Implicit Bias

This year at its annual retreat, the California Medical Association Board of Trustees was treated to an excellent talk on Implicit Bias by René Salazar MD . The effects of conscious bias and discrimination have been studied over many years and are well known; for example, most of our CME presentations have to start with some statement about possible conflicts and biases the speaker may have. But what about biases that don't even make it into our awareness? It is now thought that bias is a normal process, due to the need to organize the overwhelming amount of information that is presented to us at any given time, and that much of it is unconscious, shaped by our own personal experiences. Unconscious (or implicit) bias is not limited to ethnicity or race, but can be found around issues of age, gender, gender identity, physical abilities, religion, sexual orientation and weight among others. And these biases can be learned early in life, with young children picking up on non-verbal signals from adults around them.

In the medical world, unconscious bias may affect the medical environment of patients and staff, the hiring of doctors and staff, evaluation of our patients, and our patients overall care. There is a growing body of literature about microagressions – which are small events that are often unintentional that occur whenever people are perceived to be "different". Examples given included asking an Asian American about their ethnic origin ("where are you from?") or even complimenting a Latino for their ability to speak English without an accent. I immediately thought of a young, thin, tall African American man I had seen in clinic who felt like when he went out for a walk, he could see people in their cars noticing him and locking their doors. If these microaggressions occur in the office, they will lead to a sense of a hostile work environment. (For more about microagressions, I suggest http://world-trust.org/wp-content/uploads/2011/05/7-Racial-Microagressions-in-Every-Life.pdf)

The classic study with implicit bias involved hiring among US symphony orchestras. It found that if there was a physical screen to conceal the identity of the candidate, in increased the probability that women would advance from preliminary rounds by 50%, and increased hiring of women by 25%. Another study showed that traditionally white names received more callbacks for interviews when identical resumes were send to help-wanted ads. Even in our medical field, there have been some studies showing male students were more hireable for research science faculty, and males had had more "standout" adjectives in their faculty recommendation letters.

Finally, implicit bias can be seen in patient evaluation and care. Medical students showed more negative stereotyping, and anticipated less patient adherence when given an obese vs a non-obese virtual patient. Black children with appendicitis were found less likely to receive opioid medication than White children.

There are a set of tests called the Implicit Association Test. They were developed in 1998, and are relatively resistant to social desirability concerns, and cover a number of known age, gender, racial and other biases. You can find them at https://implicit.harvard.edu/implicit/selectatest.html - you do not have to register

or log in, just click the link for “Project Implicit Social Attitudes”. Each test takes only a few minutes to do. Being aware of your own possible biases is one thing that can help create positive changes. Other ideas suggested by the speaker included programs to enhance communications skills, and activities that enhance empathy. Having concrete objective indicators and outcomes can also reduce stereotyping. Studies have shown that institutions can see changes with even fairly short educational interventions.

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