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Stereotyping in mental health can have serious implications for individuals seeking help. The way we perceive mental health issues is influenced by various factors. Let’s break down the causes of stereotyping in mental health perceptions and how they affect individuals. 1. Societal Influences Society plays a huge role in shaping our views on mental health. Here are some key points: Cultural Norms: Different cultures have varying beliefs about mental illness. In some cultures, mental health issues are seen as a sign of weakness, while others may view them as a medical condition. Historical Context: Historical events, such as the asylum movement, have left a lasting impact on how mental health is perceived. These institutions often portrayed individuals with mental health issues in a negative light. Education: Lack of education about mental health can lead to misconceptions. Many people may not understand mental health disorders, leading to fear and misunderstanding. 2. Personal Experiences Personal experiences can greatly influence how we view mental health in others: Family Background: If someone grew up in a family that stigmatized mental health, they may carry those beliefs into adulthood. Individual Encounters: Personal experiences, whether positive or negative, can shape perceptions. For example, someone who had a bad experience with a mental health professional may develop a negative view of mental health care. 3. Media Portrayal Media representation of mental health plays a crucial role in shaping societal perceptions: Movies and TV Shows: Often, films and television portray individuals with mental health issues as violent or dangerous. This can lead to fear and misunderstanding. News Coverage: Sensationalist news stories can skew public perception. For instance, when a person with a mental disorder commits a crime, the media may focus on their mental health status rather than the crime itself, reinforcing negative stereotypes. 4. Lack of Personal Interaction Not having personal interactions with individuals who have mental health issues can lead to stereotypes: Fear of the Unknown: People often fear what they don’t understand. Without direct contact or education, individuals may rely on stereotypes to form their opinions. Generalization: When a person hears about a mental health condition, they may generalize and think that all individuals with that condition behave in a particular way. Real-Life Examples Let's consider a few real-life examples to illustrate these points: Example 1: A young woman named Sarah grew up in a household where mental illness was rarely discussed. When she faced anxiety, she felt ashamed and hesitant to seek help because of the stigma she associated with it. Example 2: A news report highlights a tragic incident where an individual with schizophrenia committed a crime. The headlines focus on the mental illness, causing the public to associate schizophrenia with violence, perpetuating harmful stereotypes. Conclusion Understanding the causes of stereotyping in mental health perceptions is essential for promoting acceptance and accurate representations in society. By recognizing these influences, we can work towards reducing stigma and fostering a more supportive environment for those affected by mental health issues. Mental health diagnoses are common across the world. Data collected by the United Nations (UN) suggests that in 2022, approximately a billion people worldwide have a mental disorder. In England alone, around 1 in 4 people will experience a mental health problem every year, with 1 in 6 people reporting experiencing a common mental health problem such as anxiety or depression. Many people unfortunately have a negative preconception of individuals with a mental health diagnosis, and people living with a mental health condition often have to battle against these stereotypes. In this article, we look at some of the most common mental health stereotypes, how mental health is portrayed in the media, and how we can combat the misconceptions surrounding mental illnesses. Common mental health stereotypes Often, the perception of an individual with a mental health diagnosis is quite negative, and may stem from the portrayal of mental health in the media, societal attitudes including stigma and prejudices, and lack of understanding. Some of the most common mental health stereotypes are that individuals with a mental health condition are lazy and lacking motivation, should try harder, or should “just get over it”. Individuals may be told they have nothing to be sad about, or nothing to worry about. The reality is that, while some external factors can contribute to an increased risk of developing a mental health condition, mental health does not discriminate, and anyone can be affected at any point in their life. Another negative perception that can be quite damaging is the idea that everyone with a mental health diagnosis is violent or dangerous. This misconception is most commonly associated with schizophrenia. However, a study conducted by Patricia R. Owen, Ph.D. found that individuals with a mental health condition are more likely to be victims of violent crime, rather than perpetrators. Many of these mental health stereotypes may arise from the way mental health conditions are portrayed in the media. Portrayal in the media It is very important to be aware of the content that we consume. Many films and tv programmes over-dramatise and exaggerate things for entertainment purposes. In this video, Help for Heroes Veteran David Dent MBE shares his thoughts on the portrayal of veterans and mental health stereotypes in TV & film: Studies have shown that individuals with mental health conditions are most often displayed as crazy, violent, and unpredictable. Negative reactions to characters with mental illnesses are also often portrayed, for example, fear, rejection, and ridicule. In this review ‘Media portrayal of mental illness and its treatments: what effect does it have on people with mental illness?’ by Heather Stuart, Heather discusses the impact this portrayal has not only on influencing the public, but also on how it makes individuals living with mental health diagnoses feel. It is important that we try to watch films and tv with an open mind. We should question the way mental health is portrayed in films and on tv, even in the news, and do our own research around different mental health conditions using credible sources. Education is a powerful tool and having a basic understanding of different mental health conditions can allow us to challenge any misconceptions we may have had, and have open conversations with others who may have these prejudices. Read more on how the media contributes to mental health stigma in this article from Very Well Mind. How we can combat mental health stereotypes As well as educating ourselves and keeping an open mind, one of the biggest ways to combat mental health stereotypes and stigma is to talk and keep conversations open. Being honest with friends and family about how we’re feeling, sharing our experiences with others if we feel comfortable to do so, and getting involved in campaigns to promote awareness, are really important ways to combat mental health stereotypes. Last year, Dr Alex George started a campaign with the aim of reducing the stigma around medication and mental health. Additionally, ITV’s “Britain Get Talking” campaign has been running for a number of years now, and encourages us all to put down the technology, turn off the TV, and have a meaningful conversation. The most recent campaign is focused on teenagers and young people, as the number of young people being treated per month for mental health problems is currently the highest on record – 400,000. Ultimately, individuals living with a mental health condition are just like anyone else. Mental illness is not a choice, and it can affect anyone at any point in their lives. Northern Healthcare teams Northern Healthcare is a 24/7 enhanced supported living service for individuals with a mental health diagnosis, learning disability or autism. Our teams support our residents to live as independently as possible, as well as advocating for mental health both within services and in our wider society, fundraising for the mental health charity Mind, and encouraging residents to share their stories where they are comfortable to do so. Read some of our resident’s stories here. Find out more about life at our services here, and find out more about our bespoke support model here. Further reading Read about the different types of anxiety disorders. Find out how to recognise the symptoms of depression. Photo by Emma Simpson on Unsplash. We see stereotypes everywhere we look: the television, the Internet, even in books and movies. While we may think there’s no harm in viewing misinformation, especially when it’s in the form of entertainment, it actually couldn’t be further from the truth. Our views on the world and others are often formed by the media as well as by friends and family. From forming first impressions on our new coworker or neighbor to having an opinion about the latest Netflix series, we all make judgements about others and our surroundings on a regular basis. So, what does this mean when we make a judgement about a person based on false information? Our views of the world are shaped by what’s around us and what we see. When we see films and television shows that show those diagnosed with Schizophrenia as dangerous, we tend to adopt a similar view, and thus enforce a negative stereotype. When someone holds a stigmatized view, they are putting the individual they are stereotyping in a box. This not only limits that person’s true capabilities and potential, but it also enforces a false notion that these people are inferior. When it comes to mental illness, there are a wide range of false stereotypes. Common Negative Stereotypes About Mental Health One of the most common negative stereotypes that gets presented in the entertainment industry is that people with mental illness are dangerous and a threat to society. Instead, people who suffer from mental illness are actually more likely to be the victim of crime, not the perpetrator. Another stereotype that many unfortunately believe is that those with mental illness have “brain damage” or are crazy. We don’t consider someone who gets bronchitis or the flu to be permanently sick, so we shouldn’t consider someone diagnosed with depression or PTSD as permanently mentally ill. They do not suffer from brain damage, nor are they crazy; they suffer from a treatable illness. It is also a popular misconception that those with mental illness cannot be cured. This, however, is not the case. While some mental illnesses such as depression or bipolar disorder may have genetic components that factor into if one develops it, nobody is born with a mental illness. Instead a variety of factors come into play determining if someone develops a mental illness, such as stress, traumatic events, abuse endured, and more. Anyone can develop a mental illness at any point in their life; however, if it is diagnosed early, many people can experience a complete recovery. Others may experience episodes throughout their lives, but with ongoing treatment, they can manage the symptoms and live healthy and productive lives. The Effects of Negative Stereotypes on Those Suffering Negative stereotypes not only impact the perceptions of others, but it also creates unhealthy views on personal identity among those who suffer from mental illness themselves. Those who are suffering from mental illnesses, such as depression, may be reluctant to seek help or get treatment. Due to formed stereotypes, they believe that admitting they are suffering also means they are admitting that they are crazy or defected. This perception is completely false and prevents those suffering from getting the help they need. Those suffering from a mental illness may also believe that their mental illness defines them, and limits their capabilities. It’s important to realize that a person’s mental illness does not define who they are as a person, nor should it limit their success in life. The Effects of Negative Stereotypes Held by Others While facing scrutiny from strangers never feels good, it can be more damaging when these misunderstandings are expressed by friends, family members, and co-workers. Everyone values what their friends and family have to say, so when a friend or family member doesn’t understand a person’s mental illness, it can feel degrading. They may even try to convince them “it’s all in your head” and deter them from seeking help. While friends and family may not have ill-intentions when saying such things, these actions are very damaging and prevent those suffering from getting the help they need. Negative stereotypes can also affect those suffering in the workplace as well as in school. Taking care of our mental health is just as important as our physical health, but while taking a sick day is normalized, we may feel scrutinized for taking a “mental health“ day. We can all work together to destigmatize mental illness. Understand that not everything portrayed on TV is accurate, and educate others about the importance of properly caring for mental health. If your mental health is suffering, you’re not alone. It’s important to get the help you need. Speak to your doctor today, and let them know what symptoms you’re experiencing, so you can best discuss your treatment options. If you’re suffering from depression, talk to your doctor to see if TMS therapy is right for you. Mental health and therapy are topics that come with many biases, stigmas, and preconceived notions. It may be beneficial for individuals new to therapy and the topic of mental health in society to approach it with an open mind, as many of the stereotypes related to mental health may hinder personal progress and hamper meaningful growth and healing. Getty/Vadym PastukhDo you often feel pressure to conform to stereotypes?Learn to assert the true you in therapyEveryone’s mental health journey is unique, and leaning on stereotypes related to therapy and mental health when considering the decision to seek mental healthcare may hold you back from healing and treatment. Avoiding stereotypes may help individuals remain open to experiencing the process in an unbiased, personalized, and committed manner. What is a stereotype?As the "word of the day," a stereotype is a widely held, fixed, and oversimplified image or idea of a particular group of people or type of thing. This commonly held perception or expectation within society can impact the way in which a group of people is perceived to have common traits or characteristics.According to the American Psychological Association, a stereotype is a set of cognitive generalizations about the qualities and characteristics of members of a group or society. They point out that stereotypes often simplify the reality of a situation, exaggerate the negative over the positive, and resist differing opinions.Stereotypes play a pivotal role in how everyday individuals perceive the importance of mental health and seeking treatment. Stereotypes can significantly impact an individual’s mental health, leading one to feel like they must conform to societal expectations or risk ostracization. To prevent this, it can help to be aware of stereotypes related to mental health and be mindful of biases that may be present.Awareness of stereotypes may help reduce social pressure and stigma surrounding mental health conditions, allowing individuals to focus more on their own needs and feelings instead of trying to fit into pre-existing societal norms. Additionally, understanding the impact of stereotypes on one's mental health can potentially help individuals understand why certain behaviors may trigger negative thoughts or feelings. In one study that looked into the impact that stigma has on mental health care, researchers discovered that being aware of societal stereotypes may be able to improve the likelihood of individuals seeking therapy. There are a few types of stereotypes that may be helpful to learn about, which we’ll explore below.Gender stereotypesGender roles are commonly assigned in society, and these expectations often create pressure on individuals who may not fit the traditional norms. Gender-related pressures may lead to feelings of personal shame, guilt, and disappointment. They may also create a sense of low self-esteem and strain relationships with friends and family.In addition to causing mental distress, gender stereotypes may limit opportunities for personal growth and exploration. These expectations may influence decision-making regarding career choices and academic pursuits or affect an individual’s willingness to explore the potential of therapy. This correlation is why it may be helpful to differentiate between gender stereotypes created by society versus individual experiences and identities. Cultural stereotypes Cultural stereotypes are assumptions that are made based on culture, social norms, or nationality. These false perceptions can lead to people being judged unfairly and prevent them from being accepted into society. Cultural stereotypes can also put undue stress and pressure on individuals who feel they need to fit into a certain mold to be accepted. Stereotyping someone’s culture may influence them to feel self-conscious or embarrassed about admitting they need help, resulting in them avoiding therapy-based interventions. Additionally, therapists may be biased towards certain cultures due to their own cultural stereotypes, which could prevent them from providing equitable care for individuals from different backgrounds. Getty/AnnaStillsStereotype threat Stereotype threat refers to the phenomenon of feeling anxiety related to being reduced to the stereotype associated with the social group individuals may belong to. Experiencing a disruptive mental state may increase the risk of conforming to negative stereotypes. In one study, researchers examined the role of stereotype threat in women’s ability to perform during math examinations. Their team found that when young women were reminded of their sex before the test when asked to tick a “female“ or “male” box, they were likelier to score lower than when there was no box to tick. This study demonstrates the effect of stereotypes on people’s ability to excel in certain situations due to the pressure of preconceived notions.Extensive research has been conducted on this subject, and researchers consistently highlight the fact that it may be helpful for treatment providers and clients in the mental health setting to acknowledge the presence of different perspectives without being disheartened by them. As individuals interact across cultural and personal divides, biases are inevitable. Some characteristics that can benefit these conversations are mutual understanding, inclusion, and compassion. Addressing stereotypes in therapyIt may benefit clients and therapists to maintain an unbiased and individual mentality when tackling mental health challenges. This approach means focusing on the interaction between individuals instead of applying broad conclusions based on stereotyped behavior or characteristics.Doing so may allow individuals to better understand themselves and others, which may help create more meaningful connections with others while also fostering their own self-acceptance. It can encourage individuals to take responsibility for their actions rather than rely on preconceived notions about how they and others should behave in any situation.Cognitive behavioral therapy (CBT) can be an effective tool that can be used to help individuals confront and dismantle negative, internalized stereotypes they may have about themselves or society. By targeting distortions in thinking and maladaptive beliefs, CBT may help break down socially-constructed and hurtful stereotypes in order to foster a more positive outlook on oneself and focus on the individual’s experiences. One way in which CBT can help individuals combat stereotypes is by teaching them how to challenge unhelpful thought patterns. In therapy, individuals may learn how to identify their negative presumptions related to mental health and replace them with more realistic, objective perspectives instead. Consistent practice may help individuals become aware of the cognitive distortions they have adopted due to ingrained societal stigmas around mental health. For example, if someone has been taught not to talk about their experiences with depression or anxiety, CBT may help them unlearn these thoughts and address the root causes. By learning how to explore the connections between emotions, behavior, and cognitions, those engaging in CBT may be able to draw attention away from society’s limiting labels and learn how to trust their judgment and intuition. How online therapy can helpIndividuals who experience depression and anxiety may experience symptoms that make it difficult to leave their homes and seek therapy. In addition, many cultural stereotypes related to therapy may make individuals with these conditions experience further barriers to finding adequate care. Online therapy through platforms like BetterHelp may offer such individuals a way to reach compassionate and culturally-sensitive therapy from the comfort of their own homes. In one study, researchers looked at the effectiveness of online CBT in addressing symptoms of anxiety and depression. In the study, researchers discovered that online therapy was effective for improving symptoms of depression. This study highlights the fact that online therapy may be able to offer professional mental health care to individuals who may be working through the negative mental health effects that can result from stereotypes.Getty/Vadym PastukhDo you often feel pressure to conform to stereotypes?Learn to assert the true you in therapyStereotypes ignore the nuances and complexity of real life by oversimplifying the subject matter. It may be helpful for individuals and treatment providers to consistently challenge stereotypes and remain open to free-thinking and experiential learning. Awareness of the role of stereotypes in mental health and maintaining an unbiased mentality may help individuals receive more benefits from therapy.Not only does an unbiased, open-minded, and compassionate approach have the ability to potentially help reduce feelings of social pressure or judgment, but it also encourages self-acceptance, which is vital in managing mental health challenges effectively. By recognizing how our thoughts and perceptions factor into our mental state, we may begin working towards creating a healthier outlook on life. If you’d like to match with a therapist who understands what you’re going through and can offer socially-aware therapy, consider reaching out to a knowledgeable online counselor at BetterHelp. As a library, NLM provides access to scientific literature. Inclusion in an NLM database does not imply endorsement of, or agreement with, the contents by NLM or the National Institutes of Health. Learn more: PMC Disclaimer | PMC Copyright Notice . 2019 Mar 18;50(1):69–90. doi: 10.1111/josp.12269 There is a burgeoning psychological literature indicating that health professionals are influenced in their clinical judgment and decision making by implicit biases. Implicit biases are automatic and unintentional associations that are made between members of particular social groups (racial, gender, socioeconomic, and so on) and certain traits (e.g., laziness, greed, athleticism, and so on) or affective responses (i.e., positive or negative affectivity).1 When automatic stereotyping occurs through the operation of implicit bias, people are associated with particular traits in virtue of their social group membership rather than their other personal characteristics. This stereotyping has been found to influence the judgment and decision making of health professionals, leading to differential medical outcomes. The quality of care that patients receive can be determined in part by their social group membership and the associations that are made with their social group by those responsible for patient care. The operation of implicit biases can thus bring substantial ethical costs, leading health professionals to treat their patients in ways that are unfair and unjust. Ethical principles of justice and fairness demand that differential outcomes are eradicated (see, e.g., Matthew 2015). They demand that people are treated equally, and given equal access to high-quality health care, without stereotypes about the social groups to which they appear to belong impacting upon the care that they receive. Ethical demands thus prima facie favor interventions that prevent health professionals from being responsive to the social group status of their patients in their clinical judgment and decision making. However, it can be crucial to successful clinical judgment and decision making that health professionals are responsive to the social group status of their patients. Certain conditions are significantly more prevalent in some social groups than others. For health professionals to make correct clinical judgments, they need to reflect the prevalence of medical conditions across different groups. In addition to this, health professionals who engage in interactions with their patients that are required to obtain the information required to make correct diagnoses and treatment decisions will often discover their social group status. For these reasons, it seems that with respect to epistemic goals, gaining true belief, knowledge, or understanding about patients' conditions, health professionals should be responsive to their patients' social group status. At face value, then, there is a conflict between ethical goals and the epistemic goals. Several philosophers have argued that people can face an ethical–epistemic dilemma with respect to implicit bias (Kelly and Roedder 2008; Gendler 2011; Egan 2011; Mugg 2013; cf. Madva 2016 and Puddifoot 2017): people who make the ethical choice to respond in an egalitarian way can suffer epistemic costs because their judgments will not reflect the distribution of traits across a population. Health professionals seem to face a dilemma of precisely this kind. They can achieve the ethical goal of responding in an egalitarian way by treating their patients the same regardless of their social group status, but they will consequently suffer epistemic costs. Alternatively, they can achieve the epistemic goal of doing the thing that is most likely to produce correct clinical judgments by reflecting their patients' social group status in their clinical judgment and decision making, but thereby suffer ethical costs, failing to meet principles of justice and fairness. In this article, I argue that although it is highly intuitive this is an oversimplified view. This is because there can be ethical gains from what is, prima facie, the best thing from an epistemic perspective. Meanwhile, and more surprisingly, there can be epistemic costs associated with what initially seems to be the best from an epistemic perspective: Even when the social group status of the patient is relevant to a judgment about her condition, recognition of her social group status can bring substantial epistemic costs. My claim is not that health care providers should be unresponsive to the social group status of their patients, for example, having patient files with information about social status removed. We shall see that such a strategy would have serious negative consequences for precisely those who could otherwise be the object of stereotyping. Instead, I aim to show that the only way to avoid substantial epistemic as well as ethical costs is to tackle the problem of implicit bias head-on so that health care professionals can respond to the social group status of their patients without consequently making the significant errors that currently follow from stereotyping. However, tackling the problem of implicit bias in health care will be especially difficult because some of the automatic associations which produce epistemic costs can be crucial to facilitating accurate diagnostic and treatment decisions. Let us begin by exploring how ethical principles seem to demand that health professionals are not responsive to the social group status of their patients when engaging in clinical judgment and decision making. The reason for this is apparent on considering the burgeoning empirical literature on implicit bias in health care. As implicit biases are automatic and unintentional responses, they can influence the judgment that a person makes without the person intending for them to do so. Mere awareness of the social group status of an individual can make a person respond to them in a way that is fitting with a stereotype of the individual's social group. In other words, implicit bias can make people engage in automatic and unintentional stereotyping, where stereotyping is defined in the following way:2 Stereotyping: making a judgment about an individual that is influenced by a mental state associating members of a group, to which that individual is perceived as belonging, more strongly than members of other groups with particular traits. It has been found that health professionals are often prone to implicit biases, associating their patients with certain traits due to their social group status, and these associations can influence the judgments they make about the patients and their conditions. Based on the empirical findings, it seems as if implicit biases influence assessments of pain, the quality of clinician–patient interactions, treatment choices, and which conditions are considered to provide a plausible explanation of a patient's condition. Evidence that health professionals' assessments of the pain of their patients can be influenced by implicit biases is found in a study undertaken by Vani Mathur et al. (2014). These authors found that experimental participants implicitly primed with a picture of a Black face prior to considering a case study perceived and responded to the pain described in the study less than those who were implicitly primed with a White face. Meanwhile, Adam Waytz, Kelly Marie Hoffman, and Sophie Trawalter (2015) measured the extent to which White participants engaged in implicit super-humanization of Black people, that is, implicitly associating them with superhuman qualities. They found that Black people were more strongly associated with superhuman qualities than White people and, correspondingly, were less likely to be thought to require pain medication. Another set of studies focuses on the quality of the physician–patient interaction, suggesting that it can be determined by the implicit racial bias harbored by the physician. In a study undertaken by Lisa Cooper and colleagues (2012), physicians' implicit racial bias, and their bias associating members of different races with compliance or noncompliance, were measured alongside their behaviors in physician–patient interactions. Where physicians were found to have higher levels of implicit bias associating Black people with noncompliance, the dialogue between the patient and the physician was rated by a third party as less patient-centered. That is, the patient was given less opportunity to speak. Similarly, Irene Blair et al. (2013) measured primary care clinicians' implicit bias, finding that two-thirds displayed a bias favoring Whites more than Blacks and Latinos. They then surveyed patients who had regular contact with those clinicians over a period of on average three years, asking for their ratings of the clinicians. They found that Black patients' ratings of their clinicians' patient-centeredness were predicted by the strength of the clinicians' implicit preference for Whites over Blacks (see also Penner et al. 2010; Hagiwara, Kashy, and Penner 2014). There is strong evidence that implicit biases like these influence treatment choice. In an early study on implicit bias in health care, high levels of negative implicit bias toward Black people predicted low levels of recommendation of thrombolytic drugs to Black patients (Green et al. 2007). In a more recent study, Jacqueline Nolan et al. (2014) explored the reasons for discrepant rates of cervical cancer screenings and follow-up care for Black women in Massachusetts in the United States. They surveyed Black women from a variety of backgrounds and found that they tended to explain the discrepant treatment by appeal to unconscious biases, with some citing a physicians' desire not to touch them as a reason why they were given inadequate care. In another study, undertaken by Diana Burgess et al. (2014), male physicians were found to be less likely to prescribe opioids to Black patients than White patients when under a condition of cognitive load, in which they were required to complete a memory exercise under time constraints while responding. It has previously been found that implicit biases are more likely to manifest under conditions of high cognitive load, time pressures, and high stress (Bertrand, Chugh, and Mullainathan, 2005; White, 2014). It is therefore highly plausible that the discrepant prescription choices were the result of the operation of implicit bias. A final set of findings suggests that implicit biases can also determine which conditions are considered in a diagnostic process. Gordon Moskowitz, Jeff Stone, and Amanda Childs (2012) primed medical doctors with images of African American or White faces, which they were shown at speeds so fast that they were not aware that they had been shown images at all. Then they engaged in a categorization task. They were presented with words and required to categorize them as either names of diseases, names of treatments or as neither. Their reactions times were measured and compared. The doctors were significantly faster to respond to diseases stereotyped as African American (in an earlier study of some doctors' knowledge of diseases strongly associated with African Americans) when they had been shown an African American face than when they had been shown a White face. The results reveal a priming effect: exposure to faces of African Americans decreased response times to diseases stereotyped as more strongly associated with African Americans seemingly because the recent exposure to the faces primed the participants to think about the stereotypical diseases. This strongly suggests that the doctors automatically associate some diseases more strongly with African Americans than others. It also suggests that health professionals who associate particular social groups with certain conditions are likely to apply the stereotypes regardless of whether or not they intend to. On mere exposure to members of the social group, conditions that are associated with the group will be made more cognitively accessible to the health professionals, so they are more likely to automatically attribute the symptoms of the patient to the condition.3 Taken together, these results provide compelling evidence that health professionals' engagement in automatic and unintentional stereotyping can influence the judgments they make about their patients.4 Whether a patient is treated well or badly, and whether or not they get treatment appropriate to their needs, can depend upon the associations made by their health care provider with the social group(s) to which the patient is perceived as belonging. There is clearly a strong case for saying that this is an unethical outcome, violating principles of justice and fairness in an area of life that is crucial to health, well-being, and even survival.5 Because the stereotypes leading to these negative outcomes operate automatically once a health professional is responsive to the social group status of their patients, there is reason for thinking that it will be ethically costly, that is, it will reduce the chance of health professionals acting fairly and justly, if they are responsive to the social group status of their patients in their clinical judgment and decision making. It might seem, then, that interventions should be developed to prevent health professionals from being responsive to the social group status of their patients, so that they base their judgments wholly on the symptoms that the patient describes and the testimony that they provide about their medical history. However, this section will show that information about the social group status of patients can be highly relevant to medical judgment and decision making and a crucial determinant of whether or not a correct judgment is made. Moreover, for health professionals to gain the information that they require to make accurate clinical judgments and decisions they will often need to be placed in a situation in which they will inevitably become aware of and respond to the social group status of their patient. Therefore, substantial epistemic costs would be incurred if health professionals were placed in a situation in which they were not likely to be responsive to the social group status of their patients. To understand the first of these points, consider how medical conditions are often unevenly distributed across social groups. For instance, hypertension, coronary heart disease, osteoarthritis, diabetes, and certain types of cancer are more commonly found among obese people than underweight, normal weight, or overweight people (Sturm 2002). People of low socioeconomic status in some countries are more vulnerable than members of other social groups to certain conditions such as tuberculosis, HIV-AIDS, and diabetes (Root 2000, cited by Sally Haslanger 2004). Meanwhile, as members of certain ethnic and racial groups, such as Black people in the United States, are statistically more likely to live in poverty, they are more likely than average to have conditions commonly found among those from low socioeconomic backgrounds (ibid). Blacks are seven times more likely to die of tuberculosis than Whites, three times more likely to die of H.I.V.-A.I.D.S. and twice as likely to die of diabetes. The diseases are biological but the racial differences are not; How is this possible? ... No mystery. Race affects income, housing, and health care, and these, in turn, affect health. Stress suppresses the immune system and being Black in the United States today is stressful. (Root 2000, S629, cited in Haslangar 2004, 11) Because medical conditions are not evenly distributed across social groups, if a patient is a member of a particular social group, they can consequently be significantly more likely than nongroup members to have a particular condition. Under these circumstances, both information about the social group membership of a patient and information about the prevalence of a medical condition within patient's social group is relevant background statistical information (i.e., base rate information). If members of social group A are more likely than members of other social groups to have a certain condition C, and patient P is a member of social group A, then P's social group membership is relevant to a judgment about whether they have condition C. Information about the prevalence of a medical condition can, for example, guide judgments about which diagnostic hypotheses are more probable than others. If diseases x, y, and z are more common among a patients' social group than other diseases, and a patient displays symptoms consistent with x, y, and z, the patient is more likely to have one of these diseases than some other disease, all else being equal. Health professionals cannot devote equal time and attention to all possible diagnostic hypotheses. This means that they are more likely to identify the correct diagnosis of a patient's disease if they focus on specific, probable, diagnostic hypotheses. If diseases x, y, and z are significantly more common among a social group than other diseases, then the diagnostic hypothesis that a patient of the social group has one of the diseases will be probable relative to the probability that the patient has another disease. The health professional who responds to the social group status of her patient by reflecting the information about the distribution of the diseases among the patient's social group in her diagnostic judgments can therefore be more likely to identify the correct diagnosis for the patient than a medical practitioner who does not do so. A health professional who does not reflect information about the distribution of medical conditions across different social groups in her clinical judgments might consider a large and varied range of diagnostic hypotheses. However, without a restriction on the scope of conditions considered to reflect the social group membership of a patient, the health professional is likely to fail to consider some clinical hypotheses that are highly likely given a patient's social group membership because she will be considering very many hypotheses that are less probable. In some scenarios, information about the social group membership of a patient will be equally if not more diagnostic than information about their symptoms and medical history. Take a patient from a low socioeconomic background in a city in which there has been a high incidence of lead poisoning in areas of high deprivation due to poor housing conditions. Lead poisoning is difficult to diagnose and the symptoms of the condition can also be indicative of a number of other conditions (for example, some key symptoms are high blood pressure, difficulties with memory and concentration, headaches). A health professional could have knowledge of the symptoms and medical history of the patient without considering lead poisoning as a plausible explanation of those things. Meanwhile, knowledge of the social group status of the patient might lead her to quickly consider that the patient has lead poisoning. To see the second point, consider how the process of gaining the information needed to make correct diagnostic and treatment decisions will frequently require direct communication between health professionals and patients and sometimes also a physical examination by the health professional of the patient. If either of these interactions happen, then the health professional is likely to discover at least some of the social group statuses of their patients, from their appearance, accent, and so on. This means that it will not be possible to do what is required to make correct diagnostic and treatment decisions without occupying a situation in which the social status of the patient is apparent. As has been noted above, mere recognition of a person's social status can lead to an automatic response. Therefore, it will often not be possible to get the information required to make correct diagnostic and treatment decisions without automatically responding to the social status of one's patient. In sum, health professionals who are responsive to the social group status of their patients are often significantly more likely to make correct clinical judgments. For this reason, it seems that if one is concerned with health professionals achieving epistemic goals, like making accurate judgments about the medical conditions of their patients, then one ought to accept that it is important for health professionals to be responsive to the social group status of patients. At this point, there appears to be good reason to believe that there is a tension between ethical and epistemic goals that must be addressed by those aiming to improve clinical practice. Ethical principles seem to dictate that health professionals' responses to patients are not determined by the patients' social group status. In contrast, the achievement of epistemic goals seems to require that health professionals be influenced by the social group status of their patients when making judgments about their condition and care. The subsequent sections show that things are not this simple. First, health professionals frequently cannot act ethically in their clinical judgment and decision making without responding differentially to patients based on their social group status. Second, responding to a patients' social group membership can bring substantial epistemic costs, so is not wholly good from an epistemic perspective. This section focuses on showing that health professionals cannot act ethically without responding differentially to patients based on their social group status. In other words, the achievement of ethical goals requires what initially appeared to be the best thing from an epistemic but not an ethical perspective, that is responding to the social group status of a patient. People who adopt the role of medical practitioner take on the responsibility of identifying and responding to patients' clinical needs. Once they take on this responsibility, the ethical goal of treating people fairly demands that they do all that they can within reasonable limits to make accurate judgments about their patients' needs. If they are more likely to make correct judgments by being responsive to the social group status of their patients, responding differently in their judgments of members of different social groups, then there can be an ethical demand on them to do so. The ethical goal of treating people fairly can therefore sometimes only be achieved via the fulfillment of the epistemic goal of making a correct judgment. Where the epistemic goal requires reflecting the social group status of a patient in their judgments, there can be an ethical demand on health professionals to be responsive to social group status. To see this point more clearly, consider the inadequacy, in the current context, of the response made by Andy Egan (2011) to the claim that people can face a dilemma with respect to implicit bias. Egan accepts that ethical and epistemic principles clash and responds by arguing that people should be willing to make inaccurate judgments in order to treat people fairly. Egan's suggestion is in a long tradition of arguments to effect that epistemic goals can be overridden for sake of other goals (Code 1987), but it is unsatisfactory in the current case. A medical practitioner who takes the risk of making an inaccurate clinical judgment in order to be egalitarian could rightly be accused of negligence, failing to meet the responsibilities of her post. She could fail to achieve ethical goals by neglecting epistemic goals. Perhaps it is not surprising that health professionals can be required, by principles of justice and fairness, to do all that they can to ensure that they make correct clinical judgments and treatment decisions. What is likely to be more surprising is that responding to facts about a patients' social group membership can bring substantial epistemic costs. Moreover, these costs can be wrought even where information about social group membership is relevant to a patient's clinical diagnosis and treatment. As we have already seen, health professionals who are sensitive to the social group status of their patients are likely to engage in implicit stereotyping. This section shows how this implicit stereotyping can bring significant epistemic costs. In this discussion, as in others (see, e.g., Bortolotti 2016; Puddifoot and Bortolotti 2018), x is viewed as viewed as epistemically costly if, as a consequence of x, one is less likely to achieve certain epistemic goals, including acquiring new true beliefs, retaining and using relevant information, increasing the coherence of a set of beliefs, and gaining understanding (Puddifoot and Bortolotti 2018).6 My claim is therefore the following: responding to the social group status of a patient can bring substantial epistemic costs. These are the epistemic costs that often follow from implicit stereotyping. Let us begin by considering how a medical practitioner is likely to respond in a way that is influenced by implicit bias if she is sensitive to social group status of a patient. The empirical evidence cited in Section II shows that responses influenced by implicit biases often occur. Moreover, studies like the Moskowitz et al. (2012) study, also cited in Section II, strongly suggest that mere exposure to a prime associated with a particular social group (e.g., racial group) can lead a medical practitioner to consider some diagnostic hypotheses and clinical treatments rather than others due to them making implicit associations with members of that social group. It is not surprising that implicit biases influence clinical judgments given that the conditions of contemporary health care mean that health professionals frequently face extremely heavy workloads, which they have to complete under significant time limitations, while undergoing stress and suffering from exhaustion (Stone and Moskowitz 2011; Byrne and Tanessini 2015). Under these types of conditions, people tend to depend on implicit forms of cognition, which operate quickly and automatically (Byrne and Tanessini 2015). They can depend on associative patterns of thought rather than thinking in a controlled, deliberate manner (ibid.). In other words, they can automatically depend on stereotyping without having the time and opportunity to engage in other forms of reasoning and decision making. Whether or not they intend it to be the case, then, health professionals who respond to the social group status of their patients can engage in automatic stereotyping of those patients. The following epistemic costs of responding to social group status of a patient are ways that a medical practitioner can be less likely to achieve particular epistemic goals due to the operation of these stereotypes. A first epistemic cost is that where the stereotype that is applied associates a patient with negative characteristics, a health professional can fail to give adequate attention and credibility to the testimony of the patient. Negative stereotypes, like the stereotype that obese people lack will power, can lead health professionals to communicate less effectively with a patient, giving the patient less time and opportunity to explain their symptoms and generally making the patient less comfortable explaining their condition. Recall the findings discussed in Section II about the poor quality of interactions between physicians and patients when the physicians are influenced by implicit biases relating to the group(s) to which their patients belong—for example, the findings suggesting that dialogue is less patient-centered when a physician harbors a negative stereotype relating to the patient's social group. These results suggest that where health professionals are influenced by negative stereotypes, they are less likely to enter into productive dialogue with their patients, listening to the details that they can provide about their condition. They can fail to give the details that the patient provides about their condition appropriate credibility due to a stereotype they associate with the patient's social group, demonstrating what Miranda Fricker (2007) calls testimonial injustice (see also Carel and Kidd 2014). When people are negatively stereotyped they can also choose to smoother their testimony, choosing not to provide information to people who they believe will not engage in appropriate uptake of it (Dotson 2011). Within the health care setting, this testimonial smothering can manifest as patients choosing not to disclose information about themselves, their symptoms, and their medical history, because they believe that the information will be either ignored or misinterpreted by their physician who they perceive to be negatively stereotyping them. Each of these phenomena can be costly because many medical practices are fundamentally aimed at soliciting and receiving knowledge via testimony from a patient. Health professionals aim to understand this information, critically evaluate it, and give appropriate weight to it. If they engage in stereotyping, however, they are less likely to access, appropriately evaluate, or give appropriate weight to it. A second epistemic cost of implicit stereotyping is that a medical practitioner can focus on characteristics of a patient (i.e., symptoms and aspects of medical history) that fit stereotypes associated with the patients' social group—for example, an unhealthy lifestyle in a person with low socioeconomic status—giving inadequate attention to non-stereotypical characteristics. This is because people have a general tendency to notice and attend to stereotypical characteristics more than non-stereotypical characteristics (Rothbart, Evans, and Solomon 1979; Srull, Lichtenstein, and Rothbart 1985). People also have a general tendency to build explanations that are consistent with stereotypes when other explanations would fit better with the available information (Duncan 1976; Sanbonmatsu, Akimoto, and Gibson 1994). Health professionals who are responsive to the social group status of their patients are therefore likely to explain some medical symptoms by appeal to stereotypes, for example, poor lifestyle choices in members of certain social groups, even when more adequate explanations of the information of the symptoms and medical history displayed, for example, in terms of genetic factors, are available. It might be thought that errors of the type just described can be avoided if health professionals only focus on the relevant information about the social group status of their patients—the statistical information about the distribution of medical conditions across a population—and are not be influenced by stereotypes associating members of particular social groups with negative characteristics like untrustworthiness or poor lifestyle choices.7 It might be thought that if health professionals focused only on the relevant information then their responsiveness to the social group status of their patients would only be positive from an epistemic perspective. There are two problems with this type of response. First of all, psychological results suggest that health professionals who are responsive to the social group status of their patients, perceiving them as members of a social group, for example, a Black patient, an obese patient, or a poor patient, will be highly likely to associate those patients with a cluster of characteristics. As noted above, due to contemporary conditions in health care, they are likely to depend on implicit stereotyping when they are responsive to social group status in this way. According to dominant theories about the psychology of stereotypes, any act of stereotyping will associate an individual with a cluster of characteristics and not one (see Puddifoot 2017). This means that if health professionals rely on stereotypes to associate members of social groups with medical conditions, they will also consequently associate those individuals with numerous other characteristics (Blair, Ma, and Lenton 2001, cited in Moskowitz et al. 2012). Some of these associations will be epistemically costly. For example, if the stereotype that an African American patient is more likely than other patients to have sickle cell anaemia is triggered, the general stereotype of an African

in a population with extremely high levels of the Ebola virus, fever-like symptoms might strongly indicate the presence of Ebola, so that it is beneficial for a medical professional to interpret fever, which would otherwise be an ambiguous symptom, as indicative of the virus. Here are two responses that can be made to these objections. First, if a condition is sufficiently prevalent in a population it is not clear that symptoms consistent with the condition should be viewed as ambiguous. If sufficiently many people within a population have Ebola, the presence of a fever might be taken to provide unambiguous, if not inconclusive, evidence in support of the conclusion that a particular person has Ebola. Second, if a symptom S is truly ambiguous between conditions x, y, and z, then each of conditions x, y, and z should be weighted as more probable than it would otherwise be due to the presence of S, unless there are some other good reasons for thinking that one of the conditions is not present. To see this point, it will be useful to compare it to a criminal case. There are three suspects of a crime: Johnston, Robertson, and Thompson. Some evidence is found suggesting that the criminal was wearing a red jumper. Each of the three suspects is known to have been wearing a red jumper at the time of the crime. The appropriate response to the evidence about the jumper is to weight as more probable each of the options: that Johnston is guilty, that Robertson is guilty, and Thompson is guilty. There might be independent reasons for thinking that one of the suspects is guilty, but the presence of the red jumper should not be interpreted in a way that is consistent with that suspect being guilty, if it is truly ambiguous. Instead, the evidence that each of the suspects wore a red jumper should be considered alongside, but independently of, other evidence suggesting that one of the suspects is guilty. Otherwise, the other evidence that supports the conclusion that the suspect is guilty is influential twice over, in a case of “double book-keeping”8 because it influences the way that the evidence about the red jumper is interpreted. Similarly, if there are three conditions that are consistent with a particular symptom, evidence that a symptom is present should lead each of the conditions to be taken equally more seriously as potential explanations of the symptoms. If there is some independent reason for thinking that one of the conditions is more likely than the others to be present, because it is prevalent within the patient's social group, then this evidence should be considered independently but alongside the presence of the symptom. Otherwise, the fact that the condition is prevalent within the patient's social group is influential twice over, once again in a case of “double book-keeping.” This section has thus identified numerous epistemic costs that are associated with responding to the social group status of a patient even where information about the social group status of the patient is relevant to judgments about their condition. Health professionals who respond to information about their patients' social group status tend to engage in stereotyping, associating the patients with a cluster of characteristics. They can consequently fail to give some patients appropriate opportunity to communicate information about their condition; they can attend closely to stereotypical features while failing to attend to non-stereotypical features; they can fail to give adequate attention to certain medical hypotheses, and so on. The fact that some of these epistemic costs can occur as the result of an automatic association between social groups and medical conditions when the association reflects the reality of the distribution of conditions across different social groups highlights a particularly serious problem for those who aim to increase the chance that health professionals achieve their epistemic goals. The problem is this: it will not be possible to prevent health professionals from making all of the stereotypical associations that bring epistemic costs without preventing them from making an association that it is extremely valuable for them to make. Evidence of implicit bias in medicine initially appeared to present an epistemic–ethical dilemma, but now it is clear that the situation is even more complex. The goal of treating patients in an ethical manner will often require being responsive to information about their social group status, that is doing what was initially thought only to be required in order to achieve one's epistemic but not ethical goals. Only by being responsive to this information can health professionals discharge their duty of doing all that they can to ensure that their patients get appropriate treatment. But being responsive to this information can bring substantial epistemic costs due to the operation of stereotypes. Therefore, what initially seemed to only bring epistemic benefits—responding to the social status of patients—brings a mixture of epistemic costs and benefits. It might seem that due to the epistemic costs associated with being responsive to the social group membership of patients, and consequently stereotyping, it would be better if health professionals were denied information about the social group membership of their patients. For instance, they could be required to make diagnostic and treatment decisions based on blinded patient files lacking details about social status. However, as discussed in Section III, health professionals often need to communicate directly with and engage in physical examination of patients to gain the information that is required to make correct diagnostic and treatment decisions. Moreover, correct judgments and decisions will often depend upon knowledge of the social group status of patients, wherever conditions are unevenly distributed across social groups. It is worth adding to these observations that those groups that are most susceptible to being negatively stereotyped will often be those that would suffer the most if patient files were blinded, or other methods were used to prevent health professionals being aware of their patients' social group status. Members of minority, stigmatized, and marginalized groups are most likely to be stereotyped by their health professionals, so it might seem that they would benefit the most from, for example, patient files being blind. However, the prevalence of conditions within their social groups are least likely to be represented in the default norms explicitly or implicitly used in diagnosis where social group status is not taken into consideration. As the probability that they will have a condition is not likely to be represented in default norms, they are most likely to be misdiagnosed if their social group status is not recognized. This is because the default norms that do not reflect the prevalence of conditions within their group will be applied to them. There are therefore numerous very good reasons not to conclude on the basis of the observation that there are epistemic costs associated with responding to the social group status of patients that health professionals should be denied the opportunity to respond to social group status. It remains likely that, due to the vast number of substantial epistemic costs associated with responding to a patient's social group status that were outlined in Section VI, there are occasions when health professionals would be more likely to make correct judgment if they were unaware of the social group membership of their patients. However, it is an open empirical question how often this will be the case. And for any given clinical encounter, it will be extremely difficult to identify if it would be better for the health professional to be unaware of the patient's social status. It will be especially difficult for a health professional to make an assessment of whether they should remain unaware of a patient's social status without becoming aware of their social status. Therefore, given the importance of the interactions between patients and health care professionals that lead to acknowledgment of the patients' social status, it would be unwise to advise that practices like introducing blinded patient files should be adopted to prevent health professionals from responding to their social group status. What should be done instead? In order to ensure that health professionals can achieve both (i) their ethical goals of treating patients justly and fairly, discharging their duty to their patients, and (ii) their epistemic goals of making correct clinical judgments and decisions, it will be necessary to reduce the extent to which stereotypes negatively influence their judgments once they are aware of a patient's social group status. Often in discussions of implicit bias and stereotyping the strategy of preventing people from being aware of the social status of group members against whom they might be biased is viewed as promising (see, e.g., defenses of making CVs anonymous). But this strategy would be detrimental in the types of cases currently under discussion. Other strategies have been advocated to prevent the negative effects of implicit bias and stereotyping. Strategies that focus on changing the psychologies of individuals have been proposed. For example, it has been argued that considering counterstereotypical examples (e.g., strong women) (Blair et al. 2001) can change one's stereotypes, thereby changing the associations that are made when stereotypes are triggered in response to individuals. And it has been proposed that developing implementation intentions or “if-then plans” that specify how one will respond to a specific stimuli can change one's responses to individuals, controlling the association that is triggered in response to an individual (e.g., Stewart and Payne 2008; Madva 2016). For example, the implementation intention “if I see a Muslim then I will think PEACE” could alter one's responses to individual Muslims. These and other methods to combat implicit stereotyping have been found to be effective under experimental conditions (Lai et al. 2014), although their effectiveness, when administered within the experimental setting appears to be short-lived (Lai et al. 2018), so there is reason to doubt that their effects will be significant outside the experimental setting. Some of those who are skeptical about the effectiveness of individualistic strategies focus on structural features of society (see, e.g., Anderson 2013). For example, attempts might be made to increase integration of members of different social groups (ibid.). Increased integration can reduce the negative biases associated with certain social groups. It can, for instance, ensure that people encounter counterstereotypical members of other social groups consistently over time rather than for a limited amount of time within an experimental setting. The hope is that through increased integration, and other methods of social change, the stereotypes that people harbor are likely to be challenged and change accordingly. There remains significant debate about which, if any, of these methods are effective at preventing people from automatically and unintentionally engaging in stereotyping. What the argument in Sections 1, 2, 3, 4, 5, 6 shows is that, if some strategies are established to be effective at combating the negative effects of this stereotyping, this could facilitate health professionals achieving both their ethical and epistemic goals. But the argument presented so far also highlights a significant and unexpected challenge that is faced by those hoping to ameliorate medical practice by tackling implicit bias in health care. This is because the current discussion suggests that the ideal strategy to use to tackle the negative effects of stereotyping in health care would not eliminate altogether the implicit biases that have been found to manifest in health care. It would not even eliminate all of the implicit biases that bring substantial epistemic costs. Instead, it would lead people to control rather than eradicate some of these stereotypes: that is those relating social groups to medical conditions. Why should these stereotypes be controlled rather than eliminated? Because associating social groups with medical conditions, where the association reflects the distribution of conditions across social groups, can facilitate the quick and efficient selection of a correct clinical hypothesis. Until control of this sort is taken over the automatic and unintentional stereotyping engaged in by health professionals, they are unlikely to achieve either their ethical or epistemic goals to the full because they will not be able to respond quickly and efficiently to what is important and relevant information—about their patients' social status—without suffering epistemic costs that reduce the likelihood that they will make correct diagnosis and treatment choices. It might be that at least a partial solution to the problem of medical professionals being susceptible to stereotyping which leads to ethical and epistemic costs is relatively easy to enact. Research suggests that people are able to correct for the effects of stereotypes if they have time to do so. In a recent study, for example, people were primed with an image of a Black face and then asked to judge another image of a face according to how threatening it was (Rivers et al. 2018). When participants had a longer interval between having the stereotype of Black people as threatening activated by the prime and making the judgment of threat, they were less likely to apply the stereotype to the face that they were judging. The lengthier interval between exposure to the prime and judgment seems to have provided the opportunity for participants to correct for the effect of the activation of the threat stereotype. What this suggests is that, if people are serious about improving the chances of health professionals achieving both (i) the ethical goal of treating patients justly and fairly, thereby discharging their duty, and (ii) their epistemic goals of making correct diagnostic and treatment decisions, then providing more time for these professionals to do their job could be an excellent place to start. At first glance, there is an ethical–epistemic dilemma that is faced by those concerned with improving conduct in health care. There will be ethical costs if people are responsive to their patients' social group status because they will be susceptible to being influenced by implicit bias, engaging in stereotyping, and providing unfair treatment. However, if they are not responsive to their patients' social group status they will suffer epistemic costs associated with failing to gather and apply relevant evidence: specific evidence relating to the social group status of their patients, and evidence (e.g., about symptoms or physical signs of a condition) that could only be gathered through the kinds of interactions that would reveal the social group status of their patients. What this article has illustrated, however, is that ethical costs follow if health professionals are unresponsive to their patients' social group status. If information about social group status is relevant to judgments about the likelihood that a person has a particular condition, and about appropriate treatments, then health care professionals can only fulfill their duty of care to their patients if they are responsive to this information. Meanwhile, there can be substantial epistemic costs associated with being responsive to patients' social group status. If one harbors implicit stereotypes relating to a patient's social group, which are triggered in the process of diagnosing and prescribing treatment for the patient, then one is likely to respond in a biased way to evidence that they might provide: failing to provide the patient with the opportunity to communicate information about their condition, failing to attend to non-stereotypical symptoms, failing to give attention to non-stereotypical medical hypotheses, and so on. Some of these epistemic costs can even follow due to the application of a stereotype even if it accurately reflects the distribution of medical conditions across social groups. What this means is that it can be an ethical choice to be responsive to a patient's social group status, and this ethical choice can also be good from an epistemic perspective, but it can also bring substantial epistemic costs. What is the way out of this problem? It cannot prevent health professionals from being responsive to the social group status of their patients because health professionals who are not responsive to the social group status of their patients are unlikely to gather the information they need to make correct diagnoses and treatment choices. To improve both the ethical and epistemic dimensions of clinical judgment and decision making, it will therefore be necessary to tackle the stereotyping operational in implicit bias head-on. Strategies to tackle implicit bias and stereotyping so far have been found to have some, limited effectiveness. Structural changes to society might be required to make further progress. One seemingly simple strategy that psychological studies suggest might be effective is giving health professionals more time to engage in clinical judgment and decision making—a point that seems particularly powerful with current conditions in health care in which people are often working under severe time constraints. Tackling implicit bias in health care effectively will be especially difficult because some of the stereotypes that are automatically activated in the health care context—that is those correctly associating members of social groups more strongly than others with particular conditions—can bring significant epistemic, and therefore ethical, benefits. Ideally their influence would therefore be controlled rather than eradicated. But whatever method turns out to be most effective, the current discussion shows that by effectively tackling implicit bias in health care it will be possible to reduce both ethical and epistemic costs, increasing the chance of health professionals achieving both ethical and epistemic goals. I would to thank Lisa Bortolotti, Ema Sullivan-Bissett, Alexander Bird, Sophie Stammers, the audience at the Bristol Philosophy of Medicine seminar, and anonymous referees for helpful comments on earlier versions of this article. I acknowledge the support of the European Research Council under the Consolidator grant agreement number 616358 for a project called Pragmatic and Epistemic Role of Factually Erroneous Cognitions and Thoughts (PERFECT). 1There has been a large amount of discussion about how exactly implicit biases should be characterized (see, e.g., Schwitzgebel 2010; Gendler 2011; Mandelbaum 2016; Levy 2015; Holroyd and Sweetman 2016). These debates do not have to be settled for current purposes. My claims relate to what can be concluded about the ethical and epistemic costs and benefits of implicit biases given what experimental studies say about them, and particularly and how they operate, regardless of their metaphysical status. 2There are alternative definitions of stereotyping according to which stereotypes always have a distorting effect on judgments (Blum 2004). However, I adopt the view of stereotyping most often found within recent social psychology, that stereotyping is any act that involves associating an individual with certain characteristics in virtue of their social group membership, regardless of the accuracy of the association. For a defense of this approach to stereotyping, see Beeghly 2015. 3The Moskowitz et al. (2012) study measures automatic associations rather than behavioral manifestations of bias (see note 2 for potential concerns about this), but it nonetheless strongly suggests that health professionals will be biased in their diagnoses because the order in which thoughts about conditions are manifest will determine the order in which they will consider clinical hypotheses 4Doubts have been raised about the effectiveness of one main measure of implicit bias—the implicit association task (IAT)—for example, about whether it measures biases or recognition of attitudes or patterns found in one's society, and about whether high levels of “bias” as measured by the IAT correlate with real-world behaviors. Some of these studies measure implicit biases using the IAT should therefore be treated with caution by those skeptical about this measure. However, the studies discussed in this overview of the literature on implicit bias in medicine use a variety of measures, including measuring patterns of treatment under conditions in which implicit cognition tends to dominate (Burgess et al. 2014) and gathering testimony from Black female patients about their lived experience of bias (Nolan et al. 2014). The latter methodologies have not received the same criticism as the IAT. In fact, there is increased recognition of the importance of the latter source of evidence, that is, testimony of those who have experienced prejudice and discrimination (Holroyd and Puddifoot forthcoming). 5For further discussion of the psychological research on implicit bias in health care, see Matthew (2015). For a philosophical discussion, see Fitzgerald (2014). 6This list of epistemic costs is not supposed to be exhaustive. 7Dana Bowen Matthew (2015) seems to suggest that it is possible to make a division between being influenced by relevant information about social group status and being influenced by stereotypes. 8Thanks to an anonymous reviewer for the suggestion to put this point in this way. Anderson, Elizabeth . 2013. “Reply to My Critics.” Gender, Race and Philosophy: The Blog Symposia on Gender, Race and Philosophy 9(2). Retrieved June 23, 2017, from [Google Scholar] Beeghly, Erin . 2015. “What Is a Stereotype? What Is Stereotyping?” Hypatia 30: 675–91. [Google Scholar] Bertrand, Marianne , Chugh, Dolly , and Mullainathan, Sendhil . 2005. “Implicit Discrimination.” American Economic Review 95: 94–98. 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[Google Scholar] Waytz, Adam , Hoffman, Kelly Marie, and Trawalter, Sophie. 2015. “A Superhumanization Bias in Whites' Perceptions of Blacks.” Social Psychological and Personality Science 6: 352–59. [Google Scholar] White, Augustus, III . 2014. “Some Advice for Minorities and Women on the Receiving End of Health-Care Disparities.” Journal of Racial and Ethnic Health Disparities 1: 61–66. [DOI] [PMC free article] [PubMed] [Google Scholar] Stereotypes are a way that we store knowledge about social categories. When a category is considered by society to be deviant, such as the group of people who are mentally ill, members of that category tend to be viewed as a homogeneous group that is accurately represented by stereotypes. There may be a grain of truth to stereotypes in some cases, but they’re not accurate when applied uniformly across a group. Those of us with mental illness are all unique individuals, and we’re a very diverse group of people, but for the society that has Othered us, they may only see all stereotype, all the time. They also tend to assume that stereotypes are factual, even though they may be entirely inaccurate. We all have both implicit and explicit beliefs. Explicit beliefs are conscious and voluntary, while implicit beliefs are unconscious and they come to mind automatically when we’re in a situation where those beliefs apply. We learn many implicit beliefs through early socialization, including stereotypes associated with mental illness. Even if people express affirming explicit beliefs about people with mental illness, they may still have stereotypes stored implicitly that they’re not consciously aware of. Here are some of the common stereotypes that the general public associates with mental illness. Every time there’s a mass shooting, people start blaming it on mental illness. In particular, people tend to believe that those with psychotic illnesses are violent. However, a mental illness diagnosis doesn’t have any predictive value in determining who will commit mass shootings. Most people who have a mental illness are no more likely to be violent than anybody else. There are a few exceptions, like people with antisocial personality disorder, substance use disorders, intermittent explosive disorder, or people experiencing command hallucinations to harm others. Psychopathy, which isn’t a mental illness, is a significantly bigger risk factor for violence than having a mental illness. So is being male, but you don’t see anyone talking about limiting gun access to angry white men with a paranoid worldview (of the non-psychotic variety). Unpredictability and unreliability are also common stereotypes, and they can fuel discrimination in contexts like employment and housing. The unpredictability stereotype often goes hand in hand with the violence stereotype. Watch out, you never know what the scary-crazy person might do! Some people see mental illness as a moral failure involving weak character, lack of control, and lack of willpower. They may blame us for the onset and continuation of our illnesses, and see us as undeserving of help as a result. Moral contagion comes from the belief that spending time around someone who has a mental illness may result in “catching” that person’s presumed moral weakness. Another common stereotype is that people with mental illness are incompetent, unable to work or function independently, and need others to make decisions for them. This stereotype may be approached in an authoritarian or a benevolent manner. An authoritarian approach can limit the rights and freedoms of mentally ill people, while a benevolent approach can mean the mentally ill person is treated like a child. One of the beliefs that can go along with incompetence stereotypes is that people with mental illness are unhygienic. This is a good example of something that has a kernel of truth but isn’t true when applied broadly to all people with mental illness. Depression can make showering hard. So can negative symptoms of schizophrenia. The fact that hygiene deficits can sometimes occur as a result of symptoms does not in any way mean that everyone and their goat who has a mental illness is dishevelled, dirty, and/or smelly. Some of us are goaty. Most of us are not. I consider the “good patient” stereotype to be the expectations that many mental health treatment providers have about how a psychiatric patient “should” behave in the context of the treatment relationship. This stereotype isn’t universally endorsed by all treatment providers, but it’s pretty common, especially in hospital settings. The specific expectations associated with the “good patient” can vary depending on the setting, but they can include: being cooperative and accepting whatever the treatment provider thinks is bestnot asking too many questionstreating the health care provider as the authoritynot challenging the treatment provider(s)being willing to tolerate side effectsbeing willing to tolerate symptoms that aren’t being addressedoperating on the treatment provider’s timeline rather than the patient’sin hospital: not making requests outside of designated times, accepting without question the various arbitrary limits that have been created The graphic below is a good example of the “good patient” stereotype in the context of chronic pain. While these expectations aren’t necessarily conveyed verbally, they often exist as unwritten, unspoken rules. When patients don’t conform to these expectations, they may be brushed off by treatment providers as being difficult. I’ve been hit with the unpredictability/unreliability stereotype in the past in work contexts. Coworkers were fine, but management clearly saw me as unreliable. I’ve encountered the incompetence stereotype from health care providers. The worse my psychomotor slowing has gotten, hence the more overt my illness is, the more I tend to be treated like I’m a complete dolt. When I was in hospital, I encountered the good patient stereotype a lot. I was not interested in meeting the expectations of that stereotype, which definitely created friction. Have you experienced stereotyping? What particular stereotypes seemed to be the most prominent?