WHY DOES BIAS MATTER?

EXPLORING IMPLICIT BIAS IN HEALTH CARE

Recommendations for the Washington State Department of Health, Office of Infectious Disease (2025)

MICHELE PEAKE ANDRASIK, PHD, EDM

SOCIAL & BEHAVIORAL SCIENCES AND COMMUNITY ENGAGEMENT; HIV VACCINE TRIALS NETWORK (HVTN); PRINCIPAL STAFF SCIENTIST

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INTRODUCTION

Health inequities experienced by Black, Indigenous, and People of color (BIPOC) and gender and sexual minority communities are pervasive in the United States. Black/African American and American Indian/Alaska Natives also have shorter life expectancies than their White peers (Williams & Mohammed, 2009). Over the past twenty years, more and more researchers have observed racial and ethnic differences in care. These differences persist even after economic, educational, and access differences are accounted for. The data suggest that bias could be a factor (Sheifer et al, 2000; Kressin & Peterson, 2001)

BACKGROUND

In the early 2000's the Institute of Medicine (IOM) reviewed over 100 studies (Smedley, et al, 2003) and found irrefutable evidence that healthcare inequities are widespread and that inequities exist even when factors such as socioeconomic status, patients' insurance status, and income are controlled. Furthermore, the research showed that minority patients receive poorer quality of care despite similar disease severity, clinical presentation, and medical insurance. These findings were presented in the 2003 report Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. In this report the IOM concluded that these differences result from multiple factors, and that the "evidence suggests that bias, prejudice and stereotyping on the part of healthcare providers may contribute to differences in care".

Every year since 2003, the Agency for Healthcare Research and Quality produces the National Healthcare Quality and Disparities Report. These reports, which utilize several indicators of health care access, process, and outcomes, have consistently shown that, White patients receive better quality care than patients who are Black/African American, Hispanic/Latino/a, Native American, Alaska Native, Native Hawaiian, or Pacific Islander. More than 20 years after the start of these reports, the 2023 National Healthcare Quality and Disparities Report continues to highlight the persistence of disparities, many of which were exacerbated by COVID-19 (Agency for Healthcare Research and Quality, 2023). The 2023 report shows that overall life expectancy for US residents has decreased for a second year in a row with American Indian or Alaska Native (65.2 years) and Non-Hispanic Black (70.8 years) having life expectancy well below the national average life expectancy (76.1 years). Although COVID-19 is a major factor in existing disparities, other factors contributing to existing disparities include lack of access to primary care services, health insurance, unintentional injuries (almost 16% were drug overdoses), heart disease, liver disease and suicide (Millet et al, 2020; Poteat, Millet, Nelson & Beyrer, 2020; Rodriguez-Diaz, et al, 2020; van Dorn, Cooney & Sabin, 2020).

FINDINGS

As humans, we all have biases. This bias is rooted in the privilege that is given to certain identities which results in societal, economic, and political benefits for one identity over another. A privileged identity results in the experiences of fewer barriers and access to greater resources. Our identities impact our worldview, upbringing, and socialization. The impact of bias is greater when we have limited engagement and interaction with diverse groups. When our lived experiences with others who have different identities is limited it can create "blind spots" which create challenges in our ability to recognize vulnerabilities. This is particularly true if our lived experience is largely from socially dominant, privileged spaces. Our blind spots can be exacerbated by negative messages we have received about certain identities, resulting in bias.

Bias develops early in life from repeated reinforced social stereotypes. A pro-White bias in children as young as 3 years old has been documented throughout the world (Bigler & Liben, 2006; Dunham, Baron & Benaji, 2006; Newheiser & Olsen, 2012). As people age, what a person explicitly believes about race may become more rooted in justice and equity, but race bias endures, often remaining unchanged and may have significant influence on behavioral interactions with individuals from stereotyped groups (Baron and Banaji, 2006). A study of college students found that although race bias had no relationship to self-reported race attitudes, it predicted friendliness in interactions with Black students (Dovidio, Kawakami & Gaertner, 2002).

Despite the numerous advances in health care achieved over the past century, race and ethnicity disparities persist across health care, quality of care received, disease incidence and prevalence, life expectancy and mortality.

In order to reduce disparities and inequities we must identify and address all possible contributing factors and bias is one of those factors.

It is important to remember that we are largely immersed in cultures that provide ongoing and consistent depictions of groups in stereotyped and negative ways. Even though we may actively reject these negative ideas and images about specific groups (and even belong to these groups), societal attitudes or stereotypes affect our understanding, actions, and decisions.

The Harvard Project Implicit Bias website has been collecting data on implicit bias for decades. The data they have collected show that approximately 70% of the general population demonstrate a level of implicit anti-Black/pro-White bias. There is also strong evidence indicating that healthcare professionals, physicians, and nurses exhibit the same levels of implicit bias as the wider population. In a 2009 study (Sabin et al, 2009), there was significant pro-White bias reported among a sample of 2,535participants who reported having an MD degree on the Harvard Project Implicit website. Research suggests that implicit bias may contribute to health care disparities by shaping physician behavior resulting in differential medical treatment based on characteristics such as race, ethnicity, or gender. Biases in health care most often disadvantage patients who are already vulnerable (have devalued identities).

Several studies have explored the association between racial bias among healthcare providers and health care outcomes. These studies have found significant relationships between provider level bias and lower quality of care, diagnosis, treatment decisions and level of care (Fitzgerald & Hurst, 2017), patient-provider relationships (Hall et al, 2015), perceptions of patients, and treatment recommendations (Paradies, Truong & Priest, 2013). In one study, Black patients were associated with uncooperativeness, particularly regarding procedures (Green, et al, 2007). Another study found that among 202 1st year medical students, 66% showed implicit preference toward Caucasians and 86% demonstrated preference toward upper class individuals (Haider et al, 2011). In another 2014 study, medical and nursing students perceived Hispanic and American Indian patients as engaging in more risky health behavior and as more noncompliant than White

patients (Bean et al, 2014). Other studies have found that physicians' implicit pro-White bias, as measured by the Implicit Associations Test (IAT), was significantly associated with patient perceptions of communication, lower quality of care, respect, longer visits and perceptions of providers as being less collaborative (Penner et al, 2010). Bias has also been found to be significantly related to being less likely to fill prescriptions (Blair et al, 2014), treatment adherence (Hagiwara et al, 2013), longer wait times and lower likelihood of admission in emergency departments (Heins et al, 2006); lower likelihood of receiving analgesia (Minor et al, 2006) and opioids for pain management (Todd et al, 1993, Todd et al, 2000).

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RECOMMENDATIONS

RECOMMENDATION #1

Increasing our awareness of our susceptibility to implicit bias can change behavior.

RECOMMENDATION #2

Reduce automatic, habitual activation of stereotypes and reduce the effect bias has on decision making.

RECOMMENDATION #3

More deliberate strategies are required.

STRATEGIES

Practicing the following strategies can help reduce the impact that our biases have on our behavior. Let's get started!!

BIAS REDUCTION STRATEGY #1: INDIVIDUATING

Individuating involves a conscious effort to focus on specific information about an individual. Learning about the personal history of each individual. The more we focus on individual information, the more likely it is to factor into decision making and the less we rely on social category information and the stereotypes and biases related to specific identities.

BIAS REDUCTION STRATEGY #2: PERSPECTIVE TAKING

Perspective taking involves a conscious attempt to envision another person's viewpoint and imagine how they feel to reduce bias. This is putting yourself in another person's shoes and making a conscious effort to understand their reality.

BIAS REDUCTION STRATEGY #3: REFRAMING PATIENT-PROVIDER

Thinking of interactions with others as an interaction between collaborating equals can shift our thinking of people who have different identities than our own as outsiders, to perceiving them as part of our own social group. For health care

providers, this requires a focus on partnership building wherein you work with the person, as an equal, toward the common goal of helping them achieve good health. This strategy involves utilizing a patient-centered care approach, which emphasizes patients as collaborative partners, with unique psychosocial needs that are as important as clinical needs. It also requires several other skills:

Asking Open Ended Questions

- Ensuring that you are listening, and the other person is doing MOST of the talking
- Open-ended questions cannot be answered with a YES or NO
- They facilitate conversation
- Examples of open-ended questions:
    - Why do you find that so frustrating?
    - Tell me more about….
    - How did you decide….?

Reflective Listening

- Paraphrases comments back
- Validate feelings
- Communicate understanding
- Examples of reflective listening:
- It sounds like…
    - What I hear you saying…
    - So, on the one hand it sounds like…and yet on the other hand..
    - I get the sense that…
    - It feels as though…

BIAS REDUCTION STRATEGY #4: QUESTIONING OUR OBJECTIVITY

All of us make decisions based in our own experiences and worldview. By definition, we are subjective. Increasing objectivity requires ongoing self-regulation and self-monitoring. Moving toward a state of "Critical Consciousness" – the ability to change ourselves by recognizing social, political and economic oppression. This requires taking action against inequities through critical dialogue, training and practice (Pereda & Montoya, 2018). The habit of nonbiased thinking requires continued conscious practice over time to learn and understand how circumstances and situations differentially impact another person's reality. It is important to set discrete goals to monitor and reflect on biases and attitudes, and to reevaluate their success over time. For example, over the next 6 months you may work to learn about the experiences of people who are unstably housed.

BIAS REDUCTION STRATEGEY #5: MINDFULNESS

Mindfulness requires emptying the mind of distracting thoughts to allow for a focus on the present moment. This is done without judgements or assumptions. It allows us to be more deliberate in our actions. Practicing mindfulness increases our ability to recognize our biases before we automatically act on them. Mindfulness exercises have also been utilized to reduce stress and to improve patient-provider communication. Mindfulness allows you to look at your thoughts and feelings, observing your mind as a stream of consciousness without attaching judgment. There are many free resources online that can be utilized to help practice mindfulness. One that may be particularly helpful can be found here: Stressing Out? S.T.O.P. - Mindful.

BIAS REDUCTION STRATEGY #6: INCREASING THE NUMBER OF AFRICAN AMERICAN/BLACK PHYSICIANS AND HEALTH CARE PROVIDERS

The Institute of Medicine stated that increasing racial and ethnic diversity in the health sector as one of their recommendations to eliminate racial and ethnic health care disparities. Black and African American physicians consistently exhibit significantly less race bias (Chapman et al, 2013) and inclusive and diverse workforce environments may promote an environment that improves patient care (Aysola et al, 2018).

CONCLUSION

Throughout the literature there are numerous examples of associations between bias, stigma, and negative HIV outcomes. People with devalued identities are more likely to engage in negative coping strategies such as isolation, denial, substance use and risky sexual behavior. For people living with HIV, significant associations have been found between HIV-related stigma and higher depression, lower levels of social support and adherence to antiretroviral medications, and barriers to access to and usage of health and social services (Rueda et al, 2016). In addition, delayed HIV care is associated with psychological distress and lack of information (Sprague & Simon, 2014). Bias also impacts the uptake of Pre-Exposure Prophylaxis (PrEP). In the US, PrEP prescribers are less likely to discuss PrEP and prescribe PrEP to racial and ethnic minority patients and tend to discuss PrEP only in response to patient requests which favor more privileged groups (Calabrese et al, 2019). Furthermore, US-based medical students rated Black patients as more likely than White patients to engage in increased unprotected sex if prescribed PrEP, resulting in reductions in willingness to prescribe PrEP to Black patients (Calabrese et al, 2014).

Increasing our awareness of our susceptibility to implicit bias can change behavior. Awareness is important. However, it is not sufficient to reduce automatic, habitual activation of stereotypes and reduce the effect bias has on decision making. More deliberate strategies are required. Practicing the following strategies can help reduce the impact that our biases have on our behavior.

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