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Podcast Transcript

What Lies Beneath: Implicit Bias in Healthcare

This course was originally published by Elite Learning in video format. The following transcript of the podcast has been lightly edited for length and clarity.

Episode 1 – What Is Implicit Bias?

Guest

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- More than 50 years' experience working on issues of race, diversity, and implicit bias
- President and CEO of BenReese, LLC, a global diversity, inclusion, and anti-racism company
- Former Vice President for Institutional Equity and Chief Diversity Officer, Duke University and Duke University Health System

Host

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Transcript

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BENJAMIN D. REESE, JR., GUEST: When laws were passed that outlawed the physical brutalization of Black people and Black women, when there were policies that forbid that kind of treatment, the practices often continue in some cases in a conscious, explicit way but more often in a subtle, unconscious way, what we call implicit bias, implicit or unconscious bias.

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JULIETTE BLOUNT, HOST: Hello, I'm Juliette Blount. I'm a certified adult nurse practitioner in New York City, and I frequently speak to, consult with, and educate healthcare professionals and the public at large on the topic of racial disparities in healthcare.

You've just heard Dr. Benjamin D. Reese, Jr., a clinical psychologist with more than 50 years' experience in examining issues of race, diversity, and implicit bias. In this three-part podcast series, Dr. Reese helps us understand what implicit bias is and how it impacts our practice as healthcare professionals.

It's a topic that I not only have experience speaking to, but also personally living. As a Black woman, I am inextricably linked to an American history that underpins biases against people of my race. Listen as Dr. Reese explains the relationship between race and inequity in healthcare.

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REESE: The focus on implicit bias really needs to be discussed in the context of the history of race in America, given the fact that so much of the focus on research in implicit bias in healthcare really relates to issues of race.

So it's important for us to understand the context in which the first Africans were brought to this country – forcibly brought on ships across the ocean, the most horrendous trip you can imagine with so many of the women being abused sexually during this trip. And the Africans weren't considered human. They were considered property. Like a car or a house, they could be bought or sold, put in the will of someone.

And the Africans who were viewed as property were the property of anyone White so that a slave walking along a road could be stopped, searched, abused by anyone who was White because they were generally property. And as property, they were rated. So if they had no physical defects, they might be rated A1 prime hand. If they were missing, say, a finger or a hand, perhaps they were rated 3/4 hand. But they were property.

And so when we think about the history of race and healthcare, it really is complex and complicated. During the beginning of American slavery, there was the promulgation of what's considered pseudoscience, this notion that Africans, not being human, inherently had thicker skin, could endure more pain, thicker skulls, fewer nerve endings. And so they could be brutalized and whipped and not feel anything.

And they were experimented on. I mean, women were experimented on in the most abusive way without any indication of any medication to manage pain. And in the early 1900s, there were a host of laws that were passed authorizing involuntary sterilization of these women. And it wasn't until the advent of American civil rights, the civil rights movement in the 1960s, that there was really an organized movement of women, Black women activists to push back on this not only horrendous history but the continuation of that practice.

But it's important to recognize how deeply embedded these practices and the notions of inequities and notions of the state of Black people, the beliefs about Black people – important to recognize how deeply embedded they are in American culture in subtle and implicit ways.

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BLOUNT: Subtle, unconscious biases are not limited to race; they apply to gender, cultural differences, sexual orientation, age, weight, and other ways in which people differ from one another. But historical inequities surrounding race have had staying power. Dr. Reese explains.

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REESE: In 1916 – 2016, rather, there was a study of medical students. And half of the medical students believe one of those notions of pseudoscience, that Black people have thicker skins, fewer nerve endings, so they weren't as sensitive to pain. In 2016, an example of how deeply embedded the notions of inequity and inferiority of Black patients, Black people.

So understanding that historical context is really an important foundation to then understanding what we mean by implicit bias related to race, but also implicit bias related to gender, perceived sexual orientation, cultural differences.

So when we think about the history of obstetrics and gynecology, that history, that foundation really was built on the abusive experimentation on Black women. And the field has a lot of indebtedness to that early brutality and just incredible treatment of Black people in general but certainly Black women.

And so when laws were passed that outlawed the physical brutalization of Black people and Black women, when there were policies that forbid that kind of treatment, the practices often continue in some cases in a conscious, explicit way but more often in a subtle, unconscious way, what we call implicit bias, implicit or unconscious bias.

So laws and policies were changed. But the practices and the beliefs live on unconsciously in so many of us who consciously believe in equity, fairness, social justice, treating everyone the same, providing high level care, consciously being focused on that. But at the same time, there is this parallel process of unconscious or implicit bias.

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BLOUNT: As healthcare professionals, we like to think that we always treat patients in the same respectful and equitable ways. That's embedded in our mission. But Dr. Reese describes that we are unwitting accomplices to the implicit biases we hold.

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REESE: What is implicit bias? It's this automatic set of stereotypes about race, complexion, stereotypes about height, weight, stereotypes about perceived sexual orientation, stereotypes about action, stereotypes about the way someone speaks. And the important point to understand is those stereotypes, those beliefs are often out of awareness and are often different than the equitable and fair and wonderful things that we say and we believe consciously.

And we don't ever want to diminish the importance of conscious, deliberate behavior. We don't want to diminish the beliefs of equity and fairness. But at the same time, but thankfully, research is suggesting ways in which we might manage, ways in which we might diminish implicit bias.

So just to emphasize that definition, if you can think of these parallel process, explicit and implicit, explicit being the thoughts and behaviors that we're conscious of. We're aware of what we're thinking. We're aware of our behavior. Our behavior is intentional. And then there's this parallel process, unconscious or implicit.

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BLOUNT: We may think that we develop unconscious bias against someone's race, gender, size, etc., as we age and expand our experiences. Dr. explains on just how early we begin to develop unconscious preferences.

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REESE: So one of the important areas of science to take apart, deconstruct, is the question of, well, just how early in one's development does implicit bias begin to show up? We used to think in early adolescence, that's when implicit bias really started to show up. But research now makes it clear that the foundation for implicit bias – not actually implicit – actual implicit bias, but the foundation for implicit bias really begins in infancy.

So, for example, if we track the eyes of infants, at about four weeks of age, they will stare longer and more frequently at female faces if a woman has been the primary caregiver. Not implicit bias, but the beginning of a differential association, a, quote, "preference." In tracking the eyes of infants at about 9 months of age, they will stare longer at faces that have the same or similar complexion as the primary caregiver. It's not about race, but it's this foundation of differential response, a, quote, "preference."

At about 10 or 11 months of age, infants will stare longer at faces that are speaking in the same or similar language as the primary caregiver. Again, not implicit bias, but this foundation of differential preference. And this foundation of differential preference then gets built upon by all of the experiences that toddlers have, that children have, the things that they see around the house, how frequently they see a parent having friends who are of different races, body types, etc.

They begin to experience what media communicates to them; what they read in books, how often they see, for example, a main character in the children's book that's a female versus a male; how often they see something online that promulgates fairness and equity or in subtle ways communicates bias. So media is really a powerful way in which young children and adults begin to make associations between things that are good, positive; things that are dangerous; things that are perceived as being positive or negative.

And so the foundation for implicit bias starts with the associations in infancy. And then shortly thereafter, we as adults begin to communicate to children in subtle and insidious ways the values that relate to the way someone looks, the way someone sounds, body type, etc.

And it works in the other way also, that we as adults begin to view children, view toddlers in different ways related to and dependent upon their perceived race, their perceived gender, sexual orientation, etc., while consciously, consciously, we're trying to behave in an equitable and fair way. But unconsciously, we adults have internalized these messages, these values, these associations in our society.

One example is this study that was done at the Yale Child Study Center in 2016. It took about 130 preschool teachers, excellent teachers, consciously talking about fairness, trying to provide equitable treatment to all of the preschoolers that they were working with. Outstanding teachers.

They came into the laboratory. They were given an apparatus, sort of like a set of binoculars. And when they looked through this apparatus, they could see a video clip. And there were preschoolers, Black and White, sitting in a classroom, getting up, walking across the classroom, speaking to other children, playing with toys. Black and White preschoolers.

At some point, a prompt was given. And the teachers looking through this apparatus were told, well, some of the clips that you're seeing, some of the video clips might contain challenging behavior. And if so, just press this button when you see the challenging behavior. They didn't know that this device they were looking through was actually tracking their eyes.

Once they were given the prompt there may be challenging behavior, their eyes started to track the Black preschoolers more than the White preschoolers. And within the group of Black preschoolers, their eyes started to track the Black male preschoolers more than even the Black female preschoolers, among teachers, who as I said, consciously believe and consciously try to practice equity and fairness. And it's not that these are bad teachers. It's that they're human. But I just want to try to convey how powerful and how early this process starts to develop.

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BLOUNT: Research has also explored such physical attributes as skin complexion, height, and weight in relation to implicit bias. Here’s Dr. Reese.

REESE: Now, going back to those early years in America, the 1800s, one of the powerful dynamics during the period of American enslavement of Black people was this powerful dynamic of complexion. And so Africans who worked in the fields, getting up early in the morning, working till late at night, often six or seven days a week, tended to be darker skinned and, quote, "tended to be raped less often."

Those Africans, those slaves who were inside of the house caring for the children of the master, cleaning, cooking, tended to be raped more often. Their offspring worked in the house and tended to be lighter skinned. And so you have this powerful dynamic of complexion within America showing up in different ways, by the way, within the Black community and within the White community. But it's one of these powerful dynamics when we think about implicit bias.

Let me give you an example. So in this research, they took a group of people, put them in one room, another group in another room. And they looked at the screen. In one room, the word “educated” flashed subliminally about [a] second and a half, two seconds. In the other room, the word “ignorant” flashed on the screen subliminally [a] second and a half, two seconds.

Next part of the experiment, in each room flashed on the screen was a face of the same Black man, again subliminally, a second and a half on the screen and down. Face of the same Black man. Third phase of the experiment, seven pictures of that same Black man appeared on the screen in each of the rooms. Same Black man, seven pictures.

But three were lighter skinned. Three were darker skinned versions. One was the exact picture, the exact photograph that they saw before sublimely. And they were asked, select which of the seven pictures is identical to the first one that you saw for a second and a half. If you were prompted subliminally, if you were primed with the word educated, you selected a lighter-skinned version, lighter-complexion version as being identical to the first picture that you saw.

If you were primed with the word ignorant, you selected a darker-skinned face as being identical to the first. Consciously, you might say, I don't care about someone's complexion. It's about their worth, the competence, etc. We believe that. That is important. But it's important to understand the unconscious process, the implicit bias; and, in this case, the powerful dynamic of complexion which lives in our culture in subtle and complex ways.

One of the things we know about child development is in primary school and in secondary school, when you look at the suspension rates for Black children and White children, just across the board in virtually every study of suspension rates, Black children are suspended more often for behaviors that are seemingly identical to behaviors exhibited by White students. So this disparity in complexions throughout the literature.

But when you dig into it and you deconstruct race and complexion and you look at the differential suspension rate related to complexion, you see this powerful dynamic. And so in this research, you see that darker skin, darker complexion Black females are suspended at a higher rate than lighter skin Black female[s]. This powerful dynamic.

But as I said earlier, implicit bias operates certainly for race, given the historical context of race in America, but in terms of gender, height, weight, even accent. So in this research, participants listened to two audiotapes. The voices on the tapes were speaking in English. And then they were shown photographs of the speakers. Again, both speakers speaking English.

When they saw a photograph of an Asian person and they were asked to rate the accent, they rated the accent as being stronger and they rated the understanding of the content as being more difficult to understand when they saw a face of an Asian person. Again, both audiotapes speaking English.

But when you saw the picture, unconsciously, you made this association, and you assess the accent as being stronger and the content as being more difficult to understand. Again, this powerful dynamic that shows up in terms of race, gender, sexual orientation, etc.

So example of how it powerfully shows up in terms of gender, particularly in the context of so many of us working online currently. So in this research, they had two professors teaching the, quote, "identical" course online. You couldn't see the face of the speaker. You heard their – you saw their PowerPoint slides. And they taught this online class.

So they would have a male professor teach two sections of this online class. Couldn't see the face. Couldn't hear the voice. You saw the slides. One class, the male professor taught using a male first name. The other class, he taught using a female first name.

Then a female professor taught two sections of the same class trying to teach them identically. Same class, only one class, she used a male name. In the other class, she used a female name. Then they sent out a survey to the students in all four classes, and they asked them to rate their professor.

And across the board, they rated the male-named professor higher. Again, this powerful, this powerful unconscious bias, which we could trace to the equities around gender going almost as far back as recorded research and showing up in this insidious and powerful way in this research.

Then they looked at the mid-year and end-of-the-year tests that were given in these four classes. And they returned the papers after the mid-year class and end-of-year-class at the same time in all four courses. And they asked the students in the four courses to rate the promptness of the return of the paper. They rated the promptness higher for male-named professors than female-named professors. The papers returned the exact same time. So, again, the powerful nature of unconscious or implicit bias.

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BLOUNT: As we listen to Dr. Reese, are we gaining a better understanding of the possible origins of my own implicit biases? How have those engrained attitudes affected the way we communicate and treat our patients? Dr. Reese gave us some insight.

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REESE: So what does this have to do with healthcare? So we know that implicit bias – part of the human condition, exists for everyone – has a powerful influence on healthcare. So it shows up in insidious ways

when we think of the choice of a provider, how we judge the competence of a provider, and how that judgment is influenced by conscious things that we're aware of that the provider does or doesn't do.

But also this parallel process – our judgment is influenced by the insidious ways, the unconscious way in which we make judgments of providers related to weight, perceived gender, perceived sexual orientation, perceive race, etc. And so in the area of healthcare, we've created research that examines the impact of communication between the provider and patient and how that communication in subtle but powerful ways can vary related to weight, complexion, sexual orientation, etc.

And then we've looked at – and this is an important area of research – the impact of implicit bias in high-discretion medical processes. By high discretion, I mean those decisions, those processes in healthcare which can vary depending on the discretion of the provider. For example, of the two or three tests that might be available for a particular condition, there is some discretion on the part of provider in terms of which test is given, how soon the test is given. And we often see the influence of implicit bias.

One of the powerful areas of discretion that we can examine is whether or not and to what amount and what degree a patient, for example, a woman, will get a medication for chronic pain, when a White woman or a Black woman presents with pain. So if a provider has a discussion with a woman about her pain, what we find in this high-discretion area is that White women tend to get pain medication more often and at a higher level than Black women who seemingly have the same pain because the provider has some discretion after listening, seeing a woman – has the discretion of whether or not and to what degree they get pain medication.

So one of the tweaks in the process is often the utilization of a protocol. It might be a 1- to-10 Likert scale. So if a woman says that her pain is at a seven, whether she's Black or White, she gets the same level of medication. If she says her pain is at a three, she gets the same level of medication based upon her self-report. So that structure, that protocol can help diminish the discretion that a provider has and consequently the possibility of that discretion being influenced by subtle or unconscious bias.

And certainly, in healthcare, we see bias showing up in the notions and beliefs about whether a particular patient will be compliant in taking their medication, will be compliant in carrying out suggestions that a provider might make. And our notion of whether patient A or B will be compliant is often influenced by unconscious or implicit bias.

And when I say influenced, I don't mean determined. The influence might be 2% of someone's behavior, 3%, 5%. But even that percentage of influence can have really powerful outcomes in terms of the disparities that we see in so many areas of healthcare.

And then in healthcare, there is the power of implicit bias when we think about the work environment, everything from who gets accepted to medical school, who gets hired, and then all of the interactions, relationships, possibility for promotion, professional development within healthcare, the ways in which those decisions, those choices are influenced by implicit bias. Again, not because someone is sexist or racist, but because someone is human.

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BLOUNT: We're all human; we're not perfect, and we're all subject to implicit bias. Those biases can impact the care we provide to our patients. To fulfill our mission to serve others equitably, it's incumbent upon us as healthcare professionals to unearth the biases that lie beneath our consciousness and work to minimize, if not eliminate, them.

Stay tuned for the next chapter in the series as Dr. Reese continues to help us understand ways in which we can overcome our implicit biases to ensure quality, equitable care for all patients.

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