Facilitators’ Manual

Bias: Understanding How It Affects Our Patients And Our Care Of Them

The goals of this session are to:

• Define bias and its significance in the clinical learning environment
• Consider how it affects health care workers and their patients personally and professionally
• Explore steps to ameliorate bias by heightened awareness, curricular interventions, and institutional priority

Bias is deeply rooted in the human brain. Evolutionarily it afforded a quick way to assess whether the approaching animal was one of your group of wildebeests or a lion looking for lunch. Distinguishing between “safe” elements in one’s environment and “unsafe” elements became automatized to allow the quick reaction times that could spell the difference between life and death. Learning which groups are “safe” (like us) or “threats” (not like us) occurs almost from birth largely unconsciously and is shaped by our own experiences and the beliefs of our society. While “bias” generally is considered a form of prejudice in favor of or against a thing or person, it may also be a cognitive bias in thought processes that is a systemic error in thinking affecting the decisions and judgments that people choose. Heuristics are mental shortcuts developed in your brain so that you don’t have to work through all the steps of a solution for similar problems when new situations arise. These rule-of-thumb strategies shorten decision-making time and allow people to function without constantly stopping to think about their next course of action. Heuristics are helpful in many situations, but they can also lead to cognitive biases. Cognitive biases are logical fallacies that are derived from heuristics and can be dangerous because they automate wrong decisions.

Bias as a form of prejudice may be either explicit and therefore present at a conscious level for an individual or implicit and therefore operating subconsciously. Implicit bias may include beliefs that are entirely opposite to those held explicitly by an individual. In this section, we help residents to understand the impact of both explicit and implicit bias on the health outcomes of their patients. Those biases may be held by the physicians and other health care workers in the system and may also be held by the patients and the groups they come from. While physicians are trained to approach all patients impartially, no human is without biases and these may affect the care they give to their patients. The slide set introduces these concepts, some of which residents may or may not have been exposed to in medical school and other settings. It is often difficult for people new to these concepts to accept that they too are affected by their biases and therefore so are their patients. It is therefore very important that this session establish a safe environment where residents and faculty can discuss how these beliefs are affecting all human beings including themselves. Faculty leading these discussions should be prepared to deal with some level of denial if not hostility when residents are asked to reflect on their own implicit and explicit biases. This work is challenging many deeply held beliefs in their own professionalism and requires faculty to normalize the distress that arises when individuals are asked to...
reflect on their biases. We strongly encourage that enough time is allocated for residents to work through these feelings to some extent in the teaching session with faculty facilitation. Faculty should also role model acknowledgment of their own implicit biases in this session and in subsequent discussions. Good references for leading this curriculum are the articles by Sukhera J et al in Acad Med Dec 2017, Karani R et al in Acad Med 2017, and Byrne Adv in Health Science Education 2015.

During this session, we recommend that residents participate in an exercise to explore their own potential sources of implicit bias. A standard exercise in identifying personal implicit biases is the Implicit Attitudes Test or IAT. Developed by the faculty at Harvard and other institutions as Project Implicit, the test is based on our tendency to associate positive words with groups we are positively biased towards and negative words with groups we are negatively biased towards. Participants can select which category they would like to assess their attitudes in including race/ethnicity, gender, sexual orientation, anxiety, depression, eating disorders, alcohol, and persons with mental health concerns. The questions are answered online and results with interpretation are immediately available. We suggest having residents assess their bias towards people with such groups as mental health issues to allow residents to experience the IAT but for a less controversial source than racial bias. It is also strongly recommended that residents be debriefed on their experience within a short period of time from taking the tests. This information can be difficult for individuals to adjust to and discussions with faculty guidance are key in helping residents to deal with the emotions (guilt, denial, even anger) that these scores may engender. Faculty should be well versed in the interpretations and limitations of the IAT. The article by Stone J and Moskowitz G in Medical Education 2011 in the bibliography can be very helpful for this discussion.

The residents and faculty are encouraged to reflect on their own experience with bias in the workplace. Discussion groups will help residents to apply the information to their own environment. The article by Camara P Jones is an excellent discussion of how bias and SDH affect the health outcomes of our patients. It is highly recommended for both faculty and residents. Having discussed in depth how bias is human and unavoidable, the faculty can then lead a discussion of how to ameliorate the effects of bias. Discussions can explore what steps can be taken to identify and acknowledge bias and work to minimize it’s effects on our patient care decisions.

Another important consideration is bias in our patients. This may be both explicit and implicit and has a significant effect on their relationships with providers, their interactions with the health care system and their own health outcomes. It is particularly difficult when patients exhibit bias against physicians especially physicians in training. Residents can be engaged in discussions of their experiences with this and work through ways for faculty and residents to address this in a professional manner. Faculty are encouraged to consult with institutional resources in these challenging situations. If time permits, a brief discussion of managing microaggressions in the work environment can be included. The website from the University of Nebraska Medical Center that displays a useful pneumonic is included in the bibliography.
A final exercise may be to have residents identify groups who encounter bias within the health care system both as patients and as providers. Discussions can work through what residents and other providers can do to provide equitable care to all groups.