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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 3 – Q&A With the Expert

Guest

Benjamin D. Reese, Jr., PsyD

- Clinical psychologist
- 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

Juliette Blount, MSN, ANP

- Experienced speaker and educator in the areas of racial health disparities and health equity
- Adult nurse practitioner with more than 30 years of clinical experience
- Alumna, Duke-Johnson & Johnson Nurse Leadership Program
- Community education volunteer on empowering healthcare consumers

Reviewer

Lisa Simani, APRN, MS, ACNP

- Editor, Nurse Regulatory/Compliance Planner for Elite Learning
- 20 years of publishing experience
- Lead author of peer-reviewed articles for print- and web-based nursing continuing education provider companies

Transcript

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JULIETTE BLOUNT, HOST: Hello, and welcome back. I'm Juliette Blount for Elite Learning.

In our series on implicit bias in healthcare, we heard from Dr. Benjamin D. Reece Jr., a clinical psychologist who has explored issues of race, diversity, and implicit bias for more than 50 years. Dr. Reese was formerly the vice president for institutional equity and chief diversity officer for Duke University and the Duke University Health System. He is currently the president and CEO of BenReese LLC, a company that works with organizations around the globe to understand issues of diversity, inclusion, and anti-racism.

In our podcast, Dr. Reese helped us as healthcare professionals identify and understand the concept of implicit or unconscious bias. He walked us through examples of implicit bias among healthcare providers and discussed its effect on patients. He helped us recognize ways to increase our awareness of our innate biases and learn evidence-based strategies to overcome them. Dr. Reese returned to answer questions posed by healthcare professionals. His answers to those questions are candid and enlightening.

Our first question involves the difference between implicit and explicit biases. Dr. Reese was asked if implicit bias is unconscious. How can someone identify it and if implicit bias is recognized and we overcompensate for it, does that overcompensation amount to explicit bias?

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DR. BENJAMIN REESE, GUEST: Yeah, well, we're compensating. Yeah, that can be an issue. You know, self-reflection, as common sense is that may seem, getting in the habit of self-reflection, particularly in interactions where your life experience has told you that that's a sensitive area, that kind of self-reflection can be helpful because you might recognize that you're overcompensating.

Personal example: In recognizing what I feel is a racial implicit bias, I tried to also factor into my assessment. The possibility that being a Black man, I might be overcompensating and seeing implicit bias related to race when it is 20% of a situation and really feeling that it's 80 or 90. So that's self-reflection. Give you a very recent example.

So I've been muting myself, so you wouldn't hear the workmen in my house. So most of the workmen have been doing some work in my house are Latinx. And so yesterday I was going out. And I was going to leave the workmen to work for the hour I was out of the house. I recognized that when I was thinking about whether or I would do that, I was thinking about the cultural background. And so I stopped myself. And as I often do, thinking about the reverse. Would I be stopping myself and having these kinds of thoughts if the workmen were White? And for me personally, I think I probably wouldn't. I wouldn't have it to the extent that I was having these thoughts popping into my head of leaving this Latino man in my house as I went out for an hour.

And so I stop myself and reflected on that cognition. And I went out for an hour and came back. And it was fine. Boy, I recognize that that's a potential area for me of sensitivity. For someone else, it might be something different. I know that one of the areas of potential unconscious bias for me, in spite of winning some awards, is ability and disability. And so my business card has been this way for years. My business card is in Braille. Not only for people who I might give my card to, but as a reminder for me, every time I hand the card. But that's an area of potential bias.

I mean, I sometimes recognize a bit of anxiety when I'm making a presentation. And I see one or more people in a wheelchair or, as happened recently, someone who I think was blind. And the anxiety is will I say something? Or should I say something? What's the appropriate way of responding to someone I was doing – I was in Australia a few years ago. And I was doing an exercise with a group of people. And they were getting up. And they were wandering around. And I had these sticky things on their foreheads of different colors, a whole interesting exercise. And there was someone in there who was blind. And here I have these sticky things of different colors.

Well, the kind of anxiety I had because I know from some life experiences that's an area of potential bias. So the process is unconscious. But I've become sensitive to that particular type of unconscious bias, so that I hope when that occurs, the light bulb goes off, so I can reflect on my behavior as I do that interaction. I know that in spite of being Black and doing this work, that there are situations with, particularly Latino men, where I can have these things rolling around in my head about safety, security, trustworthiness, etc. That is a bias that I wouldn't have to that extent if the person was White or even Black. So the process is unconscious. But self-awareness, self-reflection can help focus you on areas that you've come to see as potential blind spots.

One of the books I would recommend is called *Blind Spots*. So that's something, a book you can hopefully, Google.

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BLOUNT: Healthcare providers are certainly not alone in harboring implicit biases; patients unconsciously carry biases, too. This next question addressed when healthcare providers find themselves on the receiving end of patients' implicit biases. A healthcare professional asked what would be a good response if you experience implicit bias.

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REESE: When you're in a position of authority or power, part of what comes with that is a different set of responsibilities than being in the less-powerful positions. So I generally, as a general rule, don't try to correct patients' psychological, cognitive set or stance, if you. I will most often – and there are exceptions – not respond and correct a patient unless the context is one of psychotherapy. But as a physician, I wouldn't be in the habit of trying to modify someone's bias about race or gender when they're coming in for a kidney issue or a cardiac issue. And that's the position that I take recognizing that when I'm in the role of a provider, I'm in a powerful position. And this person coming isn't coming to have me, as a provider, modify their beliefs, conscious or unconscious, about race.

But I must say, certainly, there's been literature about that, particularly in recent years, about providers who experience racism. And so there have been some hospitals and healthcare systems that have kind of increased the support workshops that they have for providers. I'm into a year and a half of co-leading a support group for providers. And it's for things that they experience in the consultation room. It's things that they experience in the healthcare system, more generally. And then things that they've experienced in their life. And it's a year and a half, almost a year and a half. Because it was started shortly after the murder of George Floyd.

And so getting support in a system can be one way of responding to the biases that are directed towards you.

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BLOUNT: Another question similarly asked how do you handle situations in which, as a healthcare professional, you observe a coworker showing signs of implicit bias. Dr. Reese responded.

REESE: I get to working to create an environment in an organization where people are comfortable. And it's normative to give feedback and to the extent that you can, and it's on a continuum, create an environment that is more open to that. And it's more normative than I think giving feedback to colleagues. It's usually received in a positive way. And I think that's important [to] know, just as being a bystander in observing sexual harassment, all the literature about bystanders needing to give feedback to the perforator and supporting the victim. I think if you're observing an interaction that you think is an example of unconscious bias, giving that person feedback, that colleague. Feedback, I think, is important. And again the extent to which you can create an environment that's normative. That's helpful.

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BLOUNT: Creating that normative environment involves organizations, as well as individuals. Dr. Reese was asked about implicit bias in organizational culture.

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REESE: Well, in spite of the fact that I focus so much on our individual assessments our individual cognitions, in addition to that, thinking and working systemically and structurally in an organization is important. So I think to the extent that an organization and leadership is important can begin to talk about implicit bias as being important, as not meaning that you're sexist, a racist, and more that, can become culturally OK to talk about this [INAUDIBLE] easier for someone to [INAUDIBLE] and not feel offended by underlying the word and the concept of respectful feedback.

Because I can recall someone saying to me, well, Dr. Reese, what you just said might be viewed as being sexist. And you know, my immediate reaction in my head was I've been doing this for 50 years. My wife thinks that I'm sensitive. My daughter thinks I'm sensitive. But I stopped myself and tried to reflect on the feedback I was getting and thinking about what I said. And so I think the extent to which an organization can make it normative to think about one's own potential for implicit bias and attempts to make individual feedback. And to make it easier to be received in a constructive way.

BLOUNT: During the podcast, Dr. Reese discussed examples from his own experience on ways to recognize and overcome implicit bias. Here, he was asked to discuss, in further detail, how in a group workshop setting, he singled out words that prompted reminders of what the group participants had learned about implicit bias.

REESE: So the five words were the words that particular group found to be helpful to recall. So what I would recommend, if you wanted to try this strategy, is that [at] the end of a workshop that one of you might do, hand out a piece of paper with a dozen, 15 words that you've used, concepts that you've used. And then ask people in the group to circle three. Collect all the papers. Do a frequency analysis. And see for that particular group what might be the words that would stimulate recall of the workshop. And it might vary from group to group. You might have a discussion in one workshop, where you spend a lot of time on weight wise. And so for that particular group, something related to weight might stimulate recall.

Let me mention a kind of interesting caveat. So in this particular workshop with physicians who were screening applicants at school of medicine, we spent a lot of time talking about weight and weight bias, which is one of the areas of implicit bias that has been increasing in recent years. And so when I ask people to circle three things, and I collected the papers, overweight was one of the words that a lot of people circled. So I made this kind of executive decision to not put it on the poster.

BLOUNT: Finally, reflecting on how implicit biases develop early in our lives. Dr. Reese was asked to detail research that has explored the development of unconscious bias or lack of it in children who have grown up in multiracial, multi-ethnic, or diversely religious backgrounds. Once again, Dr. Reese.

REESE: Hey, at Duke University, I have a wonderful colleague, Dr. Sarah Gaither, G-A-I-T-H-E-R. And Sarah is biracial, one parent Black, one parent White. Sarah, to most people, looks White. Her research has been on biracial children. And so I would suggest that people Google her work. You can read some of her articles.

So biracial people. And it's complex, like all of these factors. So it depends upon the kinds of experiences that a child has had, the ways in which parents and other figures have talked about their biracial identity. Certainly, depends upon the kinds of situations they've been involved [in], and if they've been in a school where many children are biracial, and race and biracial identity is talked about. That's different from being the only child in the school and getting stigmatizing comments. And that's one comment I would make.

But I think Dr. Gaither said that, in general, I want to emphasize, in general, [that] this certainly isn't true for everyone. Children who are biracial tend to have greater facility in talking about race, interacting with a wider variety of people. Sarah did some research early on. And she's followed up with more specific research. But this early research looked at a group of college students, who, for a semester, were living in a dorm with students of the same race. And then a matched pair of students, who are living in a dorm, in a room, with a roommate of a different race.

And this semester, they both came in, both groups came into the lab, individually. They sat down with someone who was really part of the experiment. We engage them in a conversation about race. The conversation that sort of required them to say words, talk openly about race, about Whiteness, Blackness, etc. And they were videotaped. And they took surveys. And what she found was those students who had lived for a semester in the dorm with someone of a different race, clearly, we're more comfortable talking about race using words and talking about Blackness and Whiteness.

Video of the nonverbal behavior – people who are rating the videos rated them as being more comfortable, non-verbally, in talking about race. And the opposite was the case with students who live for a semester with other students of the same race. And so she insinuates from that [that] it appears that having biracial experiences, being biracial, seems to be, well, a plus.

But I say seems to be because there are lots of caveats. It depends upon the student that, for example, you're living with. Depends upon the larger context of the school. She doesn't know how long that “advantage” lasts after the one semester. She's done research to see to what extent this may be true for living with students of a different gender, different sexual orientation. That's a long way of saying that there appears to be a “plus” in biracial, being biracial and navigating complex diverse environments. But there's a lot of caveats and a lot of research that needs to be done.

BLOUNT: Research will continue to explore the origins and impact of implicit bias in healthcare. It is important for us to learn all that we can about biases and how to overcome them to provide the best possible experience for our patients. We hope you've enjoyed learning from Dr. Reese and that you'll further your education on this topic by following Elite Learning’s in-depth continuing education experiences.

Thank you for listening. This is Juliette Blount for Elite Learning.

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