HEALTH CARE, TITLE VI, AND RACISM’S NEW NORMAL

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## Table of Contents

### Introduction ................................................................................................................. 2

### I. THE NEED FOR REFORM .................................................................................. 6

#### A. Title VI and Health Care Equity ...................................................................... 8

#### B. Unconscious Discrimination: The New Normal in Health Care .................... 10

### II. IMPLICIT BIAS AND HEALTH CARE DISPARITIES ........................................ 12

#### A. An Updated Understanding of Implicit Bias ...................................................... 12

#### B. Evidence of Implicit Bias in Health Care ......................................................... 15

### III. MALLEABILITY ................................................................................................... 21

#### A. Empirical Evidence of Malleability ................................................................. 21

#### B. Evidence that Interventions Reduce Implicit Biases ....................................... 23

1. Type A Intervention - Stereotype Negation Training ............................................. 23

2. Type B Intervention - Promoting Counter-Stereotypes ........................................ 25

3. Type C Intervention - Social and Self-Motivation ............................................... 27

4. Limitations ............................................................................................................. 28

#### C. Malleability, Interventions, and Behavioral Realism ....................................... 30

### IV. TITLE VI – A LEGAL RESPONSE TO THE NEW NORMAL ............................. 32

#### A. Amending Title VI ............................................................................................. 32

1. Restoring The Public-Private Enforcement Model .............................................. 34

2. Introducing a Negligence Standard of Care ......................................................... 35

#### B. Advantages and Objections .............................................................................. 36

### Conclusion ............................................................................................................... 39

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Title VI closes the gap between our purposes as a democracy and our prejudices as individuals. The costs 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 less and inferior medical treatment than their white counterparts, while they are, as a group, more ill and more likely to die from virtually every disease for which we have data, has been documented beyond dispute. Whether racial and ethnic minority patients seek treatment for lung, breast, prostate or pancreatic cancer, access to coronary angiography, thrombolysis, or bypass surgery to treat coronary artery heart disease, medication for pain, treatment of asthma, access to transplant organs, emergency medical care, or a bed in a long term nursing home, across the board, minority patients generally receive inferior medical care when compared to whites in this country. 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 because of their race or ethnicity. In 2003, after reviewing the copious scientific literature evincing the inequities in American healthcare, the Institute of Medicine (IOM) published a landmark report, titled Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. In that report, the IOM also revealed that the scientific community knew little that might “elucidate the mechanisms by which these attitudes, biases, and stereotypes may result in differences in clinical treatment, or the degree to which these attitudes might affect the outcome of patient care” and called for future study to better understand and combat physician bias. 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.

A maelstrom of debate erupted following the IOM Report. One critic warned that the IOM too quickly leaped from evidence of disparities to a conclusion that discrimination in medicine is illicit, without sufficient evidence that discrimination by doctors is not economically rational. Richard Epstein asserted the IOM Report shamefully attacked dedicated physicians’ “good will” and dismissing the report as a “genteel guilt trip.” Other critics asserted the whole 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. Some scientists sought alternative explanations to avoid the claim that physician discrimination is responsible for disparate health outcomes. A small but stolid group of scientists offered a biological explanation for

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1 Congressional Record, Senate, March 3, 1964, 88th Congress, 2nd Session, 4183.
health disparities, arguing the discredited view that racial groups in the United States are genetically similar to their 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 this article focuses squarely on the growing body of scientific evidence that supports the conclusion that physician prejudice, bias, and stereotypes are substantial contributors to racial and ethnic health disparities and does so while acknowledging that the vast majority of doctors and other health care providers are neither racist nor malicious.

Nevertheless, studies have confirmed that physicians, like most Americans, generally demonstrate pro-white implicit biases against Latinos and African-Americans when tested. 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 automatic associations of diseases arising from behavioral choices such as drug abuse and obesity with blacks, while being less prompt in accurately identify these conditions in

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6 See e.g., Neil Risch et al., *Categorization of Humans in Biomedical Research: Genes, Race, and Disease*, 3 *GENOME BIOLOGY* 1 (2002). A myriad for scientific facts discredit 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, Nancy Krieger, *Stormy Weather: Race, Gene Expression, and the Science of Health Disparities*, 95 *AMERICAN JOURNAL OF PUBLIC HEALTH* 2155 (2005). There, Krieger explains that in fact, self-reported racial categories describe racial and ethnic features that arise out of gene expression, rather than heritable or innate biological traits. Moreover, 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 is fact occurs in fewer than 2% of all diseases.


11 Irene V. Blair et al., *Assessment of Biases Against Latinos and African Americans Among Primary Care Providers and Community Members*, AMERICAN JOURNAL OF PUBLIC HEALTH (November 15, 2012).


13 Id., Green et al., 22 J. INTERNAL MED. 1231.

white patients.\textsuperscript{15} Physician implicit biases have been associated with poorer communication between doctors and their minority patients, where 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.\textsuperscript{16} 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 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. Professor Kimani Paul-Emile has thoughtfully asserted that civil rights laws should accommodate patients’ racial preferences\textsuperscript{17} and Professor Rene Bowser has linked physicians’ implicit bias to institutional patterns of racial profiling in health care.\textsuperscript{18} However 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 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.”\textsuperscript{19} 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.\textsuperscript{20} 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 perversely, but also by adding new scientific findings and new legal solutions to the discourse. First, I specifically focus 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.\textsuperscript{21} 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-

\textsuperscript{16} Louis A. Penner et al., \textit{Aversive Racism and Medical Interactions with Black Patients: A Field Study}, 46 JOURNAL OF EXPERIMENTAL SOCIAL PSYCHOLOGY 436 (2010).
\textsuperscript{17} Kimani Paul-Emile, \textit{Patients’ Racial Preferences and the Medical Culture of Accommodation}, 60 UCLA L. REV. 462 (2012).
\textsuperscript{19} Wal-Mart Stores, Inc. v. Dukes, 131 S.Ct. 2541, 2554 (2011).
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 it, 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 Lopez 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. 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. However 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; this is the first article in the legal literature to comprehensively review the social science evidence that implicit biases are malleable; and this is 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. I show that implicit bias powerfully explains why minority patients are sicker and die quicker than whites as they receive inferior medical care for heart disease, cancer, diabetes and asthma when compared to whites; are less likely to be placed on transplant lists or even to be told about organ transplantation as a treatment option than similarly situated whites; and experience lower trust and satisfaction with their providers than whites patients. 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.” 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. Finally, this article applies 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-fold 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. The data in these sections has heretofore been absent from the legal literature and, in fact represents a “game-changer” in the discourse about implicit bias, intentionality, and causation in anti-discrimination law. For this reason 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 says 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.” In Section 602, Title VI goes on to say “[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 implementing regulations consistent with the aims of the law. Although the statute’s provisions have endured, its effectiveness to

38 Although Title VI broadly prohibits discrimination by any recipient of federal assistance, 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.
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 “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 burden then shifts to the defendant to produce a legitimate, non-discriminatory explanation for the challenged action. To prevail, the plaintiff must finally demonstrate the proffered reason is mere pretext and unworthy of credence. 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 declined. 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 Association v. Civil Service Commission of New York, and then later to change the statutory basis for disparate impact claims in Alexander v. Chao. 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.

Courts’ currently reach incongruous outcomes in both disparate treatment and disparate impact cases under 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. The plaintiffs presented statistical data sufficient

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to make out a prima facie case on disparate impact grounds,\textsuperscript{51} but due to \textit{Sandoval}, these private litigants alleged a disparate treatment case.\textsuperscript{52} Consequently they lost their claim when the court concluded the school did not act with “discriminatory purpose” to segregate minority students into inferior educational programs. 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.”\textsuperscript{53}

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 for Title VI, and the role courts have demoted it to become more apparent than in health care. The American health care system is a fitting focus for antidiscrimination law first because the problem of racial inequality in health care remains one of the most pervasive, unsolved racial and ethnic injustices in America. Yet the evidence of the devastating impact of implicit bias on health and health care disparities continues to mount and 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. Therefore, if Title VI can be revived to fight discrimination due to implicit bias in health care, then the health 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.\textsuperscript{54} Record of the eighty-eighth Congress floor debate as the Senate considered this landmark civil rights act reveals that proponents repeatedly cited and quoted a watershed moment in American political and governmental life, to allege that requiring medical providers to make out a prima facie case on disparate impact grounds,\textsuperscript{51} but due to \textit{Sandoval}, these private litigants alleged a disparate treatment case.\textsuperscript{52} Consequently they lost their claim when the court concluded the school did not act with “discriminatory purpose” to segregate minority students into inferior educational programs. 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.”\textsuperscript{53}

The case, \textit{Simkins v. Moses H. Cone Memorial Hospital},\textsuperscript{56} was brought by black physicians, dentists, and patients to challenge racial segregation in a publically financed

\textsuperscript{51} Id. at 761 (plaintiffs showed statistical data concerning 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).

\textsuperscript{52} Id. at 752.

\textsuperscript{53} \textit{Morales v. N.Y. St. Dep’t of Labor}, 865 F. Supp. 2d 220 (N.D.N.Y. 2012).

\textsuperscript{54} 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,” to allege that requiring medical providers to provide translation services to non-English speaking patients violated Title VI. \textit{See Colwell v. DHHS}, 558 F.3d 1112 (9th Cir. 2009)(dismissed as unripe).

\textsuperscript{55} 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, \textit{Positive Political Theory of Legislative History: New Perspectives on the 1964 Civil Rights Act and its Interpretation}, 151 U. PA. L. REV. 1417 (2003).

hospital. 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. The Fourth Circuit held in Simkins that the separate-but-equal language contained in the Hill-Burton Act was unconstitutional. On March 2, 1964, the United States Supreme Court announced its decision to deny certiorari in Simkins. 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. 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. 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 piece-meal 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.

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 as a prelude to and an impetus for the enactment of Title VI.

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. 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). 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

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58 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, at 101-105 (Univ. of Michigan Press 1999).
60 “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 969.
61 In 2009, this funding totaled $715 billion. Last year, the United States government paid 36.4% of the nation’s national health care expenditures. See, National Center for Health Statistics, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Health, United States 2011: With Special Feature on Socioeconomic Status and Health, Table 129 at 376 (May 2012).
62 Patient Protection and Affordable Care Act, Nondiscrimination at 42 U.S. C. s. 18116, Section 1557(a) “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.”
it nearly irrelevant to modern day discrimination generally, and particularly ineffective at combating the deadly race and ethnic disparities in health care. Therefore the next section provides an updated view of how racial and ethnic discrimination occurs in the health care industry by focusing on findings from three areas: heart disease, renal failure, and cancer.

**B.  Unconscious Discrimination: The New Normal in Health Care**

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, for many years, racial and ethnic disparities have been well-documented in the treatment of heart and vascular diseases. Where preventative behavior is concerned, one study showed physicians are less aggressive about urging black patients to modify risk factors for heart disease such as smoking cessation, diet modification, and increasing exercise. Once African-Americans fall ill, studies show that blacks are less likely than whites to be admitted for coronary artery bypass surgery, and less likely to be triaged for coronary heart disease. When admitted to hospitals, African American patients are more likely to receive poor quality care than white patients. For example, 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. Over a dozen 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. 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 pharmacologic treatments for heart disease.

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. Several studies show that physicians perceive blacks and low-income patients more negatively than white and higher income patients. Whether the providers studied were medical students, private doctors, or public hospital physicians, researchers have found these providers bring negative, prior beliefs about blacks’ intelligence, proclivity to engage in risky behavior, likelihood of medical cooperativeness, and adherence to treatment recommendations, unlike their positive expectations of white patients. The decision to diagnose, treat, and follow a patient’s illness medically 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. Across the board, researchers have long found disparities in physicians’ interpretations, expectations, and clinical decisions when comparing the treatment that African-American and white patients receive for coronary heart disease. However within the last 15 years these disparities have been associated with physicians’ implicit biases, and within the last 10 years the evidence of implicit bias has been linked directly to cardiovascular clinical behavior and decision-making.

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64 Katherine L. Kahn et al., *Health Care for Black and Poor Hospitalized Medicare Patients*, 271 JAMA 1169 (1994).

Black Americans represent a disproportionate number of patients with end-stage renal disease (ESRD). 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 75 – 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 compared with whites. One study found that black dialysis patients “were less likely than their clinically similar white counterparts to report that they had been told about transplantation before undergoing dialysis.” Yet, patient preferences did not explain these 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, the type of treatment facility, socio-demographics, health status, comorbidities, and the cause of renal conditions.

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 29% of the black patient cases reviewed, patients with potentially resectable pancreatic cancers never received a surgical evaluation. Once seen by a surgeon, blacks were still significantly less likely to receive surgical resection. But when data was adjusted for receiving surgical resection, racial disparities in long-term survival disappeared. Dr. Peter Bach conducted a study challenging the conjecture that such survival disparities are due to biological differences in patients.

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 89 cohorts of patients who received comparable treatment for similar stage cancers. Across the 89 cohorts, which included analysis 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 1.07% of the mortality rate experienced by whites. Moreover, for three of the four most common cancers – lung, colorectal, and prostate - there was no evidence of excess cancer mortality in blacks. Dr. Bach concluded that differences in cancer biology between racial groups are unlikely to be responsible for a substantial portion of survival disparities. Instead, disparities are more likely the result of disparate cancer treatment. Dr. Bach’s conclusion not only replicates numerous studies that have demonstrated that African-Americans are less likely to receive optimal care for cancer, 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. The three examples from heart, cancer, and renal disease data summarized here are illustrative though far from exhaustive;

66 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 12% of the total U.S. population.
68 Peter B. Bach et al., Survival of Blacks and Whites after a Cancer Diagnosis, 287 JAMA 2106 (2002).
69 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. See, http://seer.cancer.gov/faststats/selections.php?series=race.
racial disparities in treatment of disease and injury in the United States are pervasive across a broad variety of medical conditions and settings.\textsuperscript{70}

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.

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 to date. The first section of this part reviews the social science of implicit bias generally and the second section reviews the evidence that the physician-patient relationship is adversely affected by unconscious racism. 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.

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.\textsuperscript{71} 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 or express 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. 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.\textsuperscript{72} 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. Implicit biases operate whether the interaction is between two members of the same racial group, or between members of different racial groups:

\begin{itemize}
\item [Store \Rightarrow Identify \Rightarrow Retrieve \Rightarrow Activate \Rightarrow Form \Rightarrow Influence]
\item Social Group \Rightarrow Group Stereotypes \Rightarrow Implicit Judgments
\item Knowledge Membership \Rightarrow Stereotypes Triggered Biases Decisions and Conduct
\end{itemize}

Implicit biases form based on information subconsciously gathered, stored, and ultimately accessed during the course of a lifetime. The first step – storing social knowledge – is a process that takes place

\textsuperscript{70} See SMEDLEY ET AL., supra note 4.


\textsuperscript{72} Id.
wholly outside a person’s conscious awareness. 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 therefore reflect the environment and culture that surrounds us rather than views we personally endorse. 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. The second step, called “identification,” occurs the moment two people meet. Immediately upon encounter, our minds subconsciously begin to perform a sorting exercise to make sense of the information received. The task is to find categories from our stored memories to match or fit the newly encountered individual or situation. 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.

Once we identify the stored categories to which new information belongs, the process of shaping and responding to our implicit biases begins. Very quickly – social scientists say within 300 milliseconds from the moment of identification - we begin the third step called “retrieval.” During retrieval, we subconsciously access the most prominent associations we have stored in memory about that relevant racial or ethnic group. This process happens without any intentional awareness on our part. Thus, psychologists say accessing stored memories happens with “automaticity.” 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.” While stereotypes are attitudes 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. 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. 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. Implicit biases cause people who believe in equality, to act discriminatorily. And although implicit biases operate at an unconscious level, this should not be misunderstood to mean implicit racial biases cannot be influenced or controlled by the individual or the external environment. The best evidence, as we shall see in Part III, 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). The IAT is a computer based test that works

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74 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.
from the straight forward premise that when people are asked to associate photographs with words that are consistent with their implicitly held beliefs, they will make those associations quickly. But, 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. The IAT measures the time a person takes to associate selected pairs of positive and negative words with pairs of pictures.

The IAT has been used extensively to measure implicit attitudes about race using a version of the test called the Race-Attitude IAT. 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. The closer a subject’s IAT score is to zero, the more neutral their preferences are between blacks and whites. A zero score indicates the person taking the test took no more or less time to associate words with black or white faces. A high positive IAT score signals strong, automatic, implicit biases in favor of whites over blacks—a “pro-white” or “anti-black” bias. A very low or negative IAT score denotes a strong bias in favor of blacks over whites—a “pro-black” or “anti-white” bias. Over one million people have completed the publicly available Race-Attitude IAT to date. More than 70% of them show preference for white Americans over black Americans, even when their explicit, self-reported values are egalitarian.75

In 1998, Anthony Greenwald and Linda Krieger introduced the idea that anti-discrimination law should be reformed to reflect information about unconscious 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.76 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 this movement has not received the traction proponents had hoped from courts and legislatures who continue to lag behind in addressing implicit bias discrimination through the law.

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.”77 Other critics have 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. Other critics claim the emphasis on subconscious racism distracts civil rights advocates from addressing the entrenched and substantively more important sources of inequity such poverty, poor housing, and inferior education systems.78 Indeed some of the most progressive critics have decried the exceptionalism they suspect underlies implicit bias scholarship.79 The majority of social scientists have discredited the critiques of the IAT itself,80 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

75 Janice Sabin et al., Physicians’ Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender, 20 J. HEALTH CARE POOR & UNDERSERVED 896, 897 (2009).
76 See Greenwald & Krieger, supra note 40, at (stating that current anti-discrimination law is naïve in assuming that humans act solely in accordance with explicit and conscious intentions).
80 The IAT has been the subject of over 450 peer-reviewed publications; it’s scientific acceptance and validity is by now, unassailable.
bias.” Moreover, once unpacked, the leading substantive criticisms rest principally on normative disagreements about whether or not the law should concern itself with bias that is unconscious and unintentional. By exploring the harmful impact that implicit biases have on the morbidity and mortality of minority Americans, I hope to put many of these objections to rest.

B. Evidence of Implicit Bias in Health Care

Racial and ethnic discrimination arising from implicit biases have become the new normal in American health care. Using the IAT data collected from hundreds of thousands of voluntary visitors to Harvard University’s Project Implicit interactive website, one study analyzed data from over 2,500 test-takers who self-identified as “MDs.” They then compared the physicians’ IAT data, to their self-reported explicit biases, gathered from a questionnaire. First, 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 three additional noteworthy findings. White male physicians tested 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. Explicit or self-reported preferences were attitudes of which the physicians were aware and willing to describe. Hispanic and white female physicians reported relatively weak preferences for whites over blacks, though white male physicians showed slightly stronger explicit pro-white attitudes. African-Americans as a group, both male and female, reported explicit attitudes favoring blacks. Hispanic MDs who were women, 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 view that because the cognitive processes that govern explicit and implicit attitudes are separate and independent, a person may explicitly hold egalitarian beliefs while simultaneously holding implicitly biased racial views. These results become particularly important when viewed in the context of medical decision-making and health care delivery.

In 1999, Dr. Kevin Schulman and a group of physicians reported the first, path-breaking study of how patients’ race and gender influence physicians’ treatment decision-making, leading to treatment disparities for cardiovascular disease. 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 white women, white men, black women, and black men - presented identical scripts and diagnostic data. Therefore in each vignette, the patients differed only by race and gender. After reviewing the vignettes and data, the physicians were asked to make treatment recommendations based on what they had heard. 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.

Schulman first reported that his data showed white, male patients were 40% more likely to receive a recommendation for cardiac catheterization than black and female patients. However, responding to criticism of his methodology, Dr. Schulman later reduced the ratios that described the

relative odds of obtaining cardiac catheterization. Black and 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. At bottom, the doctors tested 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, the study did not attribute those considerations to the physicians’ implicitly held biases. The vexing question that remained was why might doctors distinguish between patients in this manner.

Dr. Alexander Green reported a link between physicians’ implicit biases and racially disparate treatment decisions in 2007. Dr. Green’s research team tested physicians’ level of implicit race bias by asking them to complete a survey and two Implicit Association Tests. The physicians’ explicit racial preferences were assessed using a questionnaire. Next, they were asked to watch an internet-based clinical vignette of a patient who described their chest pain and medical history. The doctors were randomly assigned to view a video of black and white actors reading the vignettes that described a patient with coronary artery disease (CAD). They 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. Thrombolysis is a preferred way to treat CAD, by introducing clot-dissolving medication through a catheter to prevent blood clots from lodging in the brain causing strokes, or near the heart causing heart attacks. The Green study findings were remarkable.

First, Green found 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 hold implicit racial biases against African-Americans, associating their black patients with negative attributes such as being generally uncooperative and medically non-compliant. The study showed a statistical interaction between physicians’ willingness to prescribe thrombolysis and their implicit biases against blacks generally, and against black patients specifically. As physicians’ level of anti-black, implicit bias increased, the likelihood those physicians would prescribe thrombolysis to treat their black patients’ CAD decreased. Also, as the physicians’ IAT scores increased, revealing greater anti-black implicit biases, the likelihood these physicians would treat white patients with thrombolysis also increased. Said another way, more unconscious race bias meant less desirable treatment for black patients and more for whites. Importantly, the physicians in this study expressed absolutely no racial bias on questionnaires asking their explicit preferences between black and white patients. In fact, for all 287 physician participants, this study showed no explicit bias in favor of white patients whatsoever. Yet, the Green study supports the conclusion that what physicians believe unconsciously is a more important determinant of the quality of patient care they give, than what they say about race or ethnicity explicitly.

In another part of this study, Dr. Green and his researchers struck a crucial and hopeful note for 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 completely 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 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

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83 *Id.*, at 1235.

physicians who knew Dr. Green’s purpose and those who did not. These findings 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. Nearly 72% of the physicians who were aware of the study’s purpose 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.” Only 60.5% of those unaware of the study’s purpose also concurred with this statement. 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 counter-intuitive claim from their study that social class and patient age had no impact on physician decision-making. 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 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.

A pair of studies reported by Dr. Janice Sabin focused on pediatricians to refine what we know about the association between implicit bias and physicians’ treatment decisions. 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. The pediatricians were also asked to self-report their explicit biases, ranking their responses to statements about their feelings towards African- and European-Americans. The ranking included their perceptions of whether white or black patients are compliant, and the doctors’ impressions of who received access to better care. Then using case vignettes written for the study, researchers asked the pediatricians to make treatment recommendations for four commonly occurring pediatric conditions: Urinary tract infections (UTI), attention deficit hyperactivity disorder (ADHD), asthma, and post-surgical pain. The study presented two patients with each condition – one black and one white. Each physician participant was randomly assigned a vignette from each disease

86 See Hal R. Arkes & Neal V. Dawson, *Presentation at the Society for Judgment and Decision Making: Race-Based Bias in Physician Decision Making* (Nov. 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. Indeed, Dr. Green did not examine the reasons behind physicians’ decisions. Yet this omission has little bearing on the relationship between bias and treatment that Dr. Green did examine and find.
87 Janice A. Sabin et al., *Physician Implicit Attitudes and Stereotypes about Race and Quality of Medical Care*, 46 MED. CARE 678 (2008).
category. Generally, Dr. Sabin found that pediatricians tested 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. However, the story was different where pain management was concerned. This group was the first to demonstrate that “physicians with more pro-white implicit bias more readily prescribed pain medication to white patients than to African American patients.”

Another noteworthy finding from this study relates to the pediatricians’ recommendations for the UTI cases. The differences found by race were counterintuitive. Physicians studied were more likely to recommend the recognized treatment of choice – outpatient care – for African-American patients than for white patients. The recommendations for white patients were most often that they receive 14 days of hospitalization. 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. 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. In both studies, the researchers were able to confirm that pediatricians tested have significantly lower implicit bias than other physicians, and that these biases had differing effects on medical decisions depending on the patient and the condition being treated.

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 also found no association between the medical students’ IAT scores, and their clinical assessments based on patient vignettes. Approximately 200 of the total 241 first-year students volunteered to participate in the study. They were shown three patient vignettes and then given 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 socio-economic class occupations. The results showed that 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 in only one vignette – 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. 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

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88 This finding is consistent with the often-reported, erroneous perception by physicians that Blacks are more likely than Whites to misuse prescribed pain drugs. This assumption is incorrect and evidence shows Black and White patients are equally likely to abuse prescribed pain drugs.


August 1, 2013

physicians’ implicit biases begin to influence their medical decision-making during the course of their medical training, or perhaps even as a consequence of how they are trained. 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 a southern U.S. university. This longitudinal study followed students over three years. Researchers administered two IATs, the Race-Attitude IAT, and one measuring skin tone preferences annually during the study. Four findings are noteworthy. First, pre-professional students in this study exhibited significantly higher levels of pro-white bias than test takers in the nation as a whole. Remarkably, 96% of Hispanic, 76% of Asian, and 64% of the black students tested revealed statistically significant unconscious preferences for whites over blacks. Secondly, the students’ implicit bias scores were negatively correlated with their self-reported levels of cultural competency. Thus students confidently believed themselves to be effective communicators in cross-cultural situations, despite their high IAT scores. Third, and perhaps most significantly, the White-Means study revealed that medical students’ implicit bias scores grew worse as their training progressed, while pharmacy and nursing students scored lower as they biases as they matriculated. Finally, the study found a correlation between students’ socioeconomic 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.

A group led by Gordon Moskowitz published a study in 2012 that continued exploring the connection between physicians’ implicit attitudes, and their diagnostic decisions. Moskowitz tested physicians’ ability to identify medical terms quickly from a group of randomly generated words appearing on a computer screen. However, immediately before the selected words appeared, physicians were subliminally “primed” with a photograph of either an African- or European-American face. The photograph flashed quickly in the physician’s peripheral field of vision so that it could not be consciously perceived. 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. 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. 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. Thus, physicians in Moskowitz’s study implicitly associated certain diseases with African-Americans, without being aware they were doing so. 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

92 Shelley White-Means et al., Cultural Competency, Race, and Skin Tone Bias Among Pharmacy, Nursing, and Medical Students: Implications for Addressing Health Disparities, 66 MED. CARE RES. & REV. 436 (2009).
93 Technically, because this study did not follow the same students over the three-year period, it is a cross-sectional rather than longitudinal study.
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 un-biased assessment and objective treatment decisions about the individual minority patient in her care. “[E]ven 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.”95 This type of stereotyping is particularly dangerous to minority patients’ health outcomes.

Implicit bias has an impact beyond the physician’s clinical decisions but also affects the interaction and communication physicians have with their patients. In 2010, a group of social psychologists led by Louis Penner coined the term “aversive racism” to describe how unconscious racism infiltrates the complex and subtle communication exchange between physicians and their minority patients.96 An aversive racist describes the individual whose implicit and explicit bias measures present a contradiction. Aversive racists, according to Penner, show very low explicit bias scores, together with very high implicit bias scores. 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 150 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. The physicians Penner studied were almost all non-black, foreign trained doctors, a typical demographic profile for inner city providers who serve poor communities of color. This lack of diversity among physicians was a limitation of the study. 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. Nevertheless, Penner’s findings are troubling. African-American patients in this study reacted most negatively towards physicians who met the criteria for an aversive racist. According to Penner, African-Americans trust these physicians least of all physicians, perceiving a lack of trust, friendliness, and teamwork in their relationships. Penner concludes black patients are unlikely to accept medical advice, adhere to treatment regimes, or schedule and attend follow-up visits with these physicians.

Further research is needed to fully understand the connection between implicit bias and health disparities. There is more to learn about how implicit biases held by patients such as whether their biases towards their providers might affect health care disparities by reducing adherence and compliance with medical recommendations. Further research will show how implicit biases affect real-life medical decision-making outside the research setting, and how implicit bias affects patients from racial and ethnic groups beyond blacks and whites. Researchers have yet to study the impact of implicit bias where other patient characteristics overlap such as socioeconomic status, gender, and sexual orientation. Yet, even at this stage, the empirical record paints a disturbing picture.

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

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95 Moskowitz et al, American Journal of Public Health (Published online ahead of print March 15, 2012) at e5.
96 L.A. Penner et al., *Aversive Racism and Medical Interactions With Black Patients: A Field Study*, 46 J.
EXPERIMENTAL SOC. PSYCHOL. 436 (2010).
groups. The Haider and White-Means studies add another nuance to suggest that biases evolve to affect treatment and communication during the course of medical training. 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 this data is serious and has been tolerated for far too long. The data that follows provides the necessary basis for principled application of anti-discrimination law to radically shift the paradigm that to date, as tolerated disparities due to 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. This is because most legal literature assumes that discrimination due to implicit biases operates automatically, without intention or conscious awareness is also unavoidable, intractable, and beyond conscious control. It is not. 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 absolutionist 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. The empirical record now offers strong evidence that implicit attitudes are neither inaccessible nor inescapable; they are not impossible to control, 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 40 and 50 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, driving habits can be altered. 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. It turns out, implicit biases can change for similar reasons. Thus malleability describes an on-going learning process in which people with old, objectionable implicit biases can learn to respond to newer, more appropriate attitudes and beliefs. Put another way, long-standing 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 . . . . The 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 to anti-discrimination efforts of this understanding of malleability cannot be overstated. First, it shows that interventions may be strategically introduced to alter implicit biases. Second, 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, what is meant is that current inputs can be adjusted so that the resulting stereotype patterns no longer conform to traditional discriminatory 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 sub-conscious 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.

103 Blair, supra note 69.
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 the intervention. Figure 2 shows when the intervention occurs during the cognitive process.\(^{104}\)

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### Figure 2
Three Types of Interventions to Reduce The Impact of Implicit Bias

<table>
<thead>
<tr>
<th>Type A Intervention</th>
<th>Type B Intervention</th>
<th>Type C Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Store</td>
<td>Identify</td>
<td>Retrieve</td>
</tr>
<tr>
<td>Social Knowledge</td>
<td>Group</td>
<td>Group</td>
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<tr>
<td>Membership</td>
<td>Stereotypes</td>
<td>Stereotypes</td>
</tr>
<tr>
<td>Activated</td>
<td>Form</td>
<td>Form</td>
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<tr>
<td>Implicit</td>
<td>Judgments</td>
<td>Decisions and Conduct</td>
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<tr>
<td>Biases</td>
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Type A methods reduce implicit biases by intervening before stereotypes are sub-consciously 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. The strategies that are introduced after stereotypes are activated, but before implicit biases are formed, are Type B interventions. 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. Psychologists explain that the goal of these interventions is to inhibit expression of implicit biases and prejudices after they have been formed. 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 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 willing to invest the “intention, attention, and time.”\(^{105}\) 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. . . . [E]limination 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

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\(^{104}\) See, Part II.A. *infra*.

\(^{105}\) Devine, *supra* note 71, Vol. 56, No. 1, 5-18 at 16 (1989) (See Study 3 in which low-prejudice individuals chose non-prejudiced thoughts to record in contradiction to a list of stereotypes about Blacks they had earlier generated).
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.\textsuperscript{106}

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.\textsuperscript{107} Cultural Competency programs typically provide episodic exposure to factual information about health disparities and minority communities.\textsuperscript{108} These curricula encourage “color blindness” or suppression of anti-group attitudes in order to achieve equality of care. 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.\textsuperscript{109} Stereotype negation instead aims at removing and replacing automatic, implicit, sub-conscious 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.\textsuperscript{110} 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.\textsuperscript{111} “[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 negators.”

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. Researchers found that training significantly reduced both implicit and explicit anti-black biases.\textsuperscript{112} Researchers measured students’ implicit biases twice. Students in both classes were tested at the end of the 14-week semester, and at the beginning to confirm that neither group was less affected initially by implicit bias than the other. This study measured implicit preferences using the Implicit Association Test, as well as the Lexical Decision Task (LDT) test to measure automatic stereotypes.\textsuperscript{113} The stereotype negation training

\textsuperscript{106}Id. at 15.


\textsuperscript{108}See, e.g., Office of Minority Health website which offers several certificate courses for health care providers to learn cultural competency. The Physicians’ Guide to Cultural Competency available here, https://cccm.thinkculturalhealth.hhs.gov/, 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. The training includes no mention or address of implicit biases or automatic stereotypes, prejudices, beliefs, or attitudes of any kind.


\textsuperscript{111}Id. at 884.

\textsuperscript{112}Laurie A. Rudman et al., “Unlearning” Automatic Biases: The Malleability of Implicit Prejudice and Stereotypes, 81 J. PERSONALITY & SOC. PSYCHOL. 856 (2001). These studies were quasi-experiments because participants were volunteers, and therefore were not randomly selected or assigned.

\textsuperscript{113}The Lexical Decision Task (“LDT”) first exposes subjects to an event that is expected to activate a stereotype (e.g. a Black man enters the room). Next, subjects are shown a series of words and phrases that are non-words (it won't let me "comment" on footnote text for some reason, but I wanted to say that this phrase is confusing. It sounds
in this study included journaling exercises that required students to document and discuss their own biases, motivations for bias, and ways to counteract their biases. Pro-social contact with members of other racial and ethnic groups including an African-American male professor played an important role in the training. Discussion that focused on personal views and experiences sometimes resulted in heated exchanges among students but allowed them to encounter, share, and process personalized experiences as well as information about prejudice over several weeks. 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. The sample of the leading studies on stereotype negation training presented here is not intended to treat the subject exhaustively. The point is to demonstrate the strength of the social science record supporting 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. This has been confirmed in numerous laboratory studies such as one in which researchers demonstrated that automatic negative attitudes could be reduced by more than 50 percent. In this 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. A follow-up experiment showed these findings were not limited to racial attitudes, but were applicable to age-related biases. In both instances, significant reductions in automatic preferences were modified. These are useful findings that have been replicated by other scientists studying race, gender, and age implicit biases. However the practical importance of 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 studies 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, women 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, college students from two campuses were asked to complete identical gender-IAT studies. These participants were asked to describe their course load, extracurricular activities, and role models on campus. In contrast to the group in the first study, these college students were exposed to live counter-stereotypes of women in leadership roles in their every-day lives. On both campuses studied, women occupied leadership positions as deans, math and science professors, college presidents and other counter-stereotypical roles. However, women more frequently occupied these leadership positions at the all-women’s college than at the co-educational

as though some of the words were non-words, which is hard to understand. Also, "phrases" makes me think of a series of words, so that aspect is a bit confusing as well.). The subjects must decide quickly whether each item is a word or a non-word. A faster response to stereotype words than to non-stereotypic attributes is defined as and measures an (this is also confusing language) automatic stereotype.


115 See Rudman et al., supra note 81, (describing a prejudice and conflict seminar taught by admired Black professor)


117 See Claire Cullen et al., The Implicit Relational Assessment Procedure (IRAP) and the Malleability of Ageist Attitudes, THE PSYCHOLOGICAL RECORD, 49; 591-620 (2009).
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 reported “[b]oth the laboratory study and the field study reported in this paper converge on the same message – women’s automatic stereotypic beliefs about their in-group can be undermined if they inhabit local environments in which women frequently occupy counter-stereotypic leadership roles.” These gender-bias studies importantly replicate results seen in other controlled laboratory settings showing the malleability of implicit race-bias.

Experiments have shown that both still and video images of counter-stereotypes work to reduce implicit biases. Photographs of an admired black, elderly, or female subject or videos showing counter-stereotype conditions can effectively reduce automatic stereotyping. In one study, some participants watched a short video showing African-Americans enjoying a family barbecue or attending church, while other participants saw videos of blacks in gang-violence scenes. 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. In another study, researchers showed that internally generated counter images also work to reduce bias.

“Imagining” is a variant on the use of counter- gender stereotypes based on an individual’s ability to think up their own counter-stereotype images. One group performed five experiments to show that 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. Put another way, this series of experiments shows that individuals can reduce their implicit biases by what they choose to think. In three of their five experiments, researchers asked undergraduate students to spend several minutes imagining what a strong woman is like, including her hobbies, what she is competent at doing, and other features that came to mind. The students reported that they had no difficulty developing mental images of counter-stereotypes, which included a businesswoman, athlete, warrior, or simply a woman who balanced family, career and friends well. A control group of student participants were asked to spend the time thinking about neutral images such as a Caribbean vacation. 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 the speed of their associations 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, they concluded implicit stereotyping was “substantially diminished by counter-stereotype imagery.”

The implications for this research showing that Type B counter-stereotypes reduce implicit biases are profound because 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 individuals and institutions can intentionally employ counter-stereotypes to reverse the impact that implicit biases have on unintentional discrimination.

119 Blair et al., supra note 85.
120 The fourth experiment used a “Go/No-go Association Test,” (GNAT) that works to examine implicit associations within a single category instead of between categories, like the IAT. The fifth experiment used a Deese-Roediger-McDermott (DRM) false memory paradigm, which is a well-recognized memory association test of implicit attitudes.
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 from a scientific point of view 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 mind reading.”

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 show lower levels of implicit prejudice. This is a second category of Type C intervention. A series of studies that manipulated participants’ sense of whether their views were approved or disapproved by peers was particularly insightful. 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 extraordinary influence that perceived social can have on reinforcing or dismantling implicitly held race stereotypes. 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 bear detailed discussion.

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 with their judgments. This feedback signaled the level of social consensus around the subjects’ explicit views on race. Experimenters then asked each student individually to follow an African-American student who entered the study room, ostensibly to usher the subject to the next phase of the test. However, the interaction between the escort and the student subject was a part of the experiment. This phase allowed researchers to observe the effect that weak and strong stereotype consensus had on students’ behavior.

Researchers reviewed the students’ interaction with the black escort, comparing students with low-prejudice and high-prejudice, and those who had received either low-consensus or high-consensus feedback. For example, the researchers provided a line of seven chairs during the waiting period and watched how closely each student chose to sit next to the African-American escort. Also, they asked students during the wait 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, students’ prejudices were strengthened by perceived high consensus. Moreover the results also reflected the impact stereotypes have on conduct. Low prejudice participants...

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121 Mitchell & Tetlock, supra note 46.
who received high consensus feedback sat closer to the African American target, as compared with individuals who did not have their low prejudice beliefs confirmed. In contrast, high-prejudice individuals in the high-consensus group sat farthest away from the African-American target when compared with individuals who did not have their beliefs validated. The group of students who believed their high prejudiced views were widely shared, estimated higher percentages of blacks held unfavorable stereotypical traits when compared with the students whose negative race views were not validated by consensus. The correlation analysis these researchers performed showed that negative implicit attitudes and express behavior was greatest for students who believed their views were widely shared.

The second experiment in this series tested the accessibility of the automatic stereotypes that were triggered by priming. As in the first experiment, researchers in this study asked students to identify their beliefs by indicating the percentage of African-Americans who possessed positive and negative stereotypical traits, and then these students were provided feedback that randomly showed their views were broadly shared or contradicted by their peers. In the next phase, students received subliminal primes by being exposed to either names frequently associated with blacks (Tyrone, Latisha) or with whites (Ryan, Amanda). Next, using the Lexical Decision Task test to measure implicit biases, researchers assessed students’ reaction times to yet another set of stereotypes that had not been previously identified. The researchers found that automatic stereotype associations with negative traits came more quickly to students who perceived their individual prejudices were validated by consensus. They also found that providing confirmation about one set of racial stereotypes made subjects quicker to access other racial stereotypes. These researchers conclude their two experiments demonstrate that “intergroup beliefs and behaviors are determined by the perception that those individual beliefs are or are not shared with others.” Moreover, both experiments show 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 various Type C interventions offer three important insights. First, individuals can inhibit negative stereotypes and activate positive ones when doing so is beneficial to their self-image and responsive to social demands or relationships. Second, social context can produce the requisite motivation to achieve these modifications. 125

4. Limitations

While the evidence that implicit biases can be affected and even reduced by interventional strategies is promising, some important qualifications should be noted. First, none of the studies suggest that implicit biases can be reduced to zero. Thus malleability strategies do not promise to eliminate implicit biases or their effects entirely. 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 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 towards blacks, do not vary implicit prejudices towards Asians. 126 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. 127 In these experiments, the variety of

125 See Rudman et al., supra note 81, at 857.
126 See Lowery et al., supra note 91.
127 See Blair, supra note 69.
distractions that could produce busyness, 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 interventions.

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. Other researchers have criticized malleability as unidirectional; they say automatic preferences are easily formed but less readily reversed. However, their conclusion is contrary to the weight of the empirical record. 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. 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 “extra-personal associations” that precede the test and have nothing to do with implicit attitudes. However even these critics admit 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. Moreover, these objections go to the validity of the IAT, which has been debated so extensively in the literature that one well-known and respected researcher has described the test’s validity as a “scientific certainty.”

The study of implicit bias presented here represents a challenge for the legal community, not only because it confronts the notion that racial bias is a thing of the past, and because findings “of a widespread, automatic form of race preference violates people’s image of tolerance,” but now the evidence of malleability directly challenges 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 effective interventions available to individuals and institutions wishing to reduce discrimination due to implicit and unconsciously held biases. Moreover, social scientists have drawn practical lessons from these studies that 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

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[129] Joy-Gaba and Nosek increased the number and types of exposures, as well as the prior day-to-day familiarity that study participants had with the people in the photographs. They added photographs of admired whites to their study and had participants complete studies online as well as in laboratories. Although Joy-Gaba and Nosek did see reductions in implicit racial biases in two of their experiments, the results were not as robust as those of prior studies. Their third study showed no reduction in implicit biases. Yet it would be foolish to generalize from these three experiments, which varied numerous factors pertaining to counter-stereotypes in laboratory experiments. The “surprising” limits that these researchers found are restricted to the laboratory conditions that the researchers produced.

[130] H. Anna Han et al., *Malleability of Attitudes or Malleability of the IAT?*, J. Exp. Soc. Psychol. 2010 March 1; 46 (2): 286-298


backfire, while enhancing providers’ understanding of the psychology of implicit bias will encourage self-correction. Ideally the most effective strategies might incorporate Type A training interventions, 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 next 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 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 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 operated primarily as a public health 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 illegal. Certainly, the evidence that intentional interventions can affect unconscious biases would have helped Lawrence to close this constitutional.

When Linda Krieger explained that 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 decreased the validity of anti-discrimination adjudication, increased costs, discouraged 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 empirical record” that discredited judicial assumptions about the intentionality of human behavior incorporated in disparate treatment doctrines. However the social science record referenced they made no mention of malleability. Similarly when Barbara Flagg wrote to advocate the doctrine of

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136 But see Richardson, supra note 2.
137 Charles R. Lawrence, The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism, 39 STAN. L. REV. 317 (1987). 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.
138 Id. at 330.
disparate impact should be reformed to remove the assumption that “transparently white 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 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, which he expects to occur, or which he should expect to occur. Indeed when Linda Krieger explained why her own proposals fell short of the negligence option, she pointed to the lack of guidance from cognitive psychologists concerning what actions serve to reduce intergroup bias to explain her fear that negligence might result in over-compliance or under-compliance. After observing the futility of courts search “for ‘discriminatory motive or intent’ without understanding the most prevalent form of discrimination today is not ‘motivational rather than cognitive in origin,’” she stopped short of endorsing a negligence standard saying, “[h]owever, 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.” Now, seventeen years 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 changes to require antidiscrimination law reckon with unconscious bias should not overlook the impact of evidence on malleability. Samuel Bagenstos questioned whether courts could realistically undertake a holistic scrutiny of workplace dynamics. 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. Amy Wax argued the cost of fixing “unpredictable and unavoidable” cognitive bias would be unproductively high. Both Wax and Bagenstos point to the ubiquity and inevitability of implicit biases to argue they should be left alone. 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...
Physician Unconscious Bias

rational 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 malleability 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 LEGAL 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 best be combated when brought to the government’s attention by its victims. Broader enforcement will also increase incentives for government contractors to employ interventions that reduce discrimination due to implicit bias. The majority of the statutory amendments needed to accomplish this change have already been proposed before Congress,148 however this section also proposes additional language 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 scientists have amassed about preventing harms due to 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 as intentional.

148 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. S4460-03.
discrimination. 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. Intentional discrimination should be defined to include the intentional failure to employ reasonable efforts to reduce discrimination due to implicit bias. 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.\textsuperscript{149}

\textsuperscript{149} The amended language that I propose would read as follows:

Section 601 of Title VI:

(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 only 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 it has taken reasonable steps to reduce discriminatory harms due to unconscious or unintentional biases; and
   c. 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
   d. the 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.

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

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, including the failure to act reasonably to mitigate discrimination due to unconscious or unintentional bias.

(c) Nothing in subsection (b) limits the authority of a Federal department or agency to enforce section 601.
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. In United States v. Fordice,150 for example, 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. Initially, the Department of Health Education and Welfare (HEW)151 filed the suit against Mississippi in 1969, 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 18-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, the Board defiantly implemented a compliance program that had been twice rejected over HEW’s objection. Yet, according to the Fordice Court’s description, segregation continued; by the mid-1980’s, 99% of Mississippi’s white students were still enrolled in the state’s five white colleges, and 71% of the state’s black students still attended one of the state’s three segregated black institutions.152

Ultimately, it was the private Fordice litigants who prevailed in the 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.153 Nevertheless, when Justice White wrote for the majority, his decision awarded the black citizens of 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. This is the goal of including a negligence standard of care under Title VI.

150 505 U.S. 717 (1992). (just as a reminder, this case was cited in Footnote 11, but I think a full cite is appropriate here, as there are many pages in between).
151 Predecessor to the Department of Health and Human Services (DHHS).
152 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, e.g., Ralph Richard Banks & Richard Thompson Ford, (How) Does Unconscious Bias Matter? Law, Politics, and Racial Inequality, 58 EMORY L.J. 1053 (2009).
153 The Fordice case has been widely criticized for failing to equalize funding for Mississippi’s historically black universities.
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 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 account” that requires institutions to manage the diversity within their organizations and minimize the operation of discriminatory bias, thereby providing an impetus for structural change and more clarity for both institutions and individuals who would be asked to undertake a contextualized inquiry into their conduct. This approach also challenges courts to incentivize social and behavioral changes based on the “core insight” that “law can serve as a powerful tool for structuring... incentives in socially beneficial ways.”

Here is how a 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 were adhered only rarely for patients of the plaintiff’s ethnic minority. This example, if proved, clearly leads to health disparities for the plaintiff’s ethnic group, but would not likely be actionable under the existing Title VI law. Under the existing Title VI, the defendant health provider in this example could respond by showing that it had a formal policy in place for patients with limited English proficiency. Apart from a showing the hospital deliberately sought to deny access to translation services for these patients, the claim would come to an end under current law. 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

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154 Oppenheimer, *supra* note 112.
155 813 F. Supp. 2d 417 (2011); see also the *Blunt, Couch,* and *Morales* cases discussed earlier in this section, where courts referred to the reasonableness of defendants’ conduct.
156 See generally *Green, supra* note 110.
158 CLAS Standards are a series of 14 mandates, recommendations, and guidelines to provide a uniform framework for health care organizations to use in designing and implementing their self-imposed programs to address health disparities. See U.S. Department of Health and Human Services, OPHS Office of Minority Health, “*National Standards for Culturally and Linguistically Appropriate Services in Health Care Executive Summary,*” (March 2001).
empirically demonstrated to influence providers’ implicit biases. The steps 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 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.\footnote{See, e.g., K. Kawakami et al., supra note 79, at 871-888; Irene V. Blair & M.R. Banaji, Automatic and Controlled Processes in Stereotype Priming, 70 J. PERSONALITY & SOC. PSYCHOL... (1999).} Alternatively, the defendant hospital could show that its required 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.\footnote{See, e.g., L. Sinclair & Z. Kunda, Reactions to a Black Professional: Motivated Inhibition and Activation of Conflicting Stereotypes, 77 J. PERSONALITY & SOC. PSYCHOL... (1999).} 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.\footnote{See, e.g., L. Kawakami et al., supra note 79, at 871-888; Irene V. Blair & M.R. Banaji, Automatic and Controlled Processes in Stereotype Priming, 70 J. PERSONALITY & SOC. PSYCHOL... (1996); Dasgupta & Greenwald, supra note 83 at 800-814.} 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 implicit ethnic bias had been structurally addressed by the hospital would result in a damages award to the plaintiff.

B. Advantages and Objections

By in large, it is likely that courts will welcome the clarity provided by the reforms to Title VI proposed here because they align with Congressional intent, and with the Supreme Court’s traditional Title VI jurisprudence. Moreover, the reasonableness standard provides an objective and workable way to operationalize the scientific evidence we now have about the way discrimination works and can be controlled. The United States Supreme Court’s early decisions plainly established that Title VI reached cases of unintentional discrimination.\footnote{See, e.g., After Sandoval: Judicial Challenges and Administrative Possibilities in Title VI Enforcement, supra note 39 at 1774 (2003). Justice Scalia went further, strongly hinting that Section 602 of Title VI might not support disparate impact claims alleging unintentional discrimination though he declined to decide the question in Sandoval.} 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 Alexander v. Sandoval.\footnote{See Note, After Sandoval: Judicial Challenges and Administrative Possibilities in Title VI Enforcement, supra note 39 at 1774 (2003). Justice Scalia went further, strongly hinting that Section 602 of Title VI might not support disparate impact claims alleging unintentional discrimination though he declined to decide the question in Sandoval.} There, Justice Scalia wrote for the Court to opine 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.\footnote{532 U.S. 275 (2001).} 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 *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* to conclude that Section 601 of Title VI only extended as far as the Equal Protection Clause and therefore encompassed only intentional discrimination, have subsequently written to denounce this view in *Guardians Association v. Civil Service Commission*. Justice White rejected this limiting view explaining, “disproportionate-impact discrimination is subject to the Title VI regime” and clarifying that “that §601 does in fact reach some instances of unintentional discrimination.” Justice White flatly asked and answered the question writing, “[t]he 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 . . . I conclude, as do four other Justices in separate opinions, that the Court of Appeals erred in requiring proof of discriminatory intent.”

Justice White, of course, could not reach this conclusion without distancing himself from his ruling in *Bakke*. Therefore, he went further to say that although “I recognize that in *Bakke* five Justices, including myself declared that Title VI does not of its own force proscribed unintentional racial discrimination. . . . [However h]olding 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. . . . [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 in *Guardians*. He wrote, “I agree with Justice White that proof of discriminatory animus should not be required.” Justice Marshall wrote, “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 to the decision in that case.” Justice Marshall went on to explain 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.

In *U.S. v. Fordice*, Justice Thomas’ concurrence made clear that the case involved unintentional discrimination which Title VI reached when he said, “[t]oday we hold that ‘if 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 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 *Grutter v. Bollinger* concurrence, 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 *Gratz v. Bollinger* she wrote, [b]ias both conscious and unconscious, reflecting traditional and unexamined habits of thought keeps up barriers that must

166 463 U.S. 582 (1983).
167 *Sandoval*, 532 U.S. at 308.
168 *Guardians Ass’n*, 463 U.S. at 584.
169 Id. at 593.
170 Id. at 615.
171 Id. at 623-24.
172 Id. at 622; see also *Alexander v. Choate*, 469 U.S. 287 (1985) (“…discrimination against the handicapped is primarily the result of apathetic attitudes rather than affirmative animus.”).
173 505 U.S. at 745 (citing *Ante at 2736*).
175 Id. at 345 (Ginsburg, J., concurring).
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.

The reform proposed here will also provide a comprehensive conceptual framework for addressing unconscious racism. In 2010, Jerry Kang and Kristin Lane provided a two-by-two quadrant model that is useful to evaluate the strength of the Title VI reform I propose. Their model categorizes legal interventions to address discrimination based on their level of specificity and the point in time at which the intervention occurs. The legislation I have proposed provides the advantages of specific, general, ex ante and ex post interventions as the quadrant model defines these spaces. The legislative amendment to Title VI is an ex ante remedy, that operates at a general level in what Lane and Kang call the “Preventative” quadrant. The reasonableness standard creates incentives for institutions to engage in specific ex ante self-analysis to enact prophylactic policies that may later be referenced as defenses to protect against liability in the event that plaintiffs bring ex ante specific remedies through litigation.

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 pose an interesting 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. They are just because liability is predictable and it is avoidable under these rules. 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 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 25 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 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

177 Id. at 300.
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**

The science of implicit bias reviewed and updated here is intended to jumpstart the conversation about the appropriate legal and policy responses to the life-threatening health disparities that continue to plague our system. Inequality in healthcare, as elsewhere, is an ethical, social, and legal concern; this discussion treats medical injustice with the level of seriousness it deserves but represents only the beginning of the conversation that will precede lasting change in the medical profession. The malleability evidence presented here affirmatively answers the question of whether it is morally acceptable to find a person culpable for action from unintentional attitudes. Because we now know enough now about unconscious racism and the harms it causes, we may hold physicians morally and legally responsible for failing to take the steps that social science reveals are reasonably available to effectively control bias, reduce discrimination, and eliminate inequities. Where courts and legislators have been reluctant to penalize unintentional attitudes or conduct, this article show we may fairly use law to incentivize reasonably prudent efforts to prevent deadly discrimination. In short, 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. The evidence that implicit biases influence physicians’ clinical decision-making, patient communication, and statistical interpretation requires a deeper conversation about legal causation. Understanding the extent to which bias causes disparities must inform the continued search for other contributors to health disparities. But the negligence standard and Title VI reforms proposed here reflect the urgency of addressing the fact that in America, African-, Latino-, Asian-, and Native-Americans live shorter and less healthy lives than whites because they are victims of unregulated physician implicit biases. Now that the empirical record demonstrates that unconscious racism is within individual, institutional, and societal control the deleterious and deadly discrimination it causes in health care must be addressed. The good news presented in this article is that the social science data now includes sufficient information to identify reasonable interventions that can effectively reduce implicit race bias, and the discrimination it causes. Moreover, the evidence that physicians themselves evince willingness and interest in improving their patient care when confronted with evidence of their own bias suggests that health care providers need not wait for Congress to enact changes to Title VI or any other civil rights statute before taking prudent steps to eliminate unconscious racism and its effects in health care today. Most assuredly, health care providers may use the information presented here to make meaningful changes to address physician bias before law requires them to. However, restoring Title VI to its originally intended scope by returning the statute’s public-private enforcement model, and implementing a negligence standard of care to regulate unintended discrimination, will radically shift the social norm throughout the health care system, that today tolerates gross inequality in health and health care, and instead create a new medical norm that values and protects justice and equality in American health care.