene Blair performed five experiments to test whether an individual who focuses attention on creating a counter-stereotypical mental image of a strong and capable woman can effectively reduce their own access to automatic stereotypes and alter the implicit associations that direct judgment and behavior toward women. 330 In three of the five experiments, researchers asked undergraduate students to spend several minutes imagining what a strong women is like, including her hobbies, what she is competent at doing, and other features that came to mind. 331 The students reported that they had no difficulty developing mental images of counter-stereotypes, which included a businesswoman, an athlete, a warrior, or simply a woman who balanced family, career, and friends well. 332 A control group was asked to spend the time thinking about neutral images, such as a Caribbean vacation. 333 Participants then took gender-IATs to measure the speed of their associations with words and pictures that contradicted stereotypes about women (e.g., strong, leader, muscular, in charge) and with words

323. See, e.g., Blair, supra note 14.
325. Wittenbrink et al., Spontaneous, supra note 324, at 818.
326. Id. at 817.
327. Id. at 820.
328. Id. at 823.
329. Blair et al., Imagining, supra note 308.
330. See id. at 249.
331. See generally id.
332. Id. at 830-33.
333. Id.
334. Id.
and pictures that were consistent with gender stereotypes (e.g., feminine, weak, dainty, quiet). The results of the first three experiments demonstrated that mental imagery moderates implicit stereotypes, reducing their impact on judgment and behavior. In their remaining two experiments, this research group tested the strength of their results using measures of implicit bias other than the IAT. Overall, Dr. Blair’s group concluded that their five experiments provided “compelling” evidence that imagining counter-stereotypes “substantially diminished” implicit stereotypes. Further, these five experiments, “in combination with prior research, suggest that both implicit and explicit stereotypes are responsive to current inputs, including the perceiver’s thoughts and social context.” The implications for this research, which show that Type B counter-stereotypes reduce implicit biases, are profound. They empirically demonstrate that whether the counter-stereotypes are provided externally or self-generated by deliberate imagining, it is possible to intervene, interrupt, and reverse the impact that unconscious biases have on a person’s judgments and their conduct. Therefore, it logically follows that individuals and institutions can intentionally employ counter-stereotypes to reverse the impact that implicit biases have on their unintentional discrimination.

3. Type C Intervention: Social and Self-Motivation

Researchers have repeatedly confirmed that individuals who are highly motivated can modify their automatic responses to implicit stereotypes and prejudices. Type C interventions are particularly interesting because they operate even after an individual has unconsciously activated their long-standing biased attitudes and beliefs. From a law and policy perspective, these interventions are intriguing, because they do not require any change in a person’s memory in order to be effective; thus, they avoid what implicit bias critics have called “the perils of mindreading.”

The classic example of Type C intervention arises when a research subject self-corrects to meet the expectations of the researcher. For example, people show less automatic negativity and give more favorable racial responses about blacks in the presence of black experimenters. Beyond this one-on-one example, other researchers have shown that individuals who deliberately work to internalize egalitarian norms communicated from the environment around them can display lower levels of implicit prejudice. This is a second category of Type C intervention. In a particu-
larly insightful series of studies, Drs. Gretchen Sechrist and Charles Stangor manipulated participants’ sense of whether their views were approved or disapproved by peers, finding that when participants learned that their unconscious use of automatic stereotypes served to discredit them, their interest in a positive self-image motivated them to inhibit their unconscious stereotypes. These experiments demonstrated the powerful influence that perceived social consensus can have on reinforcing or dismantling implicitly held race stereotype. They further showed that social consensus can reinforce or diminish students’ resulting negative racial behavior. The policy implications of these studies are profound, and therefore, the details of the Sechrist and Stangor’s two experiments bear detailed discussion.

In the first experiment, these researchers tested white students enrolled in a university’s introductory psychology class at the beginning of a semester to determine whether they held high or low explicit anti-black preferences. Next, students were grouped according to their explicit preferences, and those groups were randomly assigned to receive feedback indicating either that 81% of university students agreed with their preferences, or that only 19% of students agreed. This feedback signaled the level of social consensus around the subjects’ explicit views on race. Experimenters then asked each student individually wait in the hallway with an African-American student, who was ostensibly waiting to speak to the experimenter about participating in the study, but was really a confederate. This phase allowed researchers to observe the effect that weak and strong stereotype consensus had on students’ behavior.

In the hallway, the students found a line of seven chairs—one of which was occupied by the confederate—and the researchers watched how closely each student chose to sit next to the confederate. Researchers reviewed the students’ interaction with the black student, comparing students with low-prejudice and high-prejudice, and those who had received either low-consensus or high-consensus feedback. In addition, during the wait, they asked students to predict the percentage of African-Americans who possessed favorable stereotypical traits such as “fun-loving” or “hard-working,” and what percentage of blacks shared negative stereotypes such as “irresponsible” or “violent,” or “hostile.”

The results demonstrated that the white students’ negative race prejudices were weakest when participants perceived low social consensus on their negative views,
but that prejudices were strengthened by perceived high consensus. Moreover, the results reflected the impact that stereotypes have on conduct. Low-prejudice participants who received high consensus feedback sat closer to the African-American confederate, whereas individuals who thought their low prejudice beliefs were out of line with the consensus tended to sit farther away. Conversely, high-prejudice individuals in the high-consensus group sat farther away from the African-American confederate than high-prejudice individuals in the low-consensus group. In addition, high-prejudice individuals in the high-consensus group estimated higher percentages of blacks held unfavorable stereotypical traits when compared with the students whose negative race views were not validated by consensus.

The second experiment tested the accessibility of the automatic stereotypes that were triggered by priming. As in the first experiment, researchers asked students to identify their beliefs by indicating the percentage of African-Americans who possessed positive and negative stereotypical traits, and then the students were provided feedback that randomly showed their views were broadly shared or contradicted by their peers. In the next phase, students were exposed to names frequently associated with blacks (e.g., Tyrone, Latisha) and with whites (e.g., Ryan, Amanda), and they were asked to indicate whether the individuals were black or white on the basis of their names. Then, using the LDT test to measure implicit biases, researchers assessed students’ reaction times: first, a priming stimulus quickly flashed on the screen (the word “black,” the neutral word “chair,” and a neutral nonword “xxxxx”); second, one of seventy-two target stimuli randomly appeared on the screen, including traits that are stereotypic of African-Americans, traits that are not stereotypic of African-Americans, and nonwords. The researchers found that students who perceived their individual prejudices were validated by consensus more quickly identified words that were stereotypes of African-Americans, and responded faster to stereotypes than to nonstereotypes. The researchers conclude their two experiments lend support to the hypothesis that “intergroup beliefs and behaviors are determined by the perception that those individual beliefs are or are not shared with others.” Moreover, both experiments demonstrate that perceived consensus not only influences accessibility of implicit attitudes and cognitions, but also changes discriminatory expression of explicitly held stereotypes and beliefs.

Studies of Type C interventions offer three important insights. First, individuals can inhibit negative stereotypes and activate positive ones when doing so is beneficial

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353. Id. at 649.
354. Id.
355. Id.
356. Id. at 648-49.
357. Id. at 649.
358. Id.
359. Id. at 649-50. The purpose of this exercise “was to be certain that participants would associate the prime of black to be used in the subsequent lexical decision task with African Americans . . . .” Id. at 650.
360. Id.
361. Id.
362. Id. at 651.
363. See id.
to their self-image and responsive to social demands or relationships. Second, social context can produce the requisite motivation to achieve these modifications. Third, powerfully influential changes in social context can result from externally influencing the extent to which individuals believe consensus with peers confirms or contradicts anti-social stereotypes.

4. Limitations

While the evidence that implicit biases can be affected and even reduced by interventional strategies is promising, there are some important qualifications to note. First, none of the studies suggest that implicit biases can be reduced to zero. Thus, malleability strategies do not promise to entirely eliminate implicit biases or their effects. Because we cannot precisely quantify the health or other disparities that flow from the implicit bias, the extent to which changing these attitudes will reduce discrimination is uncertain. Nevertheless, the malleability literature speaks collectively of significant reductions in implicit bias and in race-conscious behavior. Second, not all of the methods researchers have used to demonstrate the malleability of implicit bias are created equal. Some have no immediately obvious practical applications. Others are not sufficiently understood to warrant their inclusion in policy or law. For example, evidence that automatic prejudices decline when the features of a black person’s face change from “Negroid” (darker skin, wider nose) to European (lighter skin, pointier nose), are practically useless or would produce ridiculous, morally unsound and objectionable solutions to the implicit bias problem, if applied. Still other interventions may reduce some types of implicit bias within or toward some populations, but not all. For example, researchers do not yet understand the reasons that some interventions, which operate to reduce unconscious stereotypes by European Americans toward blacks, do not vary implicit prejudices among Asians. Other research may be theoretically important, though limited in its practical usefulness. For example, several studies have shown that when a person’s focus of attention is manipulated by distractions in laboratory experiments, that person will become “cognitively busy” and produce fewer stereotypical associations during experiments. The variety of distractions that could produce busyness, the variety of implicit biases that might be responsive to distractions, and the lack of field applications make this method one that has limited application for policy intervention.

The malleability literature has its detractors within the social science community. In a recent article, researchers from the University of Virginia appeared to attack the scientific record reviewed here to assert that the malleability of implicit racial bias is overestimated. In fact, the three experiments these scholars reported were limited to and sought to raise questions only about the counter-stereotype intervention method; their results were not nearly as robust as the title of their paper suggests.

364. See Lowery et al., supra note 342, at 851.
365. See Blair, supra note 14, at 244-47.
367. See id. at 139-43. Joy-Gaba and Nosek increased the number and types of exposures, as well as the
Other researchers have criticized malleability as unidirectional; they say automatic preferences are easily formed, but less readily reversed.\textsuperscript{368} However, their conclusion is contrary to the weight of the empirical record.\textsuperscript{369} Another group has asserted that declining IAT measures post-intervention are evidence of neither a changed mindset nor a guarantee that a decrease in discriminatory behavior will follow.\textsuperscript{370} They argue the non-individualized labels assigned to test photographs (such as “good” or “bad”) are ambiguous, and, therefore, the IAT results most likely reflect “extrapersonal associations” that precede the test and have nothing to do with implicit attitudes.\textsuperscript{371} However, even these critics admit that their objections, as far as they go, may recommend changes in the IAT methodology or algorithm, but do not counsel discarding the use of the IAT or its results entirely.\textsuperscript{372} Moreover, objections to the validity of the IAT require extraordinary evidence, as the IAT has been debated so extensively that one well-known and respected researcher has described the test’s validity as a “scientific certainty.”\textsuperscript{373}

5. Implications

The study of implicit bias presented here represents a challenge for the legal community, not only because it challenges the notion that racial bias is a thing of the past, and because findings of automatic racial preferences disturbs people’s convictions regarding their explicit attitudes and beliefs, but because now the evidence of malleability directly challenges the idea that prejudice due to implicit bias is beyond the reach of anti-discrimination law. Notwithstanding its limitations, taken as a whole, the malleability literature significantly adds to the current understanding of the extent to which individuals’ and institutions’ influences can address unconscious racism.

In summary, this section reviews a variety of intervention methods that have proven to be effective in reducing discrimination due to implicit and unconsciously held biases; these interventions are readily available to any individuals or institutions wishing to take serious steps to eradicate health disparities due to physician bias. Moreover, social scientists have drawn practical lessons from these studies that sug-
suggest a catalog of strategies to reduce implicit racial biases among physicians based upon the empirical evidence. For example, they caution that current programs, which focus on cross-cultural communication skills, will have limited effect on cognitive bias. They also advise that accusatory or “politically correct” messages are likely to backfire, whereas enhancing providers’ understanding of the psychology of implicit bias will encourage self-correction. Ideally, the most effective strategies might incorporate Type A training interventions along with Type B and Type C contextualizing strategies. The next salient question, of course, is whether the scientific evidence of malleability can inform the law pertaining to intentional and unintentional discrimination. I argue that it must.

Borrowing from the widely accepted method of improved medical-decision-making that physicians call “evidence-based medicine,” legal scholars have begun to recommend that evidence-based conclusions should also inform legal disputes and decision-making. Moreover, policymakers have proposed a systematic review of research to determine how complex empirical evidence can be realistically translated into social interventions. Both these insights will prove useful to reforming Title VI. Simply put, the best behavioral research teaches that unconscious racism can be intentionally reversed. Therefore, the preponderance of evidence on malleability warrants a complete re-conceptualization of the legal interventions that address and control unintentional racial and ethnic discrimination.

C. Malleability, Interventions, and Behavioral Realism

To date, the scientific evidence of malleability has played little part in the legal scholarship analyzing how the law might intervene to address discrimination arising from implicit biases. Correctly understood, malleability is the evidentiary and substantive core to address unconscious racism that legal jurists and analysts have sought. When Professor Charles Lawrence proposed the “Cultural Meaning Test” to replace the Supreme Court’s intentionality test under the Equal Protection Clause, he urged a new and more accurate way to think about racial discrimination. He argued for a doctrine that accounted both for the cultural and historical origins of racism, and for the nature of the injuries that even unconscious discrimination inflicts. Lawrence explained that racism is not only a crime—for example, when it is intentional—but racism is also a disease, and, as such, operates primarily as a public health

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375. Id. at 882.
376. Id. at 883.
379. Lawrence, supra note 19, at 378-81. The Cultural Meaning Test has gained little traction, but Lawrence’s article continues to be one of the most cited articles of all time. Among the many reasons for its lasting impact is the fact that it is lucid, even prescient, in its explication of unconscious racism and its impact.
380. See id.
problem, because "racism is in large part a product of the unconscious." The cure, Lawrence argued, was to jettison the false dichotomy that viewed unconscious or unintentional discrimination as constitutionally acceptable, but intentional discrimination as constitutionally unacceptable. Certainly, the evidence that intentional interventions can affect unconscious biases would have helped Lawrence to close this constitutional gap.

When Linda Krieger wrote of the lack of “fit” between the real world incidence of unconscious bias and the disparate treatment doctrine under Title VII, she complained that the analytical incoherence decreases the validity of anti-discrimination adjudication, increases litigation costs, discourages voluntary settlements, and “may exacerbate rather than reduce intergroup tensions.” Krieger proposed doctrinal adjustments, such as importing the two-tier distinction between willful and non-willful discrimination from age discrimination doctrine, to address race discrimination under Title VII. In a later article, psychologist Susan Fiske joined Krieger to urge courts to “get the social science right” in light of the “enormous body of research” that discredits judicial assumptions about the intentionality of human behavior incorporated in disparate treatment doctrines. However, the social science record they referenced made no mention of malleability. Similarly, when Barbara Flagg advocated that the doctrine of disparate impact be reformed to remove the assumption that “transparently white criteri[a] of decision[making]” represents a cultural norm; when Tristen Green proposed doctrinal reforms to focus on the interplay between individual discriminatory bias and organizational systems and structures; and when Susan Sturm proposed a regulatory structural approach to disparate treatment relying upon non-governmental intermediaries to act as change agents, none of these scholars wrote with the benefit of the insights on malleability. Yet, arguably, notwithstanding the strength of legal interventions scholars have already proposed, none could be implemented without the evidence presented here.

For example, David Oppenheimer’s proposal to introduce a negligence standard into disparate treatment jurisprudence seems to virtually cry out for data on malleability. Oppenheimer suggested liability for negligence should attach if an individual fails to act to prevent discrimination that he knows or should know is occurring,

381. Id. at 330.
382. See id. at 323-24.
384. Id. at 1166.
386. See generally id.
which he expects to occur, or which he should expect to occur. 391 Similarly, the malleability evidence directly addresses the Linda Krieger’s fear that a negligence regime without guidance from cognitive psychologists might result in over-compliance or under-compliance. 392 After observing the futility of courts’ search for “discriminatory motive or intent,” based on the faulty assumption that the most prevalent form of discrimination today is “motivational, rather than cognitive, in origin,” 393 Krieger wrote: “unlike other scholars who advocate a ‘negligence’ approach to employment discrimination, I suggest that additional empirical and theoretical work must be done before the contours of such a duty can be precisely defined, let alone crafted into practical and effective legal rules.” 394 Now, nearly two decades later, the empirical record that Krieger sought has developed. Malleability data provides an evidentiary basis to give content to the reasonableness standard of care that Oppenheimer’s proposal lacked and to fill the empirical void that gave Krieger pause.

On the other side of the discussion, scholars who have resisted the call to require anti-discrimination law reflect the prevalence of unconscious bias should not overlook the impact of evidence on malleability. Samuel Bagenstos questions whether courts could realistically undertake a holistic scrutiny of workplace dynamics. 395 According to Bagenstos, “insubordination theory” advocates had not articulated an “operating theory” to describe what kinds of unconscious bias should count as unlawful or improper, making it improper, if not impossible, for courts to penalize any behavior. 396 Amy Wax argues the cost of fixing unpredictable and unavoidable cognitive bias would be unproductively high. 397 Both Wax and Bagenstos point to the ubiquity and inevitability of implicit biases to argue that this brand of discrimination should be left unchecked. 398 Malleability evidence fundamentally challenges this premise.

The scientific evidence reviewed in Parts II and III of this Article provides abundant proof that anti-discrimination law must be refined to fit the empirically supported social science record that demonstrates how implicit and unconscious biases cause discrimination and harm. The scientific basis for distinguishing unconscious and implicit bias from intentional bias has eroded. In light of the evidence of malleability, the knowledge that individuals, as well as institutions, can take affirmative steps to intervene in and reverse implicit biases dissolves the notion that one who continues to act out of implicit racial biases lack culpability. While those who ignore the well-established and scientifically proven impact of their implicit racial biases may not be overt racists or bigots, neither are they free of moral, and arguably legal, responsibility to refrain from racial and ethnic discrimination. The evidence of malle-

391. Id. at 967-72.
393. Id. at 1164.
394. Id. at 1166.
396. Id. at 35, 40.
397. See generally Amy Wax, Discrimination as Accident, 74 IND. L. J. 1129 (1999).
398. See id. at 1135-46; Bagenstos, supra note 395, at 5-10.
ability exposes a false dichotomy between intentional and unintentional discrimination; perpetrators of both conscious and unconscious bias can take steps to reduce their discriminatory conduct. Both may justifiably be held accountable for their discriminatory behavior.

IV. TITLE VI—A RESPONSE TO THE NEW NORMAL

Title VI is an appropriate starting point to construct a legal response to the disparities that result from physicians’ unconscious ethnic and racial biases. This civil rights statute has historically been the weapon of choice in the struggle to achieve justice and equality in the American health care system. While Title VI is not the only legal tool amenable to addressing unintentional discrimination, it is one of the broadest civil rights statutes, and yet the Courts have most egregiously misconstrued its drafters’ original intent and application. Today, Title VI liability is limited to circumstances in which courts can identify intentional, purposeful discrimination to make a successful disparate treatment claim, or cases showing invidious pretext designed to shield an activity’s disparate impact. A generous interpretation of the Supreme Court’s restrictive construction of the law is that the Court has been stumped by the injustice of holding actors liable for discriminatory conduct they do not intend and cannot control. Alternatively, courts may fear the ubiquity of unconscious biases could require limitless liability rules, impossible to contain. On both counts, the social science record offers a sound evidentiary basis for addressing these concerns. Therefore, this section proposes two reforms to Title VI in order to align the law with the scientific record and with the true nature of modern discrimination. Both can be accomplished through a statutory amendment that, first, restores the private cause of action for disparate impact cases, and second, redirects courts in their substantive construction of the law.

A. Amending Title VI

The statutory language of Title VI must be amended to restore the law to its original purpose and scope. To combat the subtle and entrenched forms of discrimination described throughout this Article, Title VI must be subject to private, as well as public, enforcement. Restoring a private cause of action for disparate impact claims will empower the victims directly impacted by both conscious and unconscious racism to challenge policies and programs that harm them. Private enforcement will expand and improve the government’s ability to suss out discrimination due to implicit bias, the operation and effects of which may not be easy for government bureaucrats to discover. By its nature, unconscious racism may hide from plain view, but the victims of the otherwise inexplicable exclusion, barriers, or offenses that members of minority groups continue to experience will be able to bring unconscious racism to the government’s attention. Broader enforcement will also increase incentives for government contractors to employ interventions that reduce discrimi-

399. See supra Part I.
400. Id.
nation due to implicit bias. The majority of the statutory amendments needed to accomplish this change have already been proposed before Congress; however, this section also proposes additional language designed to squarely prohibit discrimination due to unconscious racism under Title VI.

Section 601 of Title VI should be amended to expressly provide that discrimination based on disparate impact is prohibited under the law. Section 602 should be amended to restore a private right of action to prosecute discrimination based on disparate impact, as well as discrimination based on disparate treatment, through civil litigation. Additionally, language is needed in both sections to fully incorporate the knowledge that scientists have amassed about preventing harms due to implicit biases or unconscious racism. Thus, Sections 601 and 602 should also include language that recognizes any failure to employ the scientifically proven methods available to reduce unconscious race bias may be prosecuted and penalized. Conversely, the statute should provide a defense for a defendant able to discharge the burdens of production and persuasion to show it acted reasonably to ameliorate the effects of unconscious racism, or that its challenged activity relates to and is necessary to achieve a substantial and legitimate non-discriminatory purpose. The amendments should allow recovery for a plaintiff who meets the burdens of production and persuasion to show, in addition to making out a prima facie case, that the defendant rejected an existing, less discriminatory practice or policy than the one challenged. Finally, the amended language should allow for compensatory damages in cases of intentional discrimination, punitive damages against nongovernmental entities in cases of intentional discrimination, and equitable remedies, including attorneys’ fees, in all other Title VI cases. In short, the plain language of Title VI should be amended to fully restore the recovery and relief that Congress has consistently intended, and to protect against the discriminatory injustice that Congress has historically deplored.

401. During the 112th Congress, the Senate Committee on Veterans’ Affairs considered but failed to enact a bill to amend Title VI. The proposed amendment, introduced on June 20, 2012, was titled S. 3322. See 158 CONG. REC. S4, 460-03 (daily ed. June 25, 2012) (statement of Sen. Sherrod Brown).

402. Section 601 of Title VI would read as follows:

(a) No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

(b) (1) Discrimination based on disparate impact with respect to a program or activity is established under this section if—

a. A Federal department or agency, or any person aggrieved, demonstrates that an entity subject to this title has a policy or practice with respect to the program or activity that causes a disparate impact on the basis of race, color, or national origin; and

b. The entity fails to demonstrate that the challenged policy or practice is related to, and necessary to achieve, the substantial and legitimate nondiscriminatory goals of the program or activity; or

c. A Federal department or agency, or the person aggrieved, demonstrates that a less discriminatory alternative policy or practice exists, and the entity refuses to adopt such alternative policy or practice.
1. Restoring the Public-Private Enforcement Model

The public-private litigation model has historically proved to be an indispensable weapon in the attack against subtle and complex racial discrimination.403 However, one seminal case in Title VI jurisprudence provides a vivid illustration of the importance and necessity of both public and private enforcement under this statute. In

(2) In this subsection, the term ‘demonstrates’ means meets the burdens of production and persuasion.

(c) (1) Discrimination based on disparate impact with respect to a program or activity is established under this section if—
   a. A Federal department or agency, or any person aggrieved, demonstrates that an entity subject to this title has a policy or practice with respect to the program or activity that causes disparate impact on the basis of race, color, or national origin; and
   b. The entity has failed to act reasonably in light of scientific evidence, to mitigate discrimination due to unconscious, implicit, or unintentional biases on the basis of race, color, or national origin.

(d) (1) Discrimination based on disparate impact with respect to a program or activity is established under this section if—
   a. A Federal department or agency, or any person aggrieved, demonstrates that an entity subject to this title has a policy or practice with respect to the program or activity that causes disparate impact on the basis of race, color, or national origin; and
   b. The entity has failed to act reasonably in light of scientific evidence, to mitigate discrimination due to unconscious, implicit, or unintentional biases on the basis of race, color, or national origin.

(e) (1) Discrimination based on disparate impact with respect to a program or activity is established under this section if—
   a. A Federal department or agency, or any person aggrieved, demonstrates that an entity subject to this title has a policy or practice with respect to the program or activity that causes disparate impact on the basis of race, color, or national origin; and
   b. The entity has failed to act reasonably in light of scientific evidence, to mitigate discrimination due to unconscious, implicit, or unintentional biases on the basis of race, color, or national origin.

(f) (1) Discrimination based on disparate impact with respect to a program or activity is established under this section if—
   a. A Federal department or agency, or any person aggrieved, demonstrates that an entity subject to this title has a policy or practice with respect to the program or activity that causes disparate impact on the basis of race, color, or national origin; and
   b. The entity has failed to act reasonably in light of scientific evidence, to mitigate discrimination due to unconscious, implicit, or unintentional biases on the basis of race, color, or national origin.

The following language would be added to the end of Section 602 of Title VI:

(b) Any person aggrieved by the failure of an entity to comply with section 601 may bring a civil action in any Federal or State court of competent jurisdiction to enforce such person’s rights and may recover equitable relief, reasonable attorney’s fees, and costs. The aggrieved person may also recover legal relief (including compensatory and, from nongovernmental entities, punitive damages) in the case of noncompliance that amounts to intentional discrimination.

(c) Nothing in subsection (b) limits the authority of a Federal department or agency to enforce section 601.

United States v. Fordice, the United States sued the governor of Mississippi, alleging that the State’s failure to dismantle its racially segregated public university system violated Title VI and the 14th Amendment. However, the United States only entered the lawsuit on a Motion to Intervene filed after black private citizens had initiated a class action lawsuit alleging violation of the 5th, 9th, 13th and 14th Amendments, 42 U.S.C. §§ 1981 and 1983, and Title VI. A close look at the tortured procedural history of that case reveals the importance of the public-private litigation model in prosecuting complex civil rights violations.

In 1969, the Department of Health, Education, and Welfare (HEW) filed suit against Mississippi, after its Title VI investigation had revealed persistent and entrenched segregation and after its administrative efforts to develop a satisfactory compliance plan failed. HEW refused to continue to fund Mississippi’s segregated school system under Title VI, and then wrestled with a recalcitrant Mississippi Board of Trustees of State Institutions of Higher Learning (the Board) over an eighteen-year period while the Board repeatedly resisted desegregation. The Board submitted complicated but ineffective compliance plans identifying new mission statements, intricate admissions and faculty hiring targets, and elaborate changes in their degree programs. At one point, over HEW’s objection, the Board defiantly implemented a compliance program that had been twice rejected by the government, and segregation continued. By the mid-1980s, ninety-nine percent of Mississippi’s white students were still enrolled in the state’s five white colleges, and seventy-one of the state’s black students still attended one of the state’s three segregated black institutions.

Ultimately, the private Fordice litigants prevailed in their challenge against the State of Mississippi for failing to desegregate its state university system nearly 40 years after Brown v. Board of Education. To be sure, the case did not yield a wholly untarnished victory for educational equality in Mississippi. Nevertheless, when Justice White wrote for the majority, his decision awarded the black citizens of

405. Id. at 717.
406. Id. at 723-24.
407. Predecessor to the Department of Health and Human Services (DHHS).
408. See Fordice, 505 U.S. at 722-23.
409. Id. at 722-23 & nn.2-3; Brief for the United States at 8-9, Fordice, 505 U.S. 717, Nos. 90-1205, 90-6588.
411. Id. at 724-25. In reading the Fordice cases, one is struck by the correctness of Professors Ralph Banks’ and Richard Ford’s call for focus on the alleviation of the substantive educational, housing, and employment inequalities that plagued Mississippi long before black students applied for admission to the state’s white universities, notwithstanding the professors’ misunderstanding of the social psychology behind the IAT and their misguided understanding of the importance of addressing subconscious bias in the pursuit of equal civil rights for ethnic and racial minorities. See generally Banks & Ford, supra note 152.
412. Fordice, 505 U.S. at742-43.
413. The Fordice case has been widely and justifiably criticized for failing to equalize funding for Mississippi’s historically black universities. See generally, e.g., Alex M. Johnson, Jr., Bid Whist, Tonk, and United States v. Fordice: Why Integrationism Fails African-Americans Once Again, 81 CALIF. L. REV. 1401 (1993) (arguing that, based on an understanding of American history, the only appropriate result in Fordice should.
Mississippi the integrationist goals they and HEW had fought together to obtain through over twenty years of litigation. Reaching this outcome took the combined effort of public and private litigators; whatever may be said about the court’s refusal to fund Mississippi’s historically black institutions in that decision, there can be no doubt that the desegregation objectives would not have been possible without the work of private black litigants pursuing disparate impact claims directly to enforce Title VI. *Fordice* also teaches that the return of private enforcement alone will not be sufficient to address the complex forms of contemporary discrimination that persist in American society. Mississippi officials in that case might have responded more quickly to eliminate racial injustice if, under the law, they also bore the burden to take reasonable steps to address the racial inequality that resulted from biases that school officials held unconsciously.

As the *Fordice* case demonstrates, and as history has proved, the goal of achieving equal civil rights for racial minorities in this country is a “long game.” Resistance—indeed outright opposition to equality goals—are complex and potent. Public enforcement provides institutionalized stamina but often lacks the personalized commitment that private attorneys general bring. Moreover, when the rights at issue belong to underrepresented minorities, as in the context of health care injustice, public enforcement may wane without the incentive to serve a politically powerful interest group. On the other hand, private enforcement alone is often sporadic and under-resourced. When Title VI was enacted, Congress recognized that the fight to eliminate inequality in health care is too weighty a goal to resign to administrative enforcement alone. For these reasons, I recommend a return to the enforcement regime Congress originally contemplated in promulgating the Civil Rights Act of 1964. This is the goal of including a negligence standard of care under Title VI.

2. Introducing a Negligence Standard of Care

David Oppenheimer was first to comprehensively explore applying a negligence standard to antidiscrimination law when he argued to reform Title VII doctrine. In his apologetic for the recognition of a claim against employers who fail to take all reasonable steps to prevent discrimination in the workplace, Oppenheimer argued convincingly that much of the Supreme Court’s anti-discrimination jurisprudence already incorporated the underlying principles of negligence law without expressly acknowledging the claim. The same is true in the Title VI cases. In *Floyd v. City of New York*, for example, a class of black suspects survived a motion for summary

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414. See *Fordice*, 505 U.S. at 742-43.
415. See *Note, Finding a Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439 (2011) (arguing that a private cause of action should be implied under Title VI from the PPACA).
417. See id. at 936-72.
judgment in a case alleging the police department’s stop and frisk policy based on race and national origin violated Title VI. The Floyd Court cited social psychology studies regarding implicit shooter bias as evidence the defendant department may not have acted reasonably to prevent racial profiling and therefore was not entitled to dismissal. Oppenheimer’s arguments to replace the strict and intentional liability causes of action available under Title VII apply equally to the proposal to introduce a theory of negligent discrimination under Title VI. Such a revision would carry several social benefits, including eliminating the need to find moral wrongfulness before penalizing discrimination; encouraging greater care on the part of federal contractors to avoid discrimination and discriminatory practices; and turning the law’s focus towards resolving discriminatory outcomes rather than discriminatory motives.

The negligent discrimination model provides a structural approach that requires institutions to manage the diversity within their organizations and minimize the operation of discriminatory bias by individual actors within their control. The negligence regime incentivizes both institutions and individuals to undertake a contextualized inquiry into their conduct. Negligence improves upon rigid rules proscriptions by setting an objective and generalizable standard of care. Institutions and individuals can meet that standard by conforming their practices to the scientific evidence about unconscious discrimination and the steps that can control it. This approach also challenges courts to resolve litigants’ disputes in a manner that will incentivize social and behavioral changes. These changes must be based on the “core insight” that “law can serve as a powerful tool for structuring . . . incentives in socially beneficial ways.”

Here is how a negligence-based claim alleging health care discrimination due to implicit bias would proceed under the negligence model. A plaintiff would bear the initial burden to show that a defendant health care organization followed a facially neutral practice that resulted in a racially disparate impact on minorities, causing health disparities due to implicit bias. For example, a hospital may have an express policy to provide translation services for non-English speaking patients in accordance with National Standards for Culturally and Linguistically Appropriate Services in Health Care, or “CLAS,” standards. However, due to systematic unconscious racism, the patient may allege the standards are adhered to only rarely for patients of the plaintiff’s ethnic minority. The plaintiff would also be required to show how the absence of translation services caused injury to non-English speaking patients. This evidence could take the form of data comparing health outcomes for patients who

419. Floyd, 813 F. Supp. 2d at 453-56.
420. See Oppenheimer, supra note 390, at 967-72.
421. See generally Green, supra note 22.
receive translators with outcomes of those who do not. Alternatively, the evidence might be gleaned from interviews with patients who may have delayed or declined seeking health care due to language barriers.

Note how the negligence model improves on existing Title VI law, under which the plaintiff’s allegations in this hypothetical case would not likely be actionable. Under the existing Title VI, the defendant health provider could respond by showing that it had a formal policy in place for patients with limited English proficiency. After presenting that evidence, the claim would come to an end—unless the plaintiff could make the difficult showing that the hospital deliberately sought to deny access to translation services for these patients. However under a reformed Title VI, the plaintiff’s allegations would also require the hospital to demonstrate it had acted reasonably to reduce the likelihood that its health care professionals might avoid using translation services due to their unconscious biases against non-English speakers. To meet this burden, the defendant hospital could show it had taken steps that have been empirically demonstrated to influence providers’ implicit biases. The steps taken must match scientific evidence and would replace the vague and self-serving representations that the defendant had a “legitimate nondiscriminatory reason” or a “justification” for its discriminatory failure to make translation services regularly available. The hospital would have to defend its challenged practices with evidence that its actions were reasonable in light of the scientific evidence in order to pass muster.

The defendant hospital could show it provided stereotype-negation training for physicians and nurses, making them aware of evidence that they hold measurable implicit biases against the patient’s ethnic group. This defense would prevail based on evidence that increasing awareness of biasing potential may evoke self-correction. Alternatively, the defendant hospital could show that its mandatory continuing professional education program includes exposure to counter-stereotypes for the relevant patient group, based on the evidence that this type of training weakens racial, ethnic, and gender stereotypes. Additionally, the defendant hospital could show it had taken reasonable steps to promote workforce diversity through programs to hire, promote and retain physicians from the patient’s ethnic background into positions of leadership and authority within its organization, based on the evidence that fewer negative stereotypes operate following interactions with minority physicians and others in authority. Based on evidence that implicit biases are related to high cognitive load, another intervention that would demonstrate reasonableness may be related to the hospital’s efforts to reduce work-loads placed on health care providers. These evidence-based steps would be sufficient to discharge the defendant hospital from Title VI liability. However, failure to demonstrate that

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424. See, e.g., Gawronski et al., supra note 137, at 585.
425. See, e.g., Kawakami et al., supra note 292, at 871-88; Dasgupta & Greenwald, supra note 16, at 800-14; Blair & Banaji, supra note 132, at 1153-59.
implicit ethnic bias had been structurally addressed by the hospital would result in a damages award to the plaintiff. In this way, the negligence standard operates as both the proverbial “carrot” and “stick.” On one hand, by signaling that hospitals may avail themselves of an exculpatory defense by taking steps to inform and train physicians to override their implicit biases, the negligence standard positively invites preventative policies to remove implicit racial and ethnic discrimination from patient care. On the other hand, restoring a private cause of action to patients who wish to allege they were victimized by racially biased health care will penalize providers who have failed to be vigilant in striving for justice in American health care.

B. Advantages and Objections

By and large, it is likely that courts will welcome the clarity provided by the reforms proposed here to realign Title VI with Congress’ original intent for the law. These reforms also return Title VI jurisprudence to the Supreme Court’s traditional approach to the law. Moreover, the reasonableness standard provides an objective and workable way to operationalize the scientific evidence we now have about how discrimination works and can be controlled.

1. Restoring Clarity

The United States Supreme Court’s early decisions plainly established that Title VI reached cases of unintentional discrimination. But the Court has wrestled with the way to define and limit these causes of action. Recent decisions have focused almost exclusively on describing the procedural, evidentiary, and remedial elements that distinguish disparate impact claims, but they have overlooked the need to fully define the substantive meaning of “unintentional discrimination.” Perhaps most destructively, the Court lost its way in Alexander v. Sandoval. In that case, Justice Scalia wrote for the Court that disparate impact cases were prohibited only by regulatory rules promulgated under Section 602, but not by the Title VI itself, and therefore could only be administratively enforced. As many commentators have written, Justice Scalia justified this holding by extending a rejected reading of dicta from Regents of the University of California v. Bakke. Justice Scalia applied a restrictive view of Title VI, notwithstanding the fact that Justice Stevens, joined by Justices Souter, Ginsburg, and Breyer had long since dissented from the very reading of

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428. See supra Part I.A (discussing Congressional intent underlying Title VI).
429. See Guardians Ass'n v. Civil Serv. Comm'n of N.Y.C., 463 U.S. 582, 589 (1983) (citing Lau v. Nichols, 414 U.S. 563 (1974)) (“The Court squarely held in Lau v. Nichols, that Title VI forbids the use of federal funds not only in programs that intentionally discriminate on racial grounds but also in those endeavors that have a disparate impact on racial minorities.”).
431. Id. at 293; see also Note, After Sandoval: Judicial Challenges and Administrative Possibilities in Title VI Enforcement, 116 HARV. L. REV. 1774 (2003). In addition, Justice Scalia strongly hinted that Section 602 of Title VI might not support disparate impact claims alleging unintentional discrimination, though he declined to decide the question. Sandoval; 532 U.S. at 281-82.
Bakke that Scalia relied upon in Sandoval. In fact, Bakke cannot be read as a considered majority opinion on the intentionality issue. Two of the five justices who joined the majority in Bakke, concluding that Section 601 of Title VI only extended as far as the Equal Protection Clause and therefore encompassed only intentional discrimination—Justices White and Marshall—subsequently wrote to denounce this view in Guardians Association v. Civil Service Commission. The Justices, of course, could not reach this conclusion without distancing themselves from their ruling in Bakke. Therefore, Justice White carefully explained his position:

I recognize that in Bakke five Justices, including myself, declared that Title VI on its own bottom reaches no further than the Constitution, which suggests that . . . Title VI does not of its own force proscribe unintentional racial discrimination . . . . The issue in Bakke, however, was whether Title VI forbids intentional discrimination in the form of affirmative action intended to remedy past discrimination, even though such affirmative action is permitted by the Constitution. Holding that Title VI does not bar such affirmative action if the Constitution does not is plainly not determinative of whether Title VI proscribes unintentional discrimination in addition to the intentional discrimination that the Constitution forbids . . . . [In light of the evidence of precedent and congressional intent], it must be concluded that Title VI reaches unintentional, disparate-impact discrimination as well as deliberate racial discrimination.

Justice Marshall also denounced Bakke’s narrow interpretation of Title VI, writing: “I agree with Justice White that proof of discriminatory animus should not be required . . . . I frankly concede that our reasoning in Bakke was broader than it should have been. The statement that Title VI was ‘absolutely coextensive’ with the Equal Protection Clause was clearly superfluous . . . .” Justice Marshall went on to explain that the ‘effects test’ is far more practical than a test that focuses on the motive of the recipient [of federal funds], which is typically very difficult to determine.

Justice Thomas’ concurrence in Fordice made clear that the case involved unintentional discrimination, which Title VI ought to reach, when he wrote, “[t]oday we hold that ‘[i]f policies traceable to the de jure system are still in force and have discriminatory effects, those policies too must be reformed to the extent practicable

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433. Sandoval, 552 U.S. at 307-08 (Stevens, J., dissenting).
434. Id.
435. Id.; see also Guardians Ass’n v. Civil Serv. Comm’n, 463 U.S. 582, 589-90 (1983) (opinion of White, J.) (“The threshold issue before the Court is whether the private plaintiffs in this case need to prove discriminatory intent to establish a violation of Title VI of the Civil Rights Act of 1964 . . . . I conclude, as do four other Justices, in separate opinions, that the Court of Appeals erred in requiring proof of discriminatory intent.”); id. at 623-24 (Marshall, J., dissenting).
436. Id. at 589-93 (opinion of White, J.).
437. Id. at 615, 623 (Marshall, J., dissenting).
438. Id. at 622; see also Alexander v. Choate, 469 U.S. 287, 296 (1985) (“... [D]iscrimination against the handicapped is primarily the result of apathetic attitudes rather than affirmative animus.”).
and consistent with sound educational practices." Justice Ginsburg has written repeatedly to explain that both conscious and unconscious biases operate to perpetuate discrimination today, causing vestiges of overt discrimination that are also prohibited under Title VI. For example, in her concurring opinion in Grutter v. Bollinger, Justice Ginsburg wrote, "[i]t is well documented that conscious and unconscious race bias, even rank discrimination based on race, remain alive in our land, impeding realization of our highest values and ideals." In Adarand Constructors v. Pena, she wrote, "[b]ias both conscious and unconscious, reflecting traditional and unexamined habits of thought, keeps up barriers that must come down if equal opportunity and nondiscrimination ever genuinely to become this country’s law and practice." Adding statutory language to codify the private disparate impact cause of action and to incorporate a negligence standard into Title VI will bring certainty and clarity to the control Title VI extends over unintentional discrimination, while silencing irreconcilable voices and views that have emanated from the Supreme Court.

2. Operationalizing Reasonableness

Understandably, some courts and commenters will remain reluctant to extend Title VI liability to penalize unconsciously motivated conduct. They may regard the proposed amendments as penalties for mere bad thoughts. However, the health care example used throughout this Article demonstrates that the legal liability proposed here addresses real and present harms. Furthermore, the reforms I propose are narrowly tailored. This is especially important to show in the health care example where crafting a precise standard of care is crucial. Health care providers must not be penalized at all times when they consider race—whether intentionally or unintentionally—as a factor in medical decision making, since there are times when race is a perfectly legitimate clinical consideration. Yet, physicians must be held accountable when they use illegitimate considerations of race to influence the delivery of medical care while expending public funds. The proposals offered here are not entirely free from the risk of over-inclusiveness. The ubiquity of implicit biases poses a challenge to the goal of applying Title VI litigation to address the discrimination they cause. However, the fact that the vast majority of Americans evince some degree of implicit racial and ethnic bias does not mean that any effort to curb the harmful, discriminatory effects of these biases will necessarily fail. The negligence standard is just, because it makes liability is predictable and avoidable, while still providing for enforcement. The reasonableness standard is objectively discernible and one with which individuals and institutions can comply. The proposals set forth here assume that courts can reliably judge the reasonableness of evidence-based interventions with appropriate flexibility. As the social science record continues to evolve, increasingly specific and targeted measures will become relevant to Title VI claims. Courts and
contractors will stay abreast of and progressively incorporate the improving methods available to address unconscious racism.

Some may object to fashioning any legal solution at all to the problem of implicit bias, preferring instead to allow individuals and institutions to self-regulate. Some may object to over-regulating government contractors such as health care providers, already burdened by a malpractice system that randomly and inefficiently imposes liability on physicians. To these objections I point first to the abject failure of self-regulation where unconscious racism is concerned, and second to the dogged persistence of inequities where health disparities in particular have flourished. While the health gaps between minorities and whites have been slowly shrinking in some categories, such as overall life expectancy, the fact remains that over the past twenty-five years, in every race and ethnicity category, the number and proportion of all quality measures for which disparities are measured show the vast majority of racial differences in health and health care quality are not changing, and, in some cases, are worsening. These tragic differences remain, notwithstanding an era of self-regulation, substantial expenditures, and extensive investment in research and programs aimed at reducing disparities. The fact is that without a new approach—one based on the evidentiary record that addresses implicit biases directly—health care disparities will not go away. In light of the overwhelming scientific evidence that implicit biases are both harmful and malleable, no justification remains for not implementing Congress’ original intent, expressed in 1964 when Title VI was passed, to prohibit all forms of discrimination—whether intentional or unintentional, conscious or unconscious, explicit or implicit—based on a person’s race, color, or national origin.

CONCLUSION

I have argued to restore Title VI to its originally intended scope. The reforms I propose are modest: returning the statute’s public-private enforcement model, and implementing a negligence standard of care to regulate unintended discrimination. Yet, these reforms will radically shift the social norm throughout the American health care system, which today tolerates gross inequality in health and health care, creating a new medical norm that values and protects justice and equality for all patients. While reforming Title VI will extend justice and equality well beyond the health care context, it is fitting to return to health care to address the original goals that lawmakers had in enacting Title VI because racial discrimination by hospitals and physicians were fundamental to the law’s passage in 1964.

The evidence of how implicit bias works in health care demands a new standard of care for modern medicine. To be sure, there are important issues yet to be discussed by providers and researchers. The evidence that implicit biases influence physicians’ clinical decision-making, patient communication, and statistical interpretation requires a deeper conversation among practitioners about their commitment to the

ethical principles of justice, non-malevolence, and beneficence underlying the Hippocratic Oath. The empirical record must be expanded. Social scientists must work to understand the extent to which implicit bias infects institutional health care providers, nurses, physician extenders, administrators, insurers, and other actors in the health care delivery system. The social science record regarding minority groups beyond African-Americans is also sorely lacking. However, the need for further research and discussion by providers no longer justifies inaction by lawmakers. The evidence presented in this Article no longer permits lawmakers to remain bystanders as African-, Latino-, Asian-, and Native-Americans live shorter and less healthy lives than whites because they are victims of unregulated physician implicit biases. Unconscious racism is within individual, institutional, and societal control. Unintentional attitudes are subject to intentional control, and, most importantly, carefully structured interventions can directly address the deleterious and deadly discrimination that implicit bias causes.

The science of implicit bias reviewed and updated here provides a solid evidentiary basis for reforming Title VI. The evidence that these biases are malleable affirmatively answers the question of whether it is morally acceptable to find a person culpable for action from unintentional attitudes. And the continuously mounting evidence that minority patients daily are falling victim to unconsciously racist health care in America daily provides the compelling interest that justifies returning Title VI to its originally intended potency so that neither conscious nor unconscious racism in health care may be tolerated as “normal” under the law.