

# Combined Surgery and Medicine Grand Rounds Presents: *Saleh Lectureship*

## Bias at the Bedside and Beyond: A Conversation of Educators

### Moderators:

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Associate Vice Chair, Office of EDI, Department  
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### Panelists:

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#### ***Daniel Kozman, MD, MPH***

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# Case #1



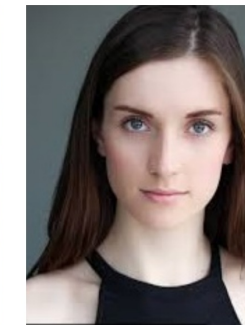
- ▶ A middle-aged Black woman presents to the ER for an exacerbation of pain that she feels all over and “in her bones”. She has had this pain for several months and her assigned Medicaid HMO PCP had referred her to Rheumatology and a Pain Specialist for a work-up but her appointments were 6 weeks away. Overnight her pain had gotten so much worse, so she decided to come to the ER at UCLA to be evaluated.
- ▶ In the ER, she was given IM pain meds which were not very effective at controlling her pain. Right before change of shift, the resident came in with a 3-day prescription for pain meds and explained she was going to be discharged and that she should have quick follow-up with your PCP in the next 2 days”. She immediately starts to become visibly upset and in a raised voice says she can’t even stand-up from the pain and that she does not have anyone to help her at home.

# Case #1

- ▶ She gets admitted to your G.Med team with the sign out from this ER. “Sorry, we tried to send her home but she didn’t want to leave. Just needs a little more pain control overnight and then can go home in the morning to finish her workup as an outpatient”.
- ▶ The next morning you stop by her room check on her and remind her that she will be d/c’d around 10am. As you enter the room, you are surprised to see one of your senior attendings sitting on the side of her bed talking with her. Confused, you ask if he had been consulted on the case. He explains that your patient is one of his community health partners that he has worked with for the past 20 years. “She’s like family”. He thanks you for admitting her and inquires about what you are going to do to work up her pain because he’s “never seen her like this before”.

# Bias in Medicine

Medell Briggs-Malonson, MD, MPH, MSHS  
Associate Professor of Emergency Medicine  
Interim Chief, Health Equity, Diversity and Inclusion  
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# What is Bias?



A bias is a tendency or inclination toward or against something or someone.



Some biases are positive and helpful.



Some biases are negative and detrimental.

# Explicit vs. Implicit Bias

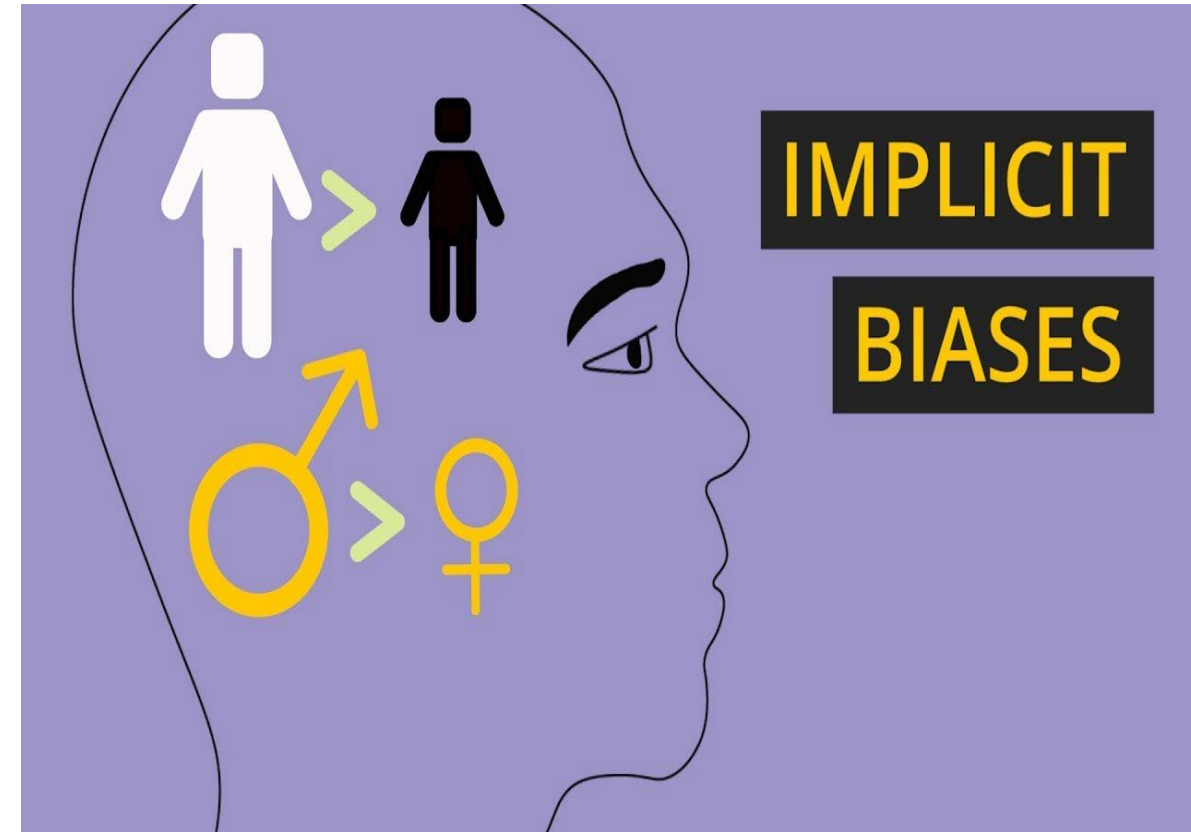
- Explicit Bias
  - Conscious attitudes that are recognized and can be measured by self-report.



# Explicit vs. Implicit Bias

- Implicit Bias

- Unconscious and involuntary attitudes and beliefs towards a person, group, or idea that can influence behavior, perceptions, or decisions.
- Learned stereotypes and ingrained beliefs can be automatically triggered during personal encounters.



# Contributors to Implicit Bias

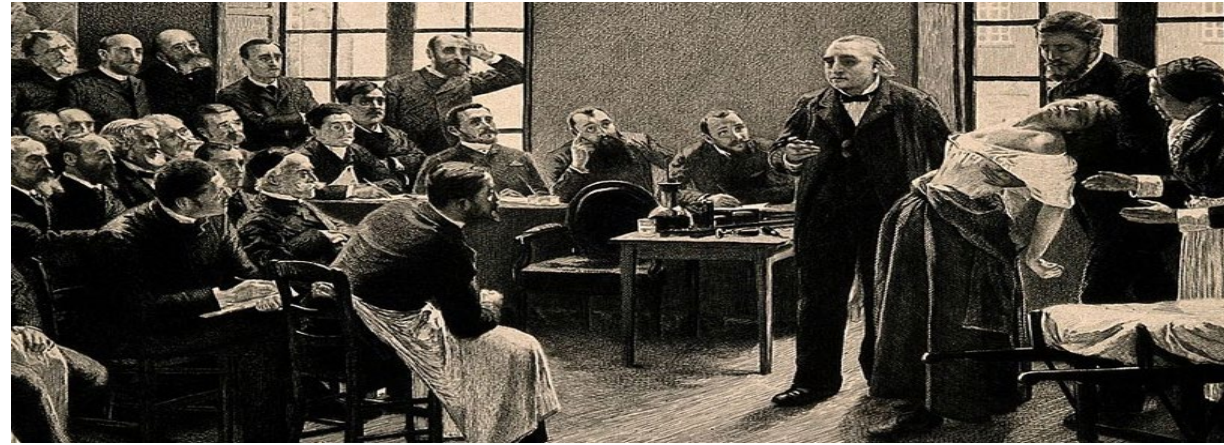
- Personal Background
  - How, where, and by whom we were raised
  - Interactions with friends, peers, and colleagues
  - School, community, and religion
- Media (new and old)
  - Images from news, print, and social media
- Politics and policy





# Contributors to Implicit Bias

- Education and Institutional Sexism and Racism
  - Visual imagery that perpetuates stereotypes
  - Sexist or racist beliefs taught in textbooks or school
  - Vertical transmission of stereotypes passed down from educators



“Hysteria” Diagnosis



US Government Supported Tuskegee Experiment

# Contributors to Implicit Bias

- Cognitive Stressors
  - Biases against patients may be due to taking “mental shortcuts” because of high or stressful cognitive loads
  - This may contribute to persistent racial and gender health inequities



# Strategies to Decrease System Bias

**TAKE  
ACTION!**

# Strategies to Decrease System Bias



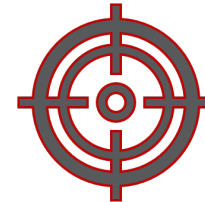
## Assess

Assess the department and system for biased practices and norms



## Act

Take intentional action through policies, protocols, and evidence-based guidelines to mitigate bias



## Track

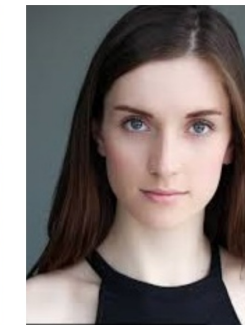
Track metrics of success to ensure equitable access, treatment, and outcomes

# As academic physicians...

- We have a ***professional and moral obligation*** to serve as leaders to ensure equitable access and high-quality care to all patients and communities
- We must be ***courageous and caring*** to challenge our norms to advance health equity through our clinical and operational practices
- We will grow **stronger in our understanding, impact, and reach** through dialogue, action, and solidarity

# Bias in Medicine

Faysal Saab, MD  
Assistant Clinical Professor  
Internal Medicine and Pediatrics  
Hospitalist Division



# A Closer Look at our Patient Reveals More

- A middle-aged **Black woman** presented to the ED in pain
- Pain existed for **several months**
- She was awaiting **rheumatology** and **pain** appointments
- Her friend **dropped her off** at the ED
- She **became upset** when she was told to go home while in pain
- ED signout suggests morning discharge **without further workup**

# Two Challenges

- How can we become aware of these biases?
- How can we decrease the impact they have on patient care?





## Take Implicit Association Test

Implicit.harvard.edu

### Native IAT

**Native American ('Native - White American' IAT).** This IAT requires the ability to recognize White and Native American faces in either classic or modern dress, and the names of places that are either American or Foreign in origin.

### Sexuality IAT

**Sexuality ('Gay - Straight' IAT).** This IAT requires the ability to distinguish words and symbols representing gay and straight people. It often reveals an automatic preference for straight relative to gay people.

### Weapons IAT

**Weapons ('Weapons - Harmless Objects' IAT).** This IAT requires the ability to recognize White and Black faces, and images of weapons or harmless objects.

### Disability IAT

**Disability ('Disabled - Able' IAT).** This IAT requires the ability to recognize symbols representing abled and disabled individuals.

### Weight IAT

**Weight ('Fat - Thin' IAT).** This IAT requires the ability to distinguish faces of people who are obese and people who are thin. It often reveals an automatic preference for thin people relative to fat people.

### Arab-Muslim IAT

**Arab-Muslim ('Arab Muslim - Other People' IAT).** This IAT requires the ability to distinguish names that are likely to belong to Arab-Muslims versus people of other nationalities or religions.

### Age IAT

**Age ('Young - Old' IAT).** This IAT requires the ability to distinguish old from young faces. This test often indicates that Americans have automatic preference for young over old.

### Race IAT

**Race ('Black - White' IAT).** This IAT requires the ability to distinguish faces of European and African origin. It indicates that most Americans have an automatic preference for white over black.

### Presidents IAT

**Presidents ('Presidential Popularity' IAT).** This IAT requires the ability to recognize photos of Donald Trump and one or more previous presidents.

### Gender-Science IAT

**Gender - Science.** This IAT often reveals a relative link between liberal arts and females and between science and males.

### Gender-Career IAT

**Gender - Career.** This IAT often reveals a relative link between family and females and between career and males.

### Religion IAT

**Religion ('Religions' IAT).** This IAT requires some familiarity with religious terms from various world religions.

### Skin-tone IAT

**Skin-tone ('Light Skin - Dark Skin' IAT).** This IAT requires the ability to recognize light and dark-skinned faces. It often reveals an automatic preference for light-skin relative to dark-skin.

### Asian IAT

**Asian American ('Asian - European American' IAT).** This IAT requires the ability to recognize White and Asian-American faces, and images of places that are either American or Foreign in origin.

### Transgender IAT

**Transgender ('Transgender People - Cisgender People' IAT).** This IAT requires the ability to distinguish photos of transgender celebrity faces from photos of cisgender celebrity faces.

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# Two Challenges

- How can we become aware of these biases?
  - Take Implicit Association Test
- How can we decrease the impact they have on our patients?
  - Mitigation strategies

# Mitigation Strategies

PERSPECTIVES

## How Clinicians and Educators Can Mitigate Implicit Bias in Patient Care and Candidate Selection in Medical Education

Quinn Capers IV

Cardiovascular Medicine, The Ohio State University College of Medicine, Columbus, Ohio

- Common identity formation
- Perspective taking
- Consider the opposite
- Counterstereotypical exemplars

# Four Strategies to Mitigate the Effect of Bias

- **Common identity formation:** During patient interview, inquire about possible common group identities between you and the patient (hometown, sports team, language proficiency, love of the arts, etc.)
- **Perspective taking:** Before or during patient encounter, pause to consider the stress the patient is under today
- **Consider the opposite:** After an initial review of patient information (history, physical, and social history) and coming up with a disposition, pause and re-review the information, actively looking for evidence for the opposite conclusion, then make a final decision
- **Counterstereotypical exemplars:** Focus on individuals we admire who are in the same demographic as the patient.

# How can we apply this to our patient?

- **Common identity formation:** We could build rapport and find things in common with her.
- **Perspective taking:** We could picture ourselves in her shoes. How would it feel?
- **Consider the opposite:** Could we be missing serious pathology? What if this is cancer?
- **Counterstereotypical exemplars:** We could pretend that the patient is Michelle Obama, then notice what that does to our brains. Does that simple trick change how we think of the patient and our medical approach to her ailments?

# The UCLA Hospitalist Experience

- After the murder of George Floyd and the anti-racism protests that ensued, there was renewed interest and energy in EDI work.
- In our division meeting, several voiced interest in brainstorming ways we can do better as individual hospitalists and as a division.
- We formed a working group
  - Created a “Best Practices” document for hospitalists
  - Formed an EDI Educational Series for our hospitalist division

**Running the Team**

- When setting expectations, call attention to our collective responsibility to look for implicit biases in our diagnostic workup, management, discharge planning, etc.
  - Emphasize that we must look past the existing “teaching hierarchy” on the team for this to succeed
  - Consider adding “bias check” to the inpatient checklist or at the end of rounds to actively look for it.
- On discharge, look for factors that may affect a patient’s ability to adhere to the recommended treatment plan, e.g. transportation to appts, video chat capabilities, visual impairments, living situation, finances, etc.
- Plan a time-out from clinical activities to engage in conversations that improve connectedness within the team as it will increase likelihood of more frank conversations about EDI. Explore ice breakers that stimulate such conversations.
- Encourage moments of perspective taking, individuation and empathy during rounds.
- Encourage inclusion of behavioral health, living environment/resources, social support, and functional status in social history
- Routinely check the patient’s language preference in CareConnect and encourage use of interpreter services unless the patient opts out of one.

**Clinical Mindfulness Tips**

- Common identity formation: During patient interview, inquire about possible common group identities between you and the patient (home town, sports team, language proficiency, love of the arts, etc.)
- Perspective taking: Before or during patient encounter, pause to consider the stress the patient is under today and what their life will be like for months after this encounter.
- Consider the opposite: After an initial review of patient information (history, physical, and social history) and coming up with a disposition, pause and re-review the information, actively looking for evidence for the opposite conclusion, then make a final decision
- Counterstereotypical exemplars: Focus on individuals you admire who are in the same demographic as the patient.
- Be mindful of clinical stereotypes of minorities (i.e., the perception that certain people feel less pain, exaggerate pain, or are more likely to abuse drugs).
- Use people-first language: 55yo man with diabetes vs. 55yo diabetic
- Encourage learners to only use race in new patient case presentations if it is actually pertinent to the care of the patient
- Refrain from attributing disparities to the individual behaviors or attributes of patients who belong to racial minority groups.
  - A1C not controlled because patient is lazy, uneducated, etc.

**Topics for Team Discussion**

- Replace one clinical teaching activity on-service with an EDI discussion topic
- All team members take Implicit Association Test (IAT). Discuss experiences as a group and probe for insights into applicability of test to the team’s work on the wards.
  - <https://implicit.harvard.edu/implicit/takeatest.html>
- Discuss key factors that increase use of stereotypes and bias: time constraints, increased stress and negative emotions. Encourage heightened awareness during these times
  - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219858/#CR45>
- Consider The 5 R’s of Cultural Humility
  - [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6445906/pdf/11606\\_2018\\_Article\\_4814.pdf](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6445906/pdf/11606_2018_Article_4814.pdf)
- POC/underserved people’s contribution to medical community
  - 1619 Podcast: Episode 4
- Strategies for before and after patient encounters
  - <https://www.atsjournals.org/doi/full/10.34197/ats-scholar.2020-0024PS>

# Gave birth to new mitigation ideas

- Schedule time to **think** about bias
  - Include a bias check in the inpatient checklist
  - Spend a few minutes after rounds discussing bias with team
    - Look for differences in the way we may be treating/talking about one patient vs. another
    - Change the race/gender/age/language of the patient, and see if our approach would change



# Hospitalist EDI Educational Series

- Monthly sessions
  - Didactic: Implicit biases, microaggressions, health disparities
  - Independent learning activities: implicit association tests, watching informative videos/lectures then discussing with the group.
  - Discussion-only sessions: sharing questions, ideas, or personal experiences with colleagues

# A Personal Note

- This is all about humanism
  - “I treat all my patients like family.”

# Case #2

- ▶ During his 3<sup>rd</sup> year Emergency Medicine rotation, a student named Edgar Ramirez enters the department on his first day to discuss patient care with the residents. A 2<sup>nd</sup> year resident comments, “Oh great! The ED is busy today. We have some interesting patients. Do you want to see the ‘total body dolor patient’ in room 3 or the ‘Hispanic panic’ in room 6?”
- ▶ Later as a surgical intern, he walks into the ICU to round on a patient with history of a recent liver transplant. After initially mistaking him for a respiratory therapist, the nurse coordinator apologizes and asks, “Where are you from?” After responding that he grew up in Los Angeles and his family is originally from Mexico, she responds, “Your parents must be very proud of you!”.

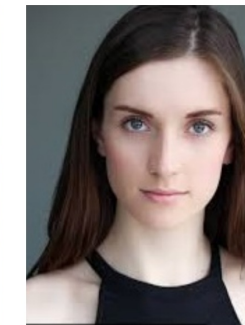
# Case #2

- ▶ Dr. Ramirez eventually joins the faculty, and during his promotion from Assistant to Associate Professor in his Division, he reads one of his peer evaluations from a colleague commenting, “Edgar’s bilingual skills have been a strong asset to the Division”.
- ▶ Dr. Ramirez is considering applying for a position on the Academic Senate at his highly ranked medical school. He is questioning whether he has the qualifications to apply for the position...

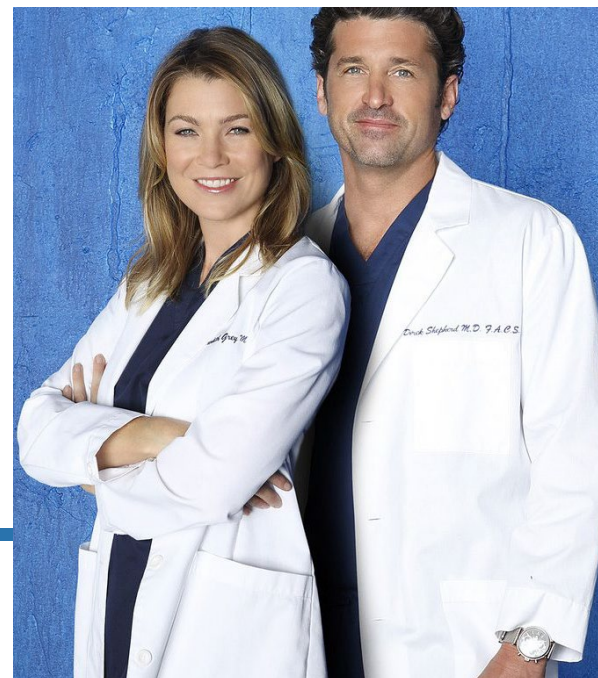
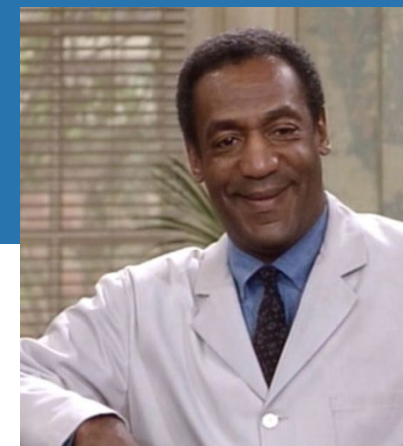
# Bias in Medicine

***Daniel Kozman, MD, MPH***

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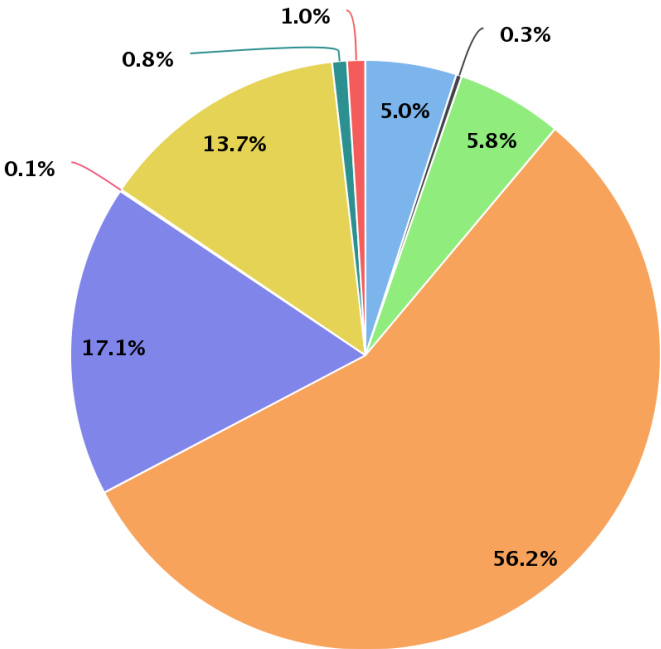


# What does a doctor look like?



# What does a doctor look like?

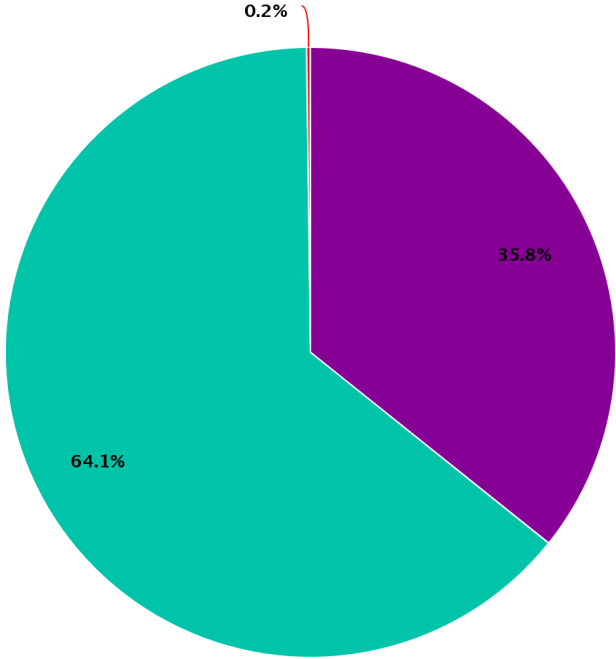
Figure 18. Percentage of all active physicians by race/ethnicity, 2018.



Click on legend item below to add or remove a section from the report.

- American Indian or Alaska Native (2,570)
- Asian (157,025)
- Black or African American (45,534)
- Hispanic (53,526)
- Multiple Race, Non-Hispanic (8,932)
- Native Hawaiian or Other Pacific Islander (941)
- Other (7,571)
- Unknown (126,144)
- White (516,304)

Figure 19. Percentage of physicians by sex, 2018.

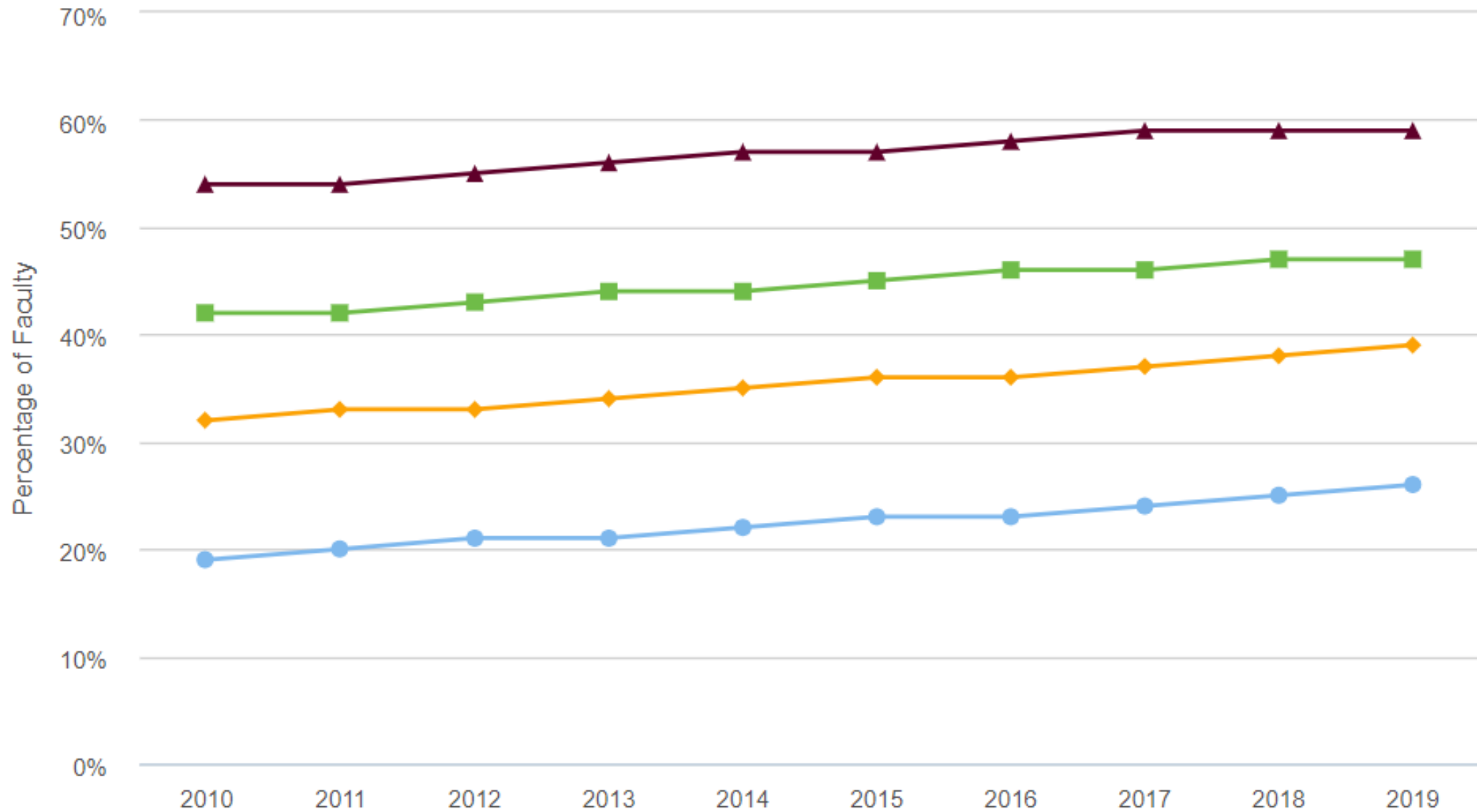


Click on legend item below to add or remove a section from the report.

- Female (328,463)
- Male (588,649)
- Unknown (1,435)

Source: Physician characteristics (sex) are from the AMA Physician Masterfile, Dec. 31, 2018.

# U.S. Medical School Female Faculty as a Percentage of Each Rank



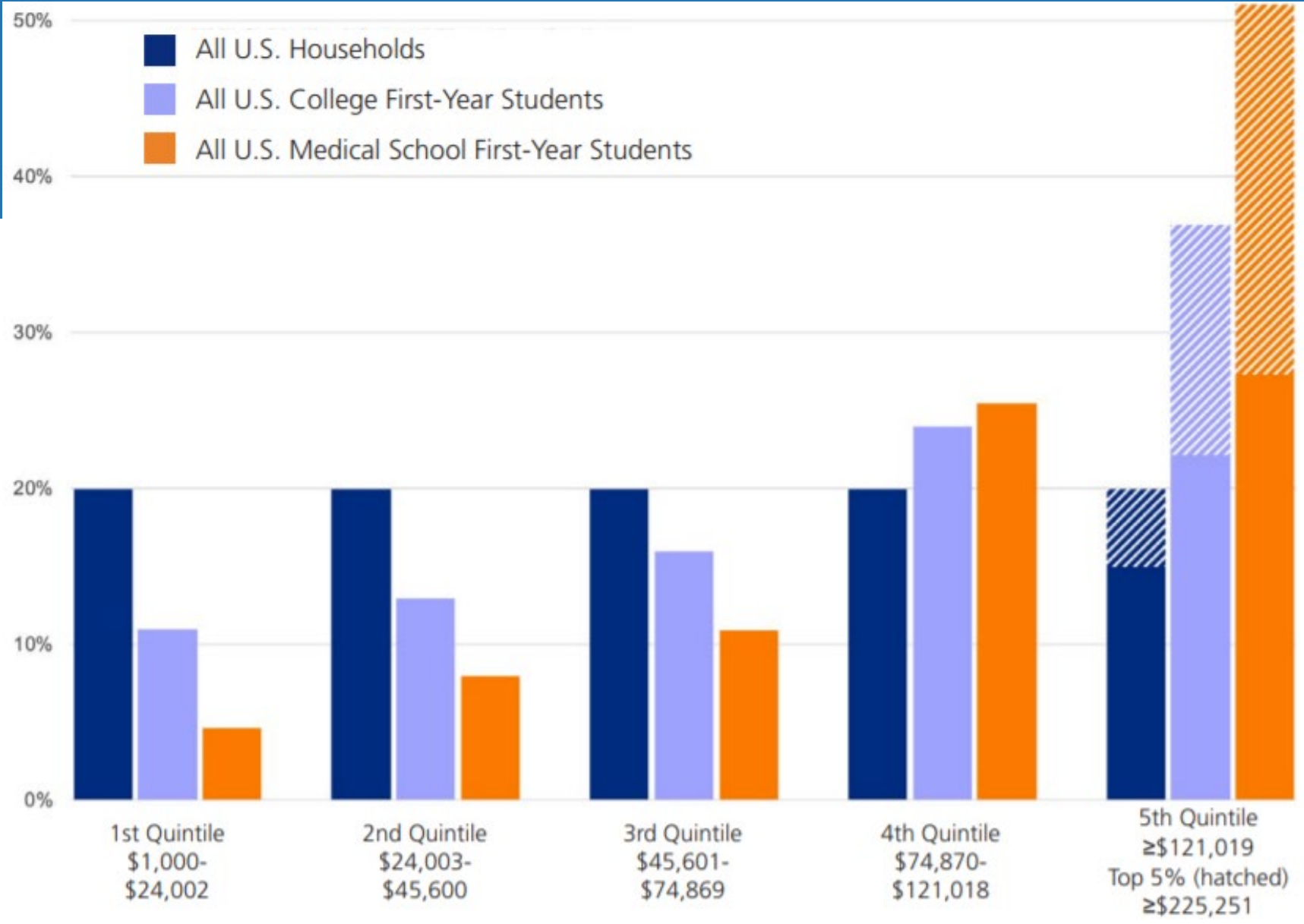
● Professor  
▲ Instructor

◆ Associate Professor

■ Assistant Professor

Source: Diversity in Medicine: Facts and Figures 2019, Assn of American Medical Colleges





# YOU want to be a doctor?



- Many of our own trainees and faculty from backgrounds underrepresented in medicine (URiM) were discouraged from pursuing medical training by career counselors
- Upon applying to competitive residency/fellowship positions, similar discouragement is given to some URiMs and women
- Bias reinforces pervasive **underestimation of one's potential or commitment**, and thus sustains underrepresentation

# Can you call the doctor?



- Bias and underrepresentation reinforce pervasive **underestimation of one's qualifications or skills**
  - ...by patients, staff, other physicians
- Assumptions that the URiM or woman physician:
  - Must be the nurse, therapist, janitor, transport, other ancillary staff
  - Is not the senior physician
  - Too young to have enough expertise
  - Trained at lower quality or foreign institutions
  - Did not earn their position based on their qualifications

## Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace

Aba Osseo-Asare, MD; Lilanthe Balasuriya, MD; Stephen J. Huot, MD, PhD; Danya Keene, PhD; David Berg, PhD; Marcella Nunez-Smith, MD, MHS; Inginia Genao, MD; Darin Latimore, MD; Dowin Boatright, MD, MBA, MHS

**Alien in one's own land** “Wow, you've really come a long way. You know, like, you know, being like a Mexican, that's just...I didn't expect somebody to be that well educated. And I said, Oh wow. Well, I did go to school, and I've been here for a while. And I'm actually not from Mexico, but I'm proud of my heritage. Actually, I'm fourth generation.”

**Assumption of lower status** “There were instances where they would just call me ‘Nurse’ or would think that I'm everything except for a doctor.”  
“Oh yeah, I mean the one that happens the most frequently is patients thinking that I'm like transport. Not recognizing that I am their physician surgeon that's going to be operating on them and just seeing that thought process go through their head. Or having patients that are like, ‘Oh you don't really look like a doctor.’”

**Race/ethnicity ambassador** “...you get tapped to do various things, and some of it is stuff that you're interested in and some of it is because they need, not necessarily a token individual, but somebody to be representative of all of the ideas of minorities because you have that insight.”

# Can you explain this?



- **Minority and LGBTQIA colleagues may be asked to:**
  - Explain to majority colleagues the culture, comments, or actions of others coming from what is perceived to be a similar background
  - Explain why they are academically successful or “articulate” while others of similar background are not perceived to be
  - Explain why patients of similar background are “non-compliant” or “being difficult”
  - Bridge gaps in trust that could have been closed with more robust informed consent and shared decision-making
  - Serve as language translators out of convenience
  - Take on EDI issues without having expressed prior interest

# Can *you* explain this?



- Underrepresentation and bias may lead to pervasive **misappropriation of colleagues' mental resources and time**
- This is exacerbated by power hierarchy
- May be couched in good intentions
- Fear that a patient or trainee may not otherwise get what they need if they don't step in to help
- Diverts energy and time away from their own career advancement

# These are all examples of microaggressions

- Coined by Harvard Psychiatrist, Dr. Chester Pierce

*“Microaggressions are the everyday slights, indignities, put-downs and insults that members of marginalized groups experience in their day-to-day interactions with individuals who are often unaware that they have engaged in an offensive or demeaning way.”*

*- Dr. Derald Wing Sue (Clinical Psychologist, Columbia University)*

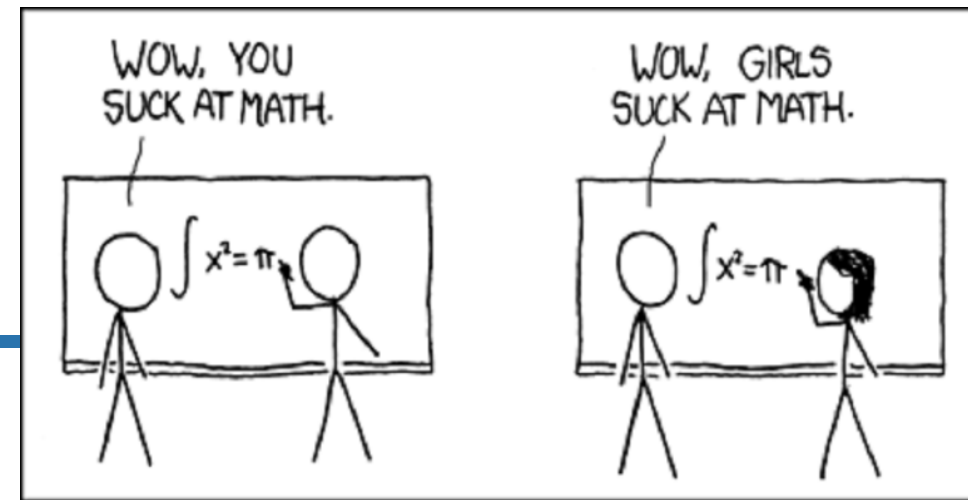
# Do I belong here?

- **Impostor Syndrome**

- Self-doubt and fear you will be exposed as lacking qualifications to deserve your position, despite clear evidence to the contrary

- **Stereotype Threat**

- Concerns that others' judgments or your own actions will negatively stereotype you
- Compounded by evaluators' Confirmation Bias
- Leads to “covering” or downplaying a stigmatized identity if possible





# What is my value at this institution?

- Microaggressions have been associated with lower self-esteem - more severely in educational/workplace settings<sup>1</sup>
    - Experiencing more is associated with lower self-esteem<sup>1</sup>, and higher anxiety and stress<sup>2</sup>
  - Trainees fear retribution for speaking out
  - Data has shown that faculty who are URiM and/or female have higher attrition rates<sup>3</sup>
- **Wellness, retention, and advancement are at stake**

1. Nadal KL, et al. The adverse impact of racial microaggressions on college students' self-esteem. J Coll Student Dev. 2014;55(5):461-474.  
2. Torres L, et al. Racial Microaggressions and Psychological Functioning Among Highly Achieving African-Americans. Journal of Soc and Clin Psych. 2010;29(10):1074-1099.  
3. Liu C, et al. U.S. Medical School Full-time Faculty Attrition. AAMC Analysis In Brief. 2018;14(2):1-2.



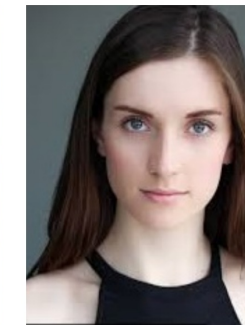
# So what are we doing...

....as an institution to clearly demonstrate that these individuals belong here and are critically needed here?

...individually to actively mitigate microaggressions and build a climate that allows these trainees & colleagues to also thrive?

# Bias in Medicine

***Vincent Rowe, MD***  
Professor, Clinical Surgery,  
Keck Medicine at USC



# What are we doing as an institution to demonstrate that these individuals belong here and are critically needed here?

- Treat them the same
  - Not looking for special treatment
  - Aware of minority status
- Stand by the targeted person

# What can we do to mitigate microaggressions and build a climate that allows these trainees & colleagues to also thrive?

## Targeted person

- Get it out
- Don't minimize
- Don't over-extend
- Call it out

## Offender

- Realize you could be one
- Apologize

## All of Us

- Empathy
- Be willing to change