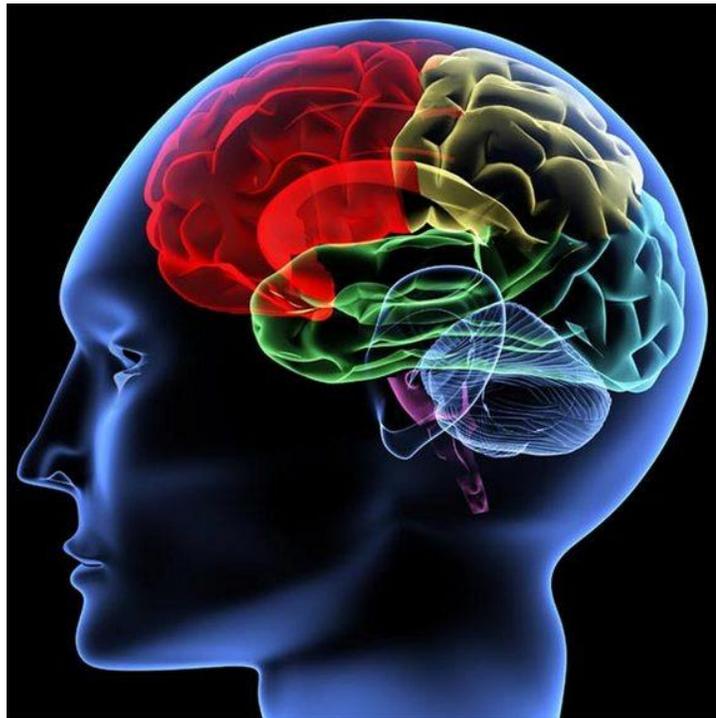


EXPLORING UNCONSCIOUS/IMPLICIT BIAS



**A PRESENTATION FOR
THE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY**

October 27, 2016

EXPLORING UNCONSCIOUS/IMPLICIT BIAS

SESSION OBJECTIVES

This session will define unconscious/implicit bias, review some of the latest research on how bias affects behavior in the workplace, engage participants in how bias affects their medical practice, and offer strategies for reducing unconscious/implicit bias. At the end of the session, participants will:

1. Know the definition of unconscious and implicit bias and why it matters in a personal and professional context.
2. Understand and be able to give examples of unconscious and implicit bias.
3. Know how to interrupt unconscious bias at the individual level and implicit bias at the organizational/professional level.

AGENDA

Time	Activity/Topic/Focus
6:30 – 6:45 am	Breakfast
6:45 – 6:50	Welcome from OB/GYN Department Director Introduction of Presenter
6:50 – 7:10	Review Definition of Unconscious and Implicit Bias and Why It Matters Personally and Professionally
7:10 – 8:00	Examples of Unconscious and Implicit Bias
8:00 – 8:30	Strategies for Minimizing the Impact of Unconscious Bias
8:30 – 8:45	Evaluation, Next Steps, Closing

IS THIS BIAS?

Following is a list of different types of situations. Review this list, and as a group, discuss the questions that follow on the next page.

1. People in supermarkets buy more French wine when French music is playing in the background, and more German wine when the music is German.
2. White National Basketball Association (NBA) referees have been found to call more fouls on black players, and black referees call more fouls on white players.
3. Scientists have been found to rate potential lab technicians lower in blind review of resumes, and plan to pay them less, if the potential technicians are women.
4. Doctors treat patients differently when the patients are overweight, and patients treat doctors differently when the doctors are overweight.
5. Prospective medical school students interviewed on rainy days tend to get lower ratings in their interviews than people interviewed on sunny days.
6. In a study by Ian Ayers at Yale Law School, white men were offered cars on average significantly lower than, in ascending order, white women, black women, and black men. The salesman had no idea there were patterns to their offers; in their minds they were simply trying to get the most they could from every sale.
7. Casasanto and Chrysikou, in the Netherlands, showed that people have a tendency to make choices toward their dominant side (e.g., right-handed people will more often choose things on the right).

QUESTIONS FOR DISCUSSION

1. Which situations on page 3 would you characterize as acts of unconscious/implicit bias?

2. What is your definition of unconscious/implicit bias?

Be prepared to share your responses to the larger group.

BIAS—CONSCIOUS AND UNCONSCIOUS, INTENTIONAL AND UNINTENTIONAL

Because bias has a negative connotation, any discussion of it is often met with anxiety and discomfort. People generally think of themselves as fair individuals who do not demonstrate bias toward others. Research about bias over the past two decades, however, offers us another way to think about bias, especially in the workplace. This section summarizes some of the key findings from this research.

The Origin of Biases

At its simplest level, **bias** is a preference or choice, an instinctive orientation to an activity, taste, idea, people, etc., rooted in our biology, influenced by our legacies and layers, and demonstrated through our behaviors. We all have biases and they operate consciously, unconsciously, intentionally, and unintentionally.

CONSCIOUS AND INTENTIONAL BIAS

Conscious biases include the beliefs and attitudes we hold about groups of people at the awareness level, whether positive or negative. **Stereotyping** is the most common form of conscious bias. It occurs when we assume that characteristics true for one individual must be true for the group to which she/he belongs.

Political commentator Walter Lippmann gave “stereotype” its current meaning in 1922, when he used it to refer to “pictures in our head that portray all members of a group as having the same attributes—often not very attractive attributes.” Lippmann suggested that this fixed mental picture of a group would enter our thoughts each time we encountered someone from that group. Stereotyping is a natural byproduct of our brains continually receiving and categorizing information. As a result, we all stereotype. But, stereotypes are not distributed equally to all groups. For example, it is less likely that a person will be stereotyped by members of his/her own group. And the more one deviates from the dominant culture, the more likely he or she will be stereotyped. Interestingly, stereotypes applied to a group are sometimes self-applied by members of the group to themselves, and in that case the stereotypes may act as self-undermining and self-fulfilling prophecies.

When applied to people, **prejudice** is a pre-formed attitude and judgment about people not based in fact or reason. Prejudices as an attitude and judgment, tend to be coupled with strong feelings, often irrational. Given this, once a prejudice is formed, it easily becomes reflected in behavior. In the context of inclusion, **discrimination**, then, is treating people differently because of a prejudice held about them.

UNCONSCIOUS AND UNINTENTIONAL BIAS

As we function in the world, we are bombarded with lots of information. In fact, it is estimated that the adult person is exposed to as many as 11 million pieces of information at any one time. We make decisions quickly and often automatically about what is safe, appropriate, helpful, and in our best interests.

Because our conscious brain can only effectively deal with about 40 pieces of information at any one time, our brains take mental short cuts to help us function. These short cuts entail sorting and categorizing information to determine what is helpful and unhelpful. These short cuts happen quickly and unconsciously. In fact, the unconscious mind processes 200,000 times more information than the conscious mind.

We develop perceptual lenses that help us filter out some information and filter in other information depending upon the situation in which we find ourselves. Our perceptual lenses help us to see some things and miss others; they filter the evidence we collect, generally supporting points of view we already hold.

Psychologist Joseph LeDoux has called our ability to sort information our unconscious “danger detector” because it helps us determine whether or not something or someone is safe before we can consciously make a determination. When the object, animal, or person is assessed to be dangerous, a “fight or flight” fear response occurs.

Biologically, we are hard-wired to prefer people who look and sound like us and who share our interests. This preference bypasses our normal, rational, and logical thinking. Brain imaging scans have demonstrated that when people are shown images of faces that differ from themselves, it activates an irrational prejudgment in the brain’s alert system for danger. This happens in less than a tenth of a second. Our biases are likely to be activated every time we encounter a person different from our own group, even if consciously we reject stereotypes about that group. **Unconscious or implicit bias** is the automatic, unintentional, and unconscious people preferences that arise because of our biology and socialization. Implicit bias and unconscious bias are often used interchangeably. This author uses unconscious bias when referring to people; implicit bias is used when referring to organizational policies and practices.

BIAS IN THE WORKPLACE

When negative bias is translated into organizational policies, practices, and behaviors, it impacts the workplace in several ways. For example, research related to negative bias in the workplace reveals the following:

- While less than 15% of American men are over six feet tall, almost 60% of corporate CEOs are over six feet tall.
- Resumes with “typically white” sounding names tend to receive more callbacks than those with “typically black” sounding names when the qualifications presented in the resumes are exactly the same.
- Resumes with female names were rated less hireable than those with male names when the qualifications presented in the resumes were exactly the same.
- During interviews, applicants who are culturally similar to interviewers are described as having a better “fit” than those who are dissimilar.
- Individuals from historically underrepresented groups are less likely to be given honest feedback about their performance.
- People waiting for interviews are rated lower because they were sitting next to someone perceived as overweight in the waiting room.
- People perceived as being overweight receive lower performance ratings than those not perceived that way.
- People with accent are less likely to be believed when they share the same information as people without an accent.
- Managers tend to report more affinity for employees culturally similar to themselves. This limits the opportunity for culturally dissimilar staff members to receive effective coaching and mentoring.

David Hunt, President & CEO of Critical Measures, shared in a presentation that a Sparticus Group survey reported that over 71 percent of the workforce has experienced some form of disrespectful behavior targeted to them because of their gender (32%), race (28%), age (20%), sexual orientation (14%), and religion (6%). This disrespectful behavior had the following impact:

- 28% of the individuals lost work time avoiding the instigator,
- 53% lost time worrying about the incident/future interactions,
- 37% believe their commitment at work declined,
- 22% decreased their effort at work,
- 10% decreased the amount of time that they spent at work,
- 12% changed jobs.

Employees of color are more than three times more likely to leave their organization solely due to being treated unfairly than white, heterosexual men.

BIAS IN HEALTH CARE

(From “Quick Safety Bulletin,” Issue 23, April 2016, Joint Commission)

“Of all forms of inequity, injustice in health care is the most shocking and inhuman”

--Martin Luther King, Jr., National Conventions of the Medical Committee for Human Rights, 1966

Two reports from the Institute of Medicine (IOM): *CROSSING THE QUALITY CHASM* and *UNEQUAL TREATMENT* noted that racial and socioeconomic inequity persists in health care. In *CROSSING THE QUALITY CHASM*, the IOM stressed the importance of equity in care as one of the six pillars of quality health care, along with efficiency, effectiveness, safety, timeliness, and patient-centeredness.

UNEQUAL TREATMENT found that even with the same insurance and socioeconomic status, and when comorbidities are controlled for, minorities often receive a lower quality of health care than do their white counterparts.

There is extensive evidence and research that finds unconscious biases can lead to differential treatment of patients by race, gender, weight, age, language, income, and insurance status. Bias in clinical decision-making does result in overuse or underuse problems that can directly lead to patient harm.

A 2011 study conducted by van Ryn et al. concludes that racism can interact with cognitive biases to affect clinicians' behavior and decisions and in turn, patient behavior and decisions (e.g., higher treatment dropout, lower participation in screening, avoidance of health care, delays in seeking help and filling prescriptions, and lower ratings of health care quality). This unconscious or implicit bias indicates many white health care providers harbor a broad racial framing of Americans of color, one that can be causative in their not providing equitable health care. Some examples of how implicit bias plays out in health care include:

- Non-white patients receive fewer cardiovascular interventions and fewer renal transplants.
- Black women are more likely to die after being diagnosed with breast cancer.
- Non-white patients are less likely to be prescribed pain medications (non-narcotic and narcotic).
- Black men are less likely to receive chemotherapy and radiation therapy for prostate cancer and more likely to have testicle(s) removed.
- Patients of color are more likely to be blamed for being too passive about their health care.

Research supports a relationship between patient care and physician bias in ways that could perpetuate health care disparities. What makes implicit bias “frightening” in health and health care is that the results is “unthinking discrimination” of which caregivers are not aware.

QUESTIONS FOR DISCUSSION

1. How do biases get embedded in or become part of policies and practices?
2. What are the benefits to organizations for addressing implicit bias?
3. Thinking about your role as a medical provider, what decisions do you make or interactions you have where there is the potential for unconscious bias?

BECOMING AWARE OF AND ELIMINATING NEGATIVE AND UNCONSCIOUS BIASES

We do have a bias control mechanism in our brain that can prevent our biases from translating into behaviors. To trigger this mechanism, our brain needs to see a mis-match between our overarching goal of being fair and our instinctive people preferences. By looking at our biases logically and addressing them systematically, we weaken their power to interfere with our accurate perceptions about and behavior toward others. At the individual level, we can do this in several ways: Embrace the concept that we all have biases and that unconscious biases are more prevalent than conscious ones.

Take the Implicit Association Test (IAT). Developed by researchers at Harvard University, this series of free tests are useful in helping individuals identify some of their unconscious associations. Tests are currently available for a number of diversity dimensions and issues. Here is how to access the tests:

- 1) Go to the website: [HTTPS://IMPLICIT.HARVARD.EDU/IMPLICIT](https://implicit.harvard.edu/implicit)
- 2) At the site, click the "demonstration button," and then "go to the demonstration tests."
- 3) Read the disclaimer, and click, "I wish to proceed."
- 4) You can then select the test(s) in which you are interested. Tests are currently available for race, weight, presidents, Arab-Muslim, age, disability, gender, skin-tone, religion, Native American, weapons, sexuality, gender-career, and Asian American. Each test takes 10-12 minutes. You will be asked to complete a brief questionnaire on demographics and the topic. This information contributes to the research being conducted.
- 5) Once you take the test, use the following page to reflect on your results.
- 6) For more information about the tests, read the "Frequently Asked Questions (FAQs) located in the "background information" section of the website.

Personal

1. Accept that you carry biases, that you are probably not aware of many of them, and that your good intentions are not enough to make them go away.
2. Be honest about your biases; try not to simply choose your more socially acceptable ones to discuss and address.
3. Develop the capacity to use a "flashlight" on yourself. This means noticing one's internal thoughts and feelings. Learn to stop and examine your reactions before acting instinctively.
4. Rewire your brain by regularly interacting with people who are different from you, both inside and outside of work. Read the work of authors who are different from you. Do this repeatedly and over time.
5. Understand our "hot buttons" or emotional triggers. The stress and anxiety we feel when our hot buttons are pushed will increase our tendency to act in a biased way. Conversely, allow plenty of time to make important decisions that could be impacted by bias.

6. Pay attention to those things about people different from ourselves that surprise us or make us feel uncomfortable. These often provide clues to our stereotypes and biases. Ask yourself, “Am I being reminded of someone?” “Do I have automatic judgments about this person?”
7. Practice “constructive uncertainty.” When making decisions that affect others, avoid the tendency to be drawn to certainty. This can often mask the complexities of interactions, and can contribute to making us blind to our biases. Be willing to challenge your own certainty, and notice when you are pulled to “be right.”
8. Gain more broad and constructive knowledge and exposure to diverse groups. Don’t be afraid to ask questions to help you understand the people with whom you are interacting. People are rarely offended when the intent is genuine and you are willing to share information about yourself first.
9. See mutual respect as mutual self-interest and commit to this goal.
10. Work with diverse people toward common goals.

Organizational:

1. Encourage staff and managers to recognize that we all have biases and expect this in themselves rather than supporting the “blind spot” notion.
2. Put process checks in place that will interrupt automatic thinking for critical decision making.
3. Prompt yourself and others to explicitly consider the possibility of bias during talent acquisition and talent management interactions and decision. For example, before sitting down to conduct an interview ask yourself what bias you may carry (positive or negative) towards that individual and plan to minimize its impact.
4. Develop peer coaching and feedback relationships that will enable you to get feedback from people who are different from you. Work hard to build sufficient trust that will enable honest feedback.
5. When you are making critical decisions that impact people and teams, ensure that there are moments in the process that interrupt the accumulation of unconscious bias. For example, require multi-source input that involves the input of a diverse group of colleagues when assessing employees’ performance and potential.

Clinical Care (from the Joint Commission, Division of Health Care Improvement)

1. Implement work policies and clinical procedures that protect clinicians from high cognitive load and promote positive emotions. When clinicians’ cognitive capacity is low or overtaxed, memory is biased toward information that is consistent with stereotypes. High cognitive load can be created by: productivity pressures, time pressure, high noise levels, inadequate staffing, poor feedback, inadequate supervision, inadequate training, high communication load, and overcrowding.
2. Have a basic understanding of the cultures from which your patients come.
3. Avoid stereotyping your patients; individuate them.
4. Understand and respect the magnitude of unconscious bias.
5. Use techniques to de-bias patient care, which include training, intergroup contact, perspective-taking, emotional expression, and counter-stereotypical exemplars.

QUESTION FOR DISCUSSION

What steps can you take to minimize potential unconscious/implicit bias in your role as medical provider?

REFERENCES AND RESOURCES

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