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Podcast Transcript

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NCTCFP: Welcome to this podcast, sponsored by the National Clinical Training Center for Family Planning. The National Clinical Training Center for Family Planning is one of the training centers funded through the Office of Population Affairs to provide trainings to enhance the knowledge of family planning staff. During this episode, we will be speaking with Dr. Natabhona Mabachi about biases and the impact it can play in health care. Dr. Mabachi is an assistant research professor at the University of Kansas Medical Center and is involved with several initiatives in the US and Kenya to educate medical students and practitioners about health disparities and social determinants of health. Welcome, Dr. Mabachi.

Dr. Mabachi: Thank you so much for having me. I’m happy to be here.

NCTCFP: Before we begin talking about bias, can you clarify for us what bias is?

Dr. Mabachi: Well, bias is a tendency or inclination resulting in judgment without question. It's an automatic response. Our brain operates with shortcuts that allows us to quickly interpret and respond to the world around us, so bias, with the way we react, we make decisions about our world so quickly that we don't even know that it's happened and this is a normal human function but, often, it has consequences that are unintended.

NCTCFP: Can you tell us a little bit about implicit, or sometimes known as unconscious bias, and how that is different than explicit bias?

Dr. Mabachi: So, implicit bias is made up of the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Implicit biases can be at odds with our personal beliefs. So, for example, our implicit attitudes can leak during interactions through inadvertent displays of negative non-verbal behaviors and sentiments, even when we consciously endorse things like racial, gender or religious equality and are averse to anyone suggesting that we have bias on any of those issues. So, for example, I may fundamentally believe that all human beings are essentially equal and should be treated as such, but my biases may be such that sometimes my actions belie that belief. Also, biases are completely normal. They allow people to simplify and sift through vast

amounts of sensory input that they receive and they can also be positive or negative. And, when I talk about positive bias, people often ask, "What's the harm with positive bias?" But, positive biases can be just as destructive as negative biases.

For example, here is a stereotype. We can stereotype a smart Asian, a person of Asian origin as being good at math, science and technically proficient in music. But, even though this is a positive bias, it may restrict the accurate perception of that person's personalities and their values and then it can distort the interactions that we have with them. And it may actually limit their ability to be themselves. So, when we have positive biases, it can give us the illusion that we're interacting, especially with non-dominant groups or marginalized groups in a tolerant and loving way when, in fact, what we're doing is the flip-side of an ism. It could be restrictive for that person and could be reductionist of the other.

Explicit biases, on the other hand, are overt and when we're aware of them, it allows us to be very deliberate and well-considered in our responses to other people and it allows us to weigh the costs and benefits of various courses of action. So, implicit biases are more difficult to monitor and control, whereas self-reported prejudice predicts overt expressions of bias. Implicit attitudes predict biases in nonverbal behavior, much more subtle behaviors. Things like our body language, our communication, our anxiety around others, our cues to friendliness and that kind of thing.

NCTCFP: How do we develop our implicit biases? Are there any mental and social processes through which these biases are created?

Dr. Mabachi: Sure. I always like to begin the discussion of how we develop our biases by quoting a French-American author, Anais Nin, who said, "We do not see things as they are. We see things as we are." And basically what she's saying is that no one approaches the world with a neutral or objective stance. Everything we experience is through our perceptual lenses and all of this is influenced from the minute we're born and we start to be socialized into our families and our communities and so on. So we know that socialization begins in infancy and we call that primary socialization. However, socialization is a lifelong process. So, once you start growing up, we embark on secondary socialization, where we're socialized through our schools, institutions and that kind of thing. And as we age, we enter into new statuses and learn the appropriate roles for them, we have new experiences that teach us lessons and potentially can lead us to alter our expectations, our beliefs, and our values.

Our socialization process is really important because that's how we internalize the values and norms of the groups we belong to. We learn the language of our culture. We learn our roles. We learn what it means to be

a good daughter, a good citizen, a good teacher, a good doctor. We learn gender expectations, what's acceptable and unacceptable behavior. We start forming our identities and internalizing our identities and this is really society's way of ensuring that we adhere to a shared way of life. Most importantly, it's through socialization that we develop our internal book of rules, or what I like to call our mental files or schemas. And we endlessly draw on these book of rules as we walk through life and these rules, implicitly or explicitly, tell us what to think, feel, what we like, what we don't like, how to interact in situations.

So, I'll give you an example. Here in the U.S., when you meet someone for the first time, one of the rules is to shake their hand and to say, "Nice to meet you." But the way we have to shake someone's hand is pretty specific here. It must be a strong, firm handshake with eye contact. Otherwise, the person may draw certain conclusions about you such as maybe you're weak if you have a weak handshake, if you don't look somebody directly in the eye, maybe you have something to hide. So, your book of rules provides you with a blueprint or a framework, as it will, for how to engage the world. So, socialization is not a political, social or even spiritually mutual process.

Our family culture, our institutions of learning, the media are all part of the socialization process and so as we develop these schemas, they help us to recognize things that are important to us and things that aren't important to us. And like I said before, it helps us to expediently move through the world and our fact brain processing causes us then to take this information quickly and rely on shortcuts. So, using things like stereotyping about groups of people, about places, about experiences, again, this is advantages because can you imagine if we had to process every single piece of information that came into our brain slowly? We'd never get out of bed. It's something that we evolved with from back when. It helped us to decide whether we were going to fight or flight if we came across a dangerous animal. It helped us to decide whether somebody was a friend or foe and so it helped us to decide whether we need to be comfortable in a situation or if we need to be worried about a situation. The thing about this fast brain processing is that it causes us to categorize the world into us versus them and people who look like us, people who act like us are our people, and people who aren't like us, we then have a tendency to make generalizations about them.

NCTCFP: So what are some clues that let us know that we may be biased?

Dr. Mabachi: so one of the things I always tell students and people I talk to is, think about situations where being with a person or a group of people made you feel uncomfortable, but you're not quite sure why. Think about the kinds of people that you're drawn to talk to or you feel comfortable around immediately in a public function. When it comes to a room full of relative

strangers, most people tend to be drawn to those who look or act similarly as they do. Again, going back to our bias where we're categorizing people as friends or foes. There's this theory called social identity theory that posits that our social identities are formed by the social groups we belong to as we grow up and some groups at different points in our life tend to be more salient at one time than at another time. And we form our identities around those groups and our inclination is to create that in-group, out-group dichotomy of them versus us.

The thing is, when we create in-group, out-group dichotomy, we have a tendency to be much more friendly towards people of our in-group. We tend to be much more nicer in our judgment about people in our in-group and we tend to do the opposite with people from our out-group. We tend to be a bit harsher in how we judge their behaviors. And so that's one of the ways we start making generalizations and we start creating stereotypes and biases by in in-group, out-group affiliations. Another question you can ask yourself is, who is in your inner circle of most trusted individuals? Who are the people who you trust the most at work? Who are the people who you the most in your friend group? Do they look like you? That might be an indication to the kinds of biases you have against other groups and also the kinds of exposures you have to other groups.

NCTCFP: What are practical examples of implicit bias in everyday life?

Dr. Mabachi: Wow, so implicit bias manifests itself in many ways and here's some of the more common ways you may see it. Selection of job candidates. Factors such as race, name, gender, accent, body size may affect the candidate's chance at selection. These are just shown time and time again that, for example, African-American sounding names may cause bias in job selection candidates. Whether your name sounds foreign may cause bias in selection of job candidates. Another way that implicit bias may manifest itself is in who you hang out with. Again, this goes back to your circle of most trusted individuals. Research shows that younger whites are almost twice as likely as Hispanics and Blacks to say they socialize mostly within their own race. Sixty-eight percent of whites aged 18 to 34, say they overwhelmingly associate with other whites compared with 37% of Hispanics and 36% of Blacks of the same age.

And the gap is just as wide on where young whites choose to live, and we know that, if you aren't exposed to other groups of people, other ways of being, then you're less likely to perspective shift. You're less likely to empathize with another group. You're more likely to not look at the other group favorably, if you haven't had an opportunity to be friends with them or live next to them or go to schools with them.

Another way that implicit bias manifests itself is through microaggressions. And microaggressions are brief and commonplace, daily, verbal, behavioral and environmental indignities, whether intentional or unintentional that communicate hostile, derogatory or negative slights and insults. And they have potentially harmful or unpleasant psychological impact on the target person or group.

There's an author of this book called *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation*, and this person says that microaggression is similar to carbon monoxide. Invisible, but potentially lethal. Continuous exposure to these types of interactions can be a sort of death by a thousand cuts.

In fact, there's a report that was written by Dr. Joan Williams and her colleagues titled, *Double Jeopardy? Gender Bias Against Women of Color* in science that found that 48% of black women and 46.9% of Latina faculty, report having been mistaken for administrative or custodial staff. And that's a really good example of a microaggression. As a woman of color, that's something I relate to. It's happened to me and my colleague who is a Latina. We as faculty have been mistaken for building maintenance staff. And in a recent presentation to fellow faculty, almost all the women of color raised their hands when we asked them if they had been mistaken for administrative or custodial staff.

NCTCFP: Wow. Is there implicit bias in healthcare?

Dr. Mabachi: Yes. It's actually well established. Research studies on implicit bias and healthcare, have shown bias to be a big contributing factor to health inequities. In fact, after reviewing more than 100 studies, the Institute of Medicine found that minorities were less likely than whites to receive needed services, including clinically necessary procedures. And the Institute of Medicine did not find racial differences in patients' attitudes and preferences for treatment that would contribute to these health disparities. So racial discrimination and other race-related stresses are considered to be the mechanisms that create and maintain these health disparities that seem to be occurring within and between racial groups. And we believe that dismantling providers' implicit bias may remove one of the barriers to healthcare racial equity.

So here's some studies that I'd like to share with you that show that implicit bias does occur in healthcare. So there's a study that was conducted by Sabin, Marini, and Nosek in 2012, looking at overweight patients who report experiencing discrimination in healthcare settings. And they found a pervasiveness of negative attitudes about weight among healthcare professionals. I'm using the Implicit Association Test that was developed by Harvard professors. So 2,284 medical doctors voluntarily took this Implicit Association Test, related to weight. If you

don't know about the Implicit Association Test, you can go online and it has ... it can test your bias in a variety of areas including race, religion, weight, etcetera.

So they found that the doctors who took the weight IAT test, that there was a strong implicit anti-fat bias. This bias was stronger among men, and it was also stronger among the thinnest test takers. Another study by Berkhoff and his research team, found that the rates of use of total joint arthroplasty among appropriate and willing candidates, were lower in women than in men. And this disparity is explained by several factors. Among them was gender bias that impacted physicians, clinical decision making. So they found that 50% more men than women were recommended for knee replacement surgery, even though they presented with the same medical evidence.

In another study, Green and associates conducted research to explore the role of physicians, explicit and implicit racial attitudes and stereotypes in their treatment decisions. So physicians' explicit and implicit attitudes towards blacks and whites were assessed. They were then presented with descriptions of hypothetical cardiology patients in which the race of the patients were systematically varied. Physicians reported no explicit biases towards blacks, relative to white. So when they were examining the explicit biases physicians, it came out that they didn't have any explicit biases. However, when the researchers delved a bit deeper and look at the implicit attitudes, they found that physicians had stronger stereotypes of blacks as uncooperative patients. Moreover, the more negative these implicit attitudes were, the less likely the physicians were to recommend thrombolytic drugs for the black patients, in the hypothetical cardiology case.

Here is one last one, I could go on and on. Here's another example, it's a recent study that was done by Capers, Clinchot, and McDougle, and basically what they did was they looked at implicit racial bias in 140 members of the Ohio State University College of Medicine Admissions Committee. And so all committee members took the black-white Implicit Association Test, prior to the 2012/2013 admission cycle. And results are collated by gender, and student versus faculty status. Participants with survey to record their impressions of the impact of IAT on the admissions process at the end of the cycle, and 71% of them completed the survey. So quite a few of members completed the survey. All groups demonstrated significant levels of unconscious bias in favor of whites. Male faculty members had the largest bias members.

Second, implicit white preference was lowest among females, which is consistent with previous reports. So previous research shows that male faculty tend to have more unconscious bias in favor of whites when compared to females. 100 committee members responded to the survey

and 67% thought that the IAT was valuable and might be helpful in reducing their bias. So 48% were conscious of their individual results, when interviewing candidates in the next admission cycle and 21% she quoted that knowledge of the IAT results impacted the admission decisions in the subsequent admission cycle. So even just the very action of taking the test and recognizing that they had an implicit bias in favor of whites, changed the way they interacted with the admissions process in the next cycle. And that's huge. And we will talk more about this, but even the very action of taking the IAT test can be helpful in reducing bias.

NCTCFP: So, if we know that there is bias in healthcare, what is the impact of clinicians' bias in how they deliver care and how they provide services? Is there any research regarding that?

Dr. Mabachi: Yeah, there is. Research shows that implicit clinician bias can affect decision-making. So treatment disparities appear to be greater when physicians engaged in high discretion procedures such as recommending the test or making a referral for a procedure or drug. Then when they engage in low discretion procedures such as emergency surgery.

So when the decision is more up to them, then they're more likely to engage in bias types of behavior. So for example, black women are less likely than white women, to receive testing for osteoporosis, and when women have both races have been diagnosed with osteoporosis, black women are less likely to receive the appropriate medication than are white women. So that's a high discretion procedure where the physician has to make a decision on whether somebody is going to get a test or not. So that's just an example of how a physician's implicit bias may affect decision making.

Implicit clinician bias can also affect patient satisfaction and their consequence adherence to medical recommendation. So, it's important to consider how the potential biases of providers which may be subtle and unintentional. So the providers themselves may not even know that their biases are leaking into their interactions. However, the patient may be sensitive to those cues. So for example, we know that black patients may feel some kind of stereotype threat when they go into medical situations, and they may be very sensitive to possible cues of bias.

So researchers, Gordon, Street, Kelly, and Souchek demonstrated that black and white patients experience similar levels of trust in the physician before the initial visit for lung cancer evaluation. However, after the visit, black patients reported significantly lower levels of trust in providers than did the white patients. And this difference in trust was predicted by the black patient's perceptions of less supportiveness, less partnership and less information during the clinical interaction. And all of those nonverbal

behaviors could be attributed to that implicit bias that the medical profession may not have known that they have.

NCTCFP: So can we really change our implicit biases? Can clinicians change them? What can we do to be more aware and interrupt implicit biases?

Dr. Mabachi: So the first thing I'd like to say is we are humans. A feature of our humanity is that we will always have some kind of bias. This is how our brain has evolved - is to categorize things so that we can quickly move through the world. And that's why I think it's problematic when people think, "Oh, if I have a bias that makes me a bad person or that makes me a racist or a sexist." Not necessarily, it oftentimes just means that we're not aware of our biases, but research shows that we can very much interrupt our biases and we can mitigate our biases, but we have to be aware of them first. And the good news about secondary socialization is that it gives us an opportunity to try and mitigate our biases and to use our prefrontal neocortex, which is our slow thinking brain, to take in information in a much more considered way.

So one of the things that I think can really interrupt our implicit biases is when we engage in slow thinking where possible. So that is when we get information, and we engage this prefrontal neocortex that I was telling you. The place where awareness and consciousness happens. The place where we actually have an opportunity to reflect on our thinking process.

We call that parts of our brain, the place where we have our metacognition. It's where our brain almost has the ability to watch ourselves think. So if we train that part of our brain more, it can help us to become aware of our biases and intervene and change direction. If we notice that those biases aren't serving ourselves, our interpersonal interactions, our team dynamics, our work with our patients, with our medical students, with our organization. So instead of our biases running our brain and making decisions for us, if we can train this metacognition part of our brain and practice a more conscious awareness in our everyday functioning, then we could interrupt some of our biases.

Another way that we can address our implicit biases is to be honest with ourselves. Tell the truth about yourself. We all have biases and these affect the decisions we make. So ask yourself, what kinds of people make you feel most uncomfortable? Are these personal traits or are these group traits? So it could be that maybe personality wise, you just don't jive with another person, or it may be that you're uncomfortable with a certain group, maybe because you have never been exposed to them, and you don't know how to interact with them.

Think about the kinds of teams you form in your work situations and healthcare. Do you attract certain kinds of people? Does this exclude any

groups? If so, question why. Another thing that we can do is to acknowledge versus justify, and what I mean by this is when somebody from a nondominant group tells you about the experiences of bias with stereotyping, acknowledged that experience. Believe them. As humans when we can't relate to an experience because we have never been there because of our privilege, there's a tendency to justify our own and others' actions almost as a defense mechanism, especially if we see it as an indictment in our in group. Take that moment to acknowledge that nobody wants to experience biases stereotyping. Believe them, and even just in that action, it starts to make you more aware of some biases that you may have. And also it helps you to honor the experience of your fellow students or coworkers, et cetera.

The other thing is to gather data about yourself. So take the IAT tests. People have different thoughts about the IAT test and question, whether it's valid, but it's been used time and time again. And the thing I like about the IAT test is that, it's a snapshot of your wiring in a certain time or place. It's not a reflection of if you're a good or bad person. It just gives you a window into potential areas of bias that you could work on, or you need to work on.

The other thing you can do is notice what influences your decision. Do you make decisions based on your gut? Iris Bohnet of the Women and Public Policy Program at Harvard, actually advices advises us to stop going with our guts. Because it may be your implicit biases that are driving your gut. You need to be more deliberate and intentional about the decisions and interactions and ask yourself instead, what am I reacting to? So when I am assessing a resume, when I am assessing a student, when I'm interacting with a patient, what am I really reacting to when I say, "Oh, my gut told me A, B, C and D. Think on that."

Shift from seeking information to seeking insight. So stimulate your curiosity about others. Stretch your comfort zones. In medical schools, there's often a tendency to group cultural groups homogeneously and say, "This is what Latinos do, this is what Asians believe about health. This is what Africans believe about health." But we know that human beings are much more dynamic than that and there's a whole bunch of context as to why they behave the way they behave and why they believe what they believe. So I encourage people to stretch their comfort zone and to ask questions. To challenge their perspective, understand your own patterns so that you can disrupt them. Keep track of the decisions you make. Do you surround yourself with people who will need, tend to agree with you, who think like you? If so, try and diversify who is around you and who your team members are and who your friends are.

The other thing you could do is think of bias as a habit. So what if we thought of implicit bias as a mental habit that we learn. We learn things by

repeatedly associating one concept to another. And learning is the building of connections of neurons in our brain. So every time you encounter an idea and the more you encounter concepts together and associations together, the stronger those connections get.

So for example, through stereotypes in our culture, the two concepts of black men and criminality get linked together all the time. Although research shows that in fact, they're linked out of proportion to what actually exists in society. So if a crime is reported in the news and if it's committed by a black person, that news outlet is twice as likely that they will show a picture of that person in the news than if it was committed by a white person. And so basically our culture has spent a lot of time through history teaching us to connect these two concepts. Now, the hard thing about this, and the unfortunate thing about this is that, human brains are really good at making associations and learning to connect things, but not so good at unlearning thing. So because of this, it's easier for a stereotype or bias to perpetuate itself in our brains than be overturned. Unless, we get consistent feedback that those connections that we're making are incorrect. But oftentimes we don't get that feedback at all, and so the deck is stacked in favor of us keeping those stereotypes, unless something happens for us to disconnect it.

So, researchers Patricia Divine and Wilcox from the University of Madison, came up with a workshop intervention that they propose can override biased concepts. And some of the strategies they identified was this idea of stereotype replacements. So what stereotype replacement asks you to do, is to first detect. Detect the implicit thoughts. And again, this will require you to be honest. This goes back to you being in an environment where you can get feedback, where you can get information in yourself and your biases. So detect. Then reflect, and do this in a nonjudgmental way. So reflect on, when is it that I think in those ways? When do those stereotypes of biases come to mind?

That awareness becomes really critical for us to be able to deal with our tendency to bias. And it's ... the part of being nonjudgmental is really important because when we judge ourselves, our defense mechanism is to panic a bit or again, to think that we're bad people and to push those thoughts down instead of actually confronting them, accepting them, and then think, and then doing the last step, which is to reject those thoughts.

So once you have detected, you have reflected upon, then reject the stereotype by replacing it with an alternative response. Replacing it with an alternative narrative. So for example, if you see a person of color approaching a white woman at a bus stop, and because of how we've been socialized to associate certain things in this culture, we may think “danger”. That's the opportunity to do stop and ask why you had that thought, whether it's true. And maybe asks you then to retract or go back

and re-look at the situation, take another look at the situation and replace that narrative of person of color “danger” to person of color “walking to the bus stop to catch a bus”.

So, Dr. Devine says that you can actually help to retrain your brain instead of allowing it to automatically make those connections. I always say that what we think eventually shapes our actions and uncovering our implicit biases is just the start of the journey. There is no quick fix for addressing our biases. And in the context of healthcare where it affects our patients, where it affects our medical students and how they become physicians. Changing our biases can be an enormous task, but it's a worthwhile task. Bias is not something that fully goes away. You just learn how to not let those associations affect your thoughts, and effect the consequent decisions that you make, affect your interactions and affect the communication that you have with people.

NCTCFP: Well, Dr. Mabachi, that was my last question. Thank you for providing this information to our listeners.

Dr. Mabachi: You are very welcome, and thank you for inviting me to talk on this topic.

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