Unconscious Bias In Healthcare
APHA Webinar on Unequal Treatment: Disparities in Access, Quality and Care

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August 25, 2015
Clinician bias is one documented contributor to health care inequalities

Large and every-growing body of evidence that patient group identity (race, gender, sexual orientation, size...) can affect clinicians’:

- Question-asking in clinical interview (and thus information gained)
- Diagnostic decision-making
- Symptom management
- Treatment recommendations
- Referral to specialty care
- Interpersonal behavior predictive of patient trust, satisfaction and adherence
Primary explanation points to the role of unconscious, automatic (implicit) attitudes

Doctors’ unconscious racial biases leave patients dissatisfied

Physicians are encouraged to remember that each patient is an individual. Exposure to different cultures improves understanding about people’s differences, health professionals say.

Research on the Provider Contribution to Race/Ethnicity Disparities in Medical Care

Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here
Numerous reviews and conceptual frameworks


Conscious

Explicit
Effortful
Deliberative
Slow

Unconscious

Implicit
Effortless
Automatic
Fast
Background

Unconscious mental processes help us deal with the millions of bits of information that surround us.

Serves our need for cognitive efficiency

Serves need to predict what is going to come next
Implicit social biases (negative implicit attitudes) are one byproduct of our cognitive processing system

• Can be as simple as an “affective flash”.
• Can be a complex set of beliefs & expectations.
• Can contain subtypes.
• Numerous other cognitive biases.
The impact of the “Affective flash”

• Towards (leaning in) & away (leaning away)

• Dozens of studies showing that we come up with cognitions, beliefs, that are consistent with our first emotional response.

• Influences non-verbal behavior, setting up negative feedback loop.
Creates a lens both in WHAT we notice and how we interpret what we notice (make meaning).
The relationship between implicit bias and structural racism

Humans are wired to have specific ways of making sense of and reacting to the world.

Structural factors shape the way we think and react. The way we think and react (or fail to) upholds social structure.

Systemic patterning of power and comparative privilege

Dominant narratives about meaningful group categories and the characteristics of group members

Implicit Attitudes (and other cognitive and affective processes)

Lack of attention to the way we perceive, process and use information is a rate limiting factor in achieving our goals.
Interventions

So what do we do about it?
If efforts to remedy societal racism and other socially structured inequalities are to be successful, they MUST take into account the way we think – must attend to implicit cognitive processes.
Manipulation of emotion-laden associations to strengthen harmful associations

We need to speak to the implicit cognitive system in our communications

Images, values, emotions, threat (due to forces not in public interest)
What works in health care?

Some interventions out there, none assessed for ability to prevent implicit biases from having an impact on patient care.
What does the evidence suggest?

Organizational/institutional level targets for change:

- Diversity climate and role-modeling
- Cognitive load
- Positive intergroup
- Counter-stereotypic imagery ...
Strongest evidence for CHANGE in implicit biases: Increase exposure to counter-stereotypes. Decrease negative-stereotype consistent cues.
What does the evidence suggest?

Individual level targets for change:

• Increase internal/intrinsic motivation
• Increase cognitive empathy
• Increase emotional regulation skills
• Increase partnership building (common in-group identity)
Strategies that may be effective regardless of motives, world-view and explicit attitudes

Under specific multisensory conditions, we can experience artificial body parts or fake bodies as our own body parts or body, respectively.

Operating an avatar with another race lowers implicit bias “Ownership of an outgroup body has been found to be associated with a significant reduction in implicit biases against that outgroup”
End.... Thank you!
Supplemental Material:
Other considerations
Intensity & type of intervention needed will vary by individual characteristics

Some sociopolitical attitudes are associated with higher implicit racial and other biases, tendencies to stereotype and make negative attributions about patients from stigmatized groups.

Existing strong internal/intrinsic motivation to control prejudice associated with lower bias, ability to prevent implicit biases from affecting behavior.
Barriers to Action

- The topic of racism triggers an automatic “away” response laden with strong emotion.
- Humans have an automatic preference for information that increases positive emotions (and an aversion to information that increases negative emotions).

![Cartoon illustration showing a person saying, “My desire to be well-informed is currently at odds with my desire to remain sane.”](image)
Barriers to Action (Automatic or implicit cognitive tendencies)

- Cognitive dissonance
- Strong motivation to protect self-concept

“I am in control of my thoughts and behavior.”

“I am not consciously aware of much of what guides my perceptions and behavior.”
Barriers to Action (Automatic or implicit cognitive tendencies)

- Cognitive dissonance
- Strong motivation to protect self-concept

“I am deeply committed to equality & eliminating discrimination.”

“I have unconscious biases can lead me to behave in discriminatory ways.”
Barriers

- Cognitive dissonance
- Need to protect self-concept
- Generalized sense of threat
- Conscious beliefs justify implicit attitudes

Reject conflicting evidence! Tension Resolved!

- The IAT isn’t valid.
- This might be true for other people but I am enlightened/a social justice activist/self-aware/different.
- There is a black President – bias is a thing of the past
- People who talk about this are… (fill in any number of discrediting adjectives or motives)
Barriers

“Notice flaws!”

Studies showing inequalities in health care, education, evaluation, pay, promotions, hiring, Mortgage.

“Much better studies!”

Studies finding no inequalities
White people – even egalitarian white people – tend to have automatic “away” response to word privilege.

Connected to automatic human wiring/response tendencies:
- Guilt
- Threat/fear
- High salience of their own struggle-jump to feeling struggles are being invalidated
- Overgeneralization and difficulties holding complexity = any acknowledgement of privilege is interpreted as “all the good in your life is unearned and un-deserved”

Maybe term comparative will help.
Empathy/ Perspective-taking skills

• Perspective-taking skills (the cognitive component of empathy) have been shown to: inhibit the activation of unconscious stereotypes and prejudices.
• Increases both individuation and sense of commonality.

• Challenges: empathy for pain of someone of another race is diminished compared to same-race empathy.
Emotional regulation skills

• Providers who experience positive emotion during clinical encounters may be less likely to categorize patients in terms of their racial group
• Use of more inclusive social categories,
• View themselves as being part of a larger group which can facilitate empathy and increase the capacity to see others as members of a common “ingroup”.
Partnership-building skills

- Reduce the likelihood that implicit bias will affect provider behavior and decision-making;
- Create common “in-group identity”, develop a sense that their partner is on the same “team”, working together towards a common goal.
- Perceptions of common in-group identity facilitates perspective taking and affective empathy.
Intensity of intervention needed will vary by individual characteristics

- For example, individuals with strong INTERNAL motivation to control prejudice have:
  - Lower implicit bias
  - With sufficient cognitive resources, can reduce implicit bias activation & application.

Dijksterhuis & van Knippenberg, 1998; Stape et al 1998)