

## Chapter 2

# The Inconvenient Truth About Unconscious Bias in the Health Professions



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*“Not everything that is faced can be changed, but nothing can  
be changed until it is faced.” – James Baldwin*

### Introduction

In 2003, the Institute of Medicine (now the National Academy of Medicine) released two reports that focused widespread attention on the crucial issue of disparities in healthcare access [1, 2]. These pivotal reports documented that Americans’ access to quality care was fractured along racial and socioeconomic lines and concluded that “bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care” [1]. The reports included equity of care as one of the six pillars of quality health care and pointed out that, as long as health disparities exist, our health system cannot claim to deliver quality care to all patients [1, 2].

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More than 15 years later, a multitude of studies demonstrate examples of health disparities and inequities in healthcare delivery. Patients of color—especially black and African-Americans, Hispanics, and Native Americans—have higher overall risks and poorer outcomes than whites with a wide range of conditions, including asthma, diabetes, HIV/AIDS, hypertension, obesity, preterm births, and tuberculosis. Racial and ethnic minority patients have less access to quality care and have lower life expectancies and higher mortality rates [3]. These differences cannot be explained away solely by socioeconomic status, patient preference, lack of health insurance coverage, or other external factors. While health inequity is a multifactorial problem, health professionals must also recognize the role provider attitudes, behavior, and clinical decision-making play in unequal care and disparate health outcomes [3–5].

Despite federal Title VI protections in place against overt discrimination in the workplace or in patient care, incidences of explicit bias—in which individuals are aware of their prejudices toward certain groups—persist [6]. There is also a subtler form of prejudice that can be more difficult to address. This is called unconscious—or implicit—bias, meaning the prejudices we are not aware of.

With today’s intense focus on the population’s health, healthcare organizations and healthcare professionals of all types are looking at ways to improve the delivery of quality health care. It is clear that meeting the goals of the Triple Aim—to improve the healthcare experience, improve the health of populations, and reduce the costs of care [7]—requires that we confront the unconscious biases that influence quality care [4].

## Discussion

### *Unconscious Bias in Health Care*

Healthcare professionals pledge to “do no harm,” adhere to ethical standards, and support the rights of patients to receive equal care. Many clinicians would deny that they treat patients differently based on characteristics such as race, gender, weight, age, sexual orientation, or disability [4]. However, reports of discrimination and inequitable care remain common [3–5, 8–11]. This disconnect is likely a direct result of unconscious bias.

Unconscious bias affects everything from the admissions processes at health science schools to the hiring and promotion of healthcare professionals, the administration of healthcare organizations, and—ultimately—the delivery of care to patients [5, 8, 12, 13].

### *What Is Unconscious Bias?*

Based on research into unconscious bias, our brains operate on associations—automatic responses or shortcuts that allow us to quickly interpret and respond to our environment. In the blink of an eye, the brain takes in bits of data, interprets them,

and leads us to conclusions—all without us realizing it is happening. By quickly categorizing situations, people, images, and sounds, we recognize friends, family members, symbols, and letters on the page, for example. This sorting is involuntary and happens in a millisecond, without conscious thought. Our capacity to sort helps us learn, keeps us safe, and allows us to build on previous knowledge [14, 15].

While this process is normal, and very human, it also has unintended consequences—especially in health care—where quick thinking can make the difference in a patient’s diagnosis and treatment. Sometimes these split-second judgments provide us with accurate, useful, and even lifesaving information. But some may also be inaccurate and unintentionally obstruct our decision-making and relationships with patients and even inflict unintentional harm [5, 9, 10, 14–17]. This is unconscious bias.

None of us are immune to unconscious bias; it permeates all aspects of society. Scholars have detected and documented unconscious bias in education, criminal justice, and employment practices [17]. A recent review of the literature found that the prevalence of unconscious bias in the health professions is as high as it is in the general population. The same review determined that 20 out of 25 studies found at least some evidence of bias in clinicians’ diagnosis, treatment, or interaction with patients based on characteristics such as race, ethnicity, sexual orientation, gender, weight, mental illness, substance abuse, disability, and social circumstances [18]. Moreover, the high-stress environment of health care may increase the incidence of unconscious bias [17, 19]. Researchers found that cognitive stressors such as time pressure, competing demands, overcrowding, stress, and fatigue were associated with an increase in implicit bias among emergency room physicians [20].

In 2016, the Joint Commission issued a Quick Safety bulletin on implicit or unconscious bias. The authors wrote:

The ability to distinguish friend from foe helped early humans survive, and the ability to quickly and automatically categorize people is a fundamental quality of the human mind. Categories give order to life, and every day, we group other people into categories based on social and other characteristics. This is the foundation of stereotypes, prejudice and, ultimately, discrimination.... Studies show people can be consciously committed to egalitarianism, and deliberately work to behave without prejudice, yet still possess hidden negative prejudices or stereotypes [21].

### ***What the Research Shows***

In their 2017 literature review, FitzGerald and Hurst found that despite advanced training in a profession that strives for objectivity, clinicians are just as likely as anyone else to harbor unconscious bias. They reviewed 42 peer-reviewed journal articles that examined unconscious bias in different aspects of health care over the course of a decade and noted that there is a complex relationship between clinical decision-making and a clinician’s unconscious bias. While this may not always translate into negative treatment outcomes, a trusting relationship between a health-care professional and her patient is essential to providing good treatment. Thus, it seems likely that the more negative the clinical interaction, the worse the eventual

treatment outcome. Over time, negative clinical interactions may leave patients less likely to seek medical attention for future worries or problems [18].

Patients can sustain harm, sometimes in subtle forms, even when they are receiving care that appears equivalent. For example, a 2015 study in the *Journal of Pain Symptom Management* examined differences in physicians' verbal and nonverbal communication with black and white patients who were at the end of life [22]. The study looked at how 30 hospital physicians interacted with black and white patients in mock end-of-life scenarios. Verbal communication was consistent across the races: physicians provided accurate and thorough information to all the mock patients. Nonverbal communication, however, differed by the race of the patient. Findings with black patients indicated that physicians were more likely to stand farther away, make less eye contact, and cross their arms when speaking and listening. This study demonstrates that clinician assumptions based on misinformation or biases based on patient characteristics can affect delivery of appropriate care.

Research also has shown that racial and ethnic minority patients tend to be undertreated for pain, compared with white patients [19, 23–26]. In a study published in 2016, researchers at the University of Virginia uncovered perceptions among clinicians that might contribute to these discrepancies in care [27]. The team surveyed more than 400 medical students and residents. The study participants were asked to indicate whether the following false statements had any truth behind them:

- Blacks age more slowly than whites.
- Blacks' nerve endings are less sensitive than whites' nerve endings.
- Black people's blood coagulates more quickly than white people's.
- Whites have larger brains than blacks.
- Blacks' skin is thicker than whites' skin.
- Whites have a more efficient respiratory system than blacks.
- Black couples are significantly more fertile than white couples.
- Blacks have stronger immune systems than whites.

Study findings indicated that half of the students and residents endorsed one or more of these false statements.

In 2014, the AAMC had the opportunity to put unconscious bias in academic medicine under the microscope when it partnered with the Ohio State University Kirwan Institute for the Study of Race and Ethnicity to convene a daylong gathering that included unconscious bias researchers and administrative leaders charged with developing unconscious bias interventions at their institutions. Attendees spoke candidly about instances of unconscious bias they have experienced and observed.

The proceedings from this meeting led to the AAMC-Kirwan Institute publication, *Unconscious Bias in Academic Medicine: How the Prejudices We Don't Know We Have Affect Medical Education, Medical Careers, and Patient Health* [8]. The report details instances of unconscious bias experienced by leaders and also offers appropriate interventions to make academic medicine more inclusive at all levels, ultimately improving patient care and quality outcomes. While the publication focused specifically on physicians and the culture at medical schools and academic

medical centers, unconscious bias affects all health professions, and the suggested interventions are equally relevant [28].

### ***Successful Strategies for Mitigating Unconscious Bias***

Recent studies demonstrate that becoming more aware of unconscious biases and resolving to overcome them can help shift attitudes and lead to active strategies to mitigate the effects of bias [29, 30]. The AAMC report highlights several of these strategies, including engaging leadership to create a culture of inclusion, encouraging exploration and mitigation of bias through education and training, and using data strategically to identify bias in all aspects of health care from the hiring and promotion of clinicians to the diagnosis, treatment, and delivery of care to patients [8].

Howard J. Ross, a leading expert trainer on unconscious bias and the author of the groundbreaking 2014 book *Everyday Bias: Identifying and Navigating Unconscious Judgments in Our Daily Lives* [15], recommends that we all take the following steps:

- Recognize and accept that we have biases and that if we don't act on our biases, they will act on us.
- Develop the capacity for honest self-assessment. Once we accept that we have biases, we are more capable of recognizing them as they emerge and before they become entrenched.
- Practice “constructive uncertainty.” Question assumptions. Are the “gut feelings” we are experiencing actually our own unconscious biases at work?
- Explore awkwardness and discomfort. Realize that specific people, locations, and situations may seem uncomfortable only because we are not familiar with them.
- Engage with people who might be considered “others” and seek out positive role models in those groups.
- Solicit candid feedback from friends and colleagues, or use self-assessment tools such as the Implicit Association Test to analyze progress [15].

We can explore our own biases by taking the Implicit Association Test developed by researchers at Harvard University in 1998 [31]. The test measures the strength of associations between concepts through a matching exercise. The IAT, which has been validated repeatedly, is based on the idea that matching two highly associated concepts is easier and faster than pairing disparate ideas. Taking the test can reveal biases of which we were previously unaware [28, 32–38].

Ultimately, ensuring a more diverse workforce can help address these disparities in care. Research has shown that diverse work teams are more capable of solving complex problems than homogenous teams [39, 40]. Other studies have also shown that diversity in the healthcare workforce leads to improved access and satisfaction

with care [2, 41, 42]. Thus, building a diverse health professions workforce is a key component in improving our ability to deliver quality care to all [43, 44].

Unfortunately, diversifying the healthcare workforce remains a challenge. Although some racial and ethnic minorities have made headway in certain healthcare professions, specialties, or regions of the country, others still lag behind their majority counterparts. Women, people of color, and members of other underrepresented groups are still less likely to hold leadership or decision-making positions in healthcare organizations [12, 13, 43].

In recent years, an increasing number of healthcare institutions have been taking steps to mitigate unconscious bias in training, employment, and patient care [8, 45, 46]. Although many healthcare institution leaders have shared the results of these efforts at professional conferences as case studies, relatively few have yet been subjected to the scholarly peer-reviewed process. One peer-reviewed case study looked at medical school admissions at Ohio State University College of Medicine (OSUCOM) and appeared in *Academic Medicine* in 2017 [47].

Capers et al. reported that all 140 members of the OSUCOM admissions committee were required to take the black–white IAT prior to the 2012–2013 admissions cycle to measure implicit racial bias. They collated the results by gender and student versus faculty status. Individual results were visible only to the test taker and only at the time of the test. All other annual admissions cycle activities proceeded normally. At the end of the admissions cycle, committee members took a survey that recorded their impressions of the impact of the IAT on the admissions process. Capers et al. concluded that all groups (men, women, students, and faculty) displayed significant levels of implicit white preference. Men and faculty members had the largest bias measures. Two-thirds of survey respondents thought the IAT might be helpful in reducing bias, and nearly half (48%) were conscious of their individual results when interviewing candidates in the next cycle. Just over one in five (21%) reported that their knowledge of their IAT results influenced their admissions decisions in the subsequent cycle. The class that matriculated following the IAT exercise was the most diverse in OSUCOM's history at that time. This case study indicates that widespread change is possible at both the individual and institutional levels and that purposeful effort can help overcome unconscious biases.

## Conclusion

Unconscious bias, while part of the normal human process, can negatively impact the delivery of quality care. However, when we recognize our own biases and how they influence interactions, we can more consciously consider the best steps toward health equity and achieving the Triple Aim. This recognition must happen at all

levels of the healthcare system—from the C-suite to support services—to create real and lasting improvement.

As you read the following chapters, which delve into more specifics about different kinds of unconscious bias in the clinical setting, think about what you can do individually and collectively at your healthcare organization to effect meaningful change. The many clinical scenarios that follow should give you much food for thought. Take the initiative to transform thought into deed. The next generation of health professionals and patients will thank you for it.

*NOTE: The AAMC publication is available for free download at [www.aamc.org/publications](http://www.aamc.org/publications)*

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