

Implicit Bias and Cultural Sensitivity: Effects on Clinical and Practice Management

An Information Paper

Abstract

Bias can be defined as a prejudice in favor or against a thing, person or group when compared to another that usually results in judgement without question. Implicit bias is an unconscious reflex judgement that is linked to the human inclination to filter and categorize information and groups which leads to action without thought. The emergency department (ED) is a uniquely vulnerable environment in which providers are at risk for the negative implications of implicit bias on patient care and clinical practice. This paper will explore unconscious institutional and individual provider bias through case scenarios and provide a set of recommendations for mitigating their negative effects which begin with self-awareness.

Introduction

In 2016, following the American College of Emergency Physicians Diversity Summit, emergency physician (EP) Kevin Klauer wrote about cultural diversity – representing not a minority, but from a perspective of male, white, middle-class privilege; he wrote about advantages given to a person, not for merit, but because of gender, class, and race. This results in an implicit assumed right. A person with this privilege considers persons who do not share this perspective as “other” or outside the norm. Klauer, however, also noted that small personal differences from this norm can create a sense of unease; he extrapolated how major differences of race, gender, or class may magnify unease in many situations. Unconscious or implicit bias guides our actions and may affect social and clinical outcomes. Awareness of bias toward others outside of one’s personal norms is a primary step toward avoiding negative effects.^{1,2}

Bias is simply a tendency or inclination resulting in judgement without question and therefore preferences one group or its members over another. We as human beings incorporate bias to protect ourselves and help us to function daily. When we have stress or time constraints, the influence of our unconscious biases helps us make quicker (though not necessarily correct) decisions. **Explicit bias** exists with personal awareness of a group assessment or stereotype and sufficient belief in its correctness to act upon that judgement. **Implicit bias** occurs without conscious endorsement of an assessment or intent to act upon it. Explicit gender, racial, and ethnic bias generally has declined after the major movements for women’s and black civil rights although it remains at risk for a resurgence. Although explicit bias generally declined, implicit bias persists – perhaps as a reservoir for later explicit expression.^{3,4,5}

Two generally unconscious perceptual processes may contribute to the persistence of implicit bias, illusory correlation and out-group bias. Both support stereotyping persons outside one’s own norms. Illusory correlation perceives rare findings in one environment as related, when in fact, no such relationship exists. For example, seeing a mentally handicapped white person in a predominately black neighborhood and attributing mental handicap to being white. Out-group bias perceives persons from other cultures as homogeneous. Both processes are normal human responses to differences in environment. The following cases illustrate examples which may evoke unconscious institutional or individual provider bias and further describe mitigation strategies.⁶

Case A: Climbing the Ladder

A well-qualified candidate for a medical director position in your emergency department (ED) is a young Latino female. There are no women in leadership positions in the organization, and cultural diversity does not appear to be a priority for board of directors. She has several interviews scheduled with the department

and hospital leadership. What are the biases regarding gender, race and culture that she may face in her quest for this position? Can policies or debiasing strategies help facilitate the benefits of diversity?

Clearly this candidate has two potential obstacles as a medical director candidate: gender bias and ethnicity bias. There has been a wealth of literature confirming the existence of gender differences and bias in academic promotion, attainment of leadership positions, and salary differences.⁷⁻¹¹ Similar differences exist for race and ethnicity bias. Another difference in genders is related to the relationship between agreeableness and leadership where being more disagreeable or less agreeable was associated with higher salaries for men but not for women.¹² Furthermore, evidence shows women perceived as disagreeable also negatively affects promotion. In addition to this candidate facing gender bias, a recent paper by Capers, et al, demonstrated high degrees of implicit bias and “white preference” among medical school admissions committee members using the implicit bias association test (IAT), a finding widely demonstrated in other groups despite low explicit bias.^{13,14}

The first step to decrease negative effects of explicit and implicit biases is accepting that these biases exist, which can be accomplished through education and taking the IAT, the tool most commonly used to measure unconscious bias. Although explicit bias (conscious and controlled) issues can be remediated using educational methods that raise awareness and improve ability to recognize diversity, implicit bias requires more time, effort and a more programmatic approach.¹⁵

Recommended strategies for implicit biases emphasize avoiding tiredness and stress and slowing down the decision-making process. Also, small group discussions regarding implicit biases uncovered by the IAT help participants recognize the gap between egalitarian values and unconscious prejudiced stereotypes. Because time can extinguish such recognition, educators should encourage developing nonconscious processes to inhibit bias activation. One example is associating individuals from stereotyped groups with egalitarian values or goals that promote fairness. Biased individuals could approach individuals from stereotyped groups as opportunities to commit to egalitarian values. Habituation is also recommended to associate nonconscious egalitarian values with individuals having implicit bias. Byrne, et al, recommends having these egalitarian goals become chronically accessible so that behaviors associated with these goals becomes habitual.¹⁵ This habituation process requires conscious effort over time to form these nonconscious associations.

In summary, education, small group discussions, creating positive associations and using habituation can lead to improvement in correcting bias. For this particular Latino candidate, biases of hiring committee members could cause them to misinterpret her cultural communication style and body language, impacting their perception about her “qualifications” for the job. Using an egalitarian qualifications checklist could keep committee members focused on priority objectives. In addition, the hospital can push for a transparent approach to combat bias by providing online resources to staff that include the IAT, learning modules and evidence-based articles.

Case B: Cultural Differences in the ED

A cancer patient is brought into your ED by his family for being withdrawn around his grandchildren and sleeping more. When asked what their understanding is, they say his cancer is in the colon and liver. He was on chemotherapy in the past but is on “a break” and does not have a scheduled date to restart. His family thinks he is in pain and is not telling them about it. On physical exam, you see a cachectic black elderly man who is mostly non-verbal and grimaces with extremity movement. Based on his exam and symptoms, there is a concern that his pain is not controlled, and that he is near the end of his life. You ask the family if his doctors have discussed palliative care or hospice in the past. They seem unfamiliar with hospice and stress “he’s a fighter” and wants providers to “do everything” to take care of him; however, they also want him to be with his family and comfortable. One family member seems upset stating “They

said the chemo would work, now look at him.” You want to approach the patient and family about involving palliative care. You believe that aggressive medical management would not prolong his life in a meaningful way, especially if their priority is for him to be at home and comfortable. You perceive a sense of resentment for the medical system based on their experience and culture differences. How do you overcome perceived cultural biases? How can practitioners strive to be culturally competent with diverse patient populations? What biases do I bring to the interaction due to my personal medical belief system?

Over the past century, the trend has been to take death from home to the hospital and with hospitals being viewed as a place to maintain or prolong life, the default is often to push towards life-prolonging treatment especially within the emergency department. Different cultures, races and immigrant communities might rightfully have a sense of mistrust in the medical community.^{16,17} Poor provider communication skills can contribute to increased tension with families and stress among physicians.¹⁸ To address this, EPs must first recognize their own biases and be sensitive to others’ cultural perspectives. Practical next steps can be naming the patient's and family's emotions or worries. A phrase as simple as “you seem upset” can often be an effective opener. Finding common ground in the human experience by sharing a personal struggle with discussing end of life care in your own family may help families see you as a person and not just a physician. This is often uncomfortable and awkward for providers because we worry about patients or caregivers lashing out, but addressing their worries and hesitation facilitates critical conversations that need to occur.¹⁹

Acknowledging that the you and the treatment team may not completely understand the family's concerns can serve as bridge to improved shared decision making rather than a wall. Questions should be asked with respect and genuineness. Approachable language such as, “I’d like to understand your family’s greatest fears or worries,” encourages honest and collaborative interactions. When families sense the intent of the physician is to understand and provide the best possible care, emotion or bias often becomes the third party in the room that patients, caregivers and providers can address together in order to achieve the patient's ultimate goals.

Case C: Difficult Patients

A young white male with multiple tattoos arrives to the ED in police custody, he is combative and intoxicated with alcohol and drugs on board. Based on this presentation, what biases might an emergency physician have against this patient?

This clinical vignette suggests that some stereotypes may evoke an implicit bias against patients with this appearance and behavior. The main problem is that repeated exposure to patients with similar appearance may trigger in a clinician an implicitly held stereotype or negative thoughts about a social group. In this case, prejudices about dangerous characters, questionable lifestyles and prison time, may be automatically activated by the physical finding of multiple tattoos. The contextualized features of being incapacitated due to intoxicants, combative behavior, and brought in by the police (not EMS) for ED evaluation also manage to infiltrate and influence medical judgments made on his behalf.

Research has shown social biases or attitudes to be ubiquitous. Everyone has biases they hold implicitly or explicitly, and which are capable of dissociation. Focusing on just implicit biases, it is established that these attitudes direct behavior without conscious control or intention.²⁰ Several clinical studies have demonstrated that implicit biases of physicians can predict behavior that leads to health care disparities.²¹⁻²³ These inequalities manifest in a variety of ways including substandard treatment,²⁴ missed diagnosis,²⁵ and oligo-anesthesia in the ED.²⁶

Educational interventions have mostly relied on increasing provider awareness of bias to combat it. However, while this approach works to erode explicit bias, it can be less effective at ameliorating implicit

bias. Since automatic, implicit biases have been in place from a very young age, it can take years to change these impulses effectively. There appear to be no shortcuts for learning how to inhibit stereotype activation or weaken its effects. Bias-free care that solves implicit attitudinal habits will require provider investment in a transformational change process and years to accomplish.

In the meantime, the case of this combative patient's management involves EPs who may be tired and cognitively loaded in a busy ED. In this circumstance, the likelihood that providers will take mental shortcuts unknowingly in making questionable decisions in this patient's case, is quite high. He might receive biased care due to implicit judgment automatisms including stereotype activation and selective attention.

Conclusion

Each of these cases highlights how implicit bias can creep into the decision-making of emergency physicians. This bias affects the diversity and representation of our providers and leadership, the communication and treatment options of our vastly different patient populations, and the health outcomes and ED experiences of patients every day. While it may be easy to demonize "bias" and passively criticize behaviors that are ubiquitous in all providers, it is important to acknowledge that bias assists us in performing our jobs. Recognition of patterns and deviations from "norms" allows us to diagnose, risk stratify and treat patients on a daily basis. Certain biases, however, if not recognized, can have negative effects on our interactions and the care that we provide and could be potentially dangerous. The necessity for a constant self-awareness of a nonconscious process leaves us in quite the conundrum.

Bias in healthcare settings contributes to health care disparities, which may appear both between and within providers. This applies to both institutional and individual providers. Although some research using clinical vignettes²⁷ showed that despite the implicit preference for white people, this bias did not affect clinical decision-making; other research has demonstrated that providers with stronger implicit bias had worse physician-patient communication that that increased cognitive stressors were associated with increased implicit bias.^{28,29} For the individual provider, unconscious bias leads to actions based upon stereotypes which may affect treatment recommendations for minority or marginalized patients, especially in high-pressure, time-limited locations like emergency departments. Provider responses by stereotype in clinical situations may fail to address individual needs, breach trust at the core of patient-provider relationships, and lead to inappropriate interventions by the provider or negative outcomes, such as patients not following treatment recommendations.³⁰

Burgess et al present recommendations to mitigate bias. These start – as Klauer recognized - with self-awareness of unease with difference. Their strategies seek to enhance provider motivation to reduce bias despite external pressures, increase understanding of the psychology behind implicit bias, improve provider confidence when interacting with patients outside their own cultural norm, enhance provider skills in regulating emotions, and improve provider ability to develop partnerships with patients.⁴ Utilizing these tools is helpful in the battle against implicit bias that exists in all clinical settings.

The ED poses a uniquely vulnerable environment in which implicit bias may thrive amongst conditions of stress and high intensity clinical scenarios. What are best strategies to help mitigate implicit bias for emergency physicians? Here are our top ten recommendations:

- First, acknowledge that while bias may be ubiquitous to human thought, we can work to change our unconsciousness.
- Second, strive to be an egalitarian in the ED and in all aspects of your professional and personal life.
- Third, seek out patients who are different from you to interact with and always look for common ground.

- Fourth, engage your creative problem-solving skills and take aim at reducing intolerance and its consequences.
- Fifth, mentally rehearse difficult encounters daily at first, or until new habits become second nature and understand your own implicit bias. Try taking the IAT (<https://implicit.harvard.edu/implicit/>).
- Sixth, volunteer to manage difficult clinical encounters to practice advocacy and assessment skills in the face of conflict.
- Seventh, utilize standard procedures and protocols to cut down on the negative influences of bias. For example, the primary and secondary surveillance techniques learned in trauma management provide structure, and likely reduce the chance for missed diagnosis in vulnerable patients.
- Eighth, practice interactive skills, and take the opportunity to invest in small acts of inclusion and graciousness to decrease the mental bandwidth available for takeover by implicit biases.
- Ninth, remember graceful acts of listening, and caring gestures in reaching out to the incapacitated patient.
- And finally, tenth, stay vigilant and be mindful about avoiding prejudice and discrimination. Personally reflect on how to better deliver care and the purposes of healing, and always act to promote the welfare of ED patients.

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