Managing Implicit Bias for Healthcare Excellence

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- [Carolyn] Hello and welcome to today's course, "Managing Implicit Bias for Healthcare Excellence." Our presenters are Katrinna Matthews and Anna Smith. My name is Carolyn Smaka. I was a contributor for this course along with Joanne Slater. These are the bios of our presenters, and you can read these on our website. These are our presenters disclosures that you will also find on our website. And lastly, I'd like to review our learning outcomes. After today's course, you will be able to define unconscious implicit bias, recognize how unconscious implicit bias develop, consider how unconscious implicit bias influence our interactions and work and identify interventions that aid in dismantling unconscious implicit bias. So without further ado, I'll turn the course over to our presenters.

- So to get this presentation started, I would like for you all to read this slide and think about this. Consider this scenario. How would you explain this? A father and a son were involved in a car accident in which the father was killed and the son was seriously injured. The father was pronounced dead at the scene of the accident, and his body was taken to a local morgue. The son was taken by ambulance to a nearby hospital and was immediately wheeled into an emergency operating room. A surgeon was called up on arrival and upon arrival of seeing the patient, the attending surgeon exclaimed, "Oh no, it's my son!" So take a few seconds and think about that scenario.

How would you explain that? Who is the attending surgeon, or what is the attending surgeon's relation to the son, considering that the attending surgeon exclaimed, "Oh my, it's my son." So take a few seconds and think about that. The surgeon is the boy's mother. If you assumed that the surgeon is the boy's mother, then you are correct. But unfortunately, more often than not, it is not assumed that the surgeon is the boy's mother. Instead of considering that the surgeon is the boy's mother, most people think of very complex and highly elaborate stories. For example, it is assumed that the boy was adopted and the surgeon is his natural father, or the father in the car was a priest.

For many, the thought that the surgeon is a female is not considered. That thought never comes to mind. In fact, around 40% of participants who are faced with this challenge, they do not think of the most plausible answer that the surgeon is the boy's mother. So this is a very basic, simple exercise that illustrates the powerful pull of our automatic thoughts or how we automatically stereotype or make associations about certain things. So for example, in this particular scenario, we automatically make the association between surgeon and men. That association is so strong that it becomes just a natural thought that prevents us from problem solving or thinking critically and thinking outside of the fact that the surgeon could very well be a woman or could very well be female.

So this is not, this is just a simple exercise that demonstrates our automatic associations and how we make automatic associations regarding professions in particular, and how we tie certain professions to gender. So as we think about this, can you think of other professions that we stereotype or associate with gender? So for example, we tend to think of teachers, nurses, ballerinas, we tend to think of people that are teachers, nurses are ballerinas as female, and we tend to associate males with professions such as pilots, law enforcement officers, and as we noted in this particular exercise as surgeons. So now that we have done this exercise and have gotten to thinking about some of the automatic associations that we make, let's take a deeper dive and really give these automatic associations a term or a name.

So implicit bias, what we just experienced in that very simple demonstration was implicit bias. So what is implicit bias? So implicit bias is also known as unconscious bias. And just a basic definition is that it's the preference for or against a person, thing or group that's held at an unconscious level. It can also be defined as the attitudes or stereotypes that affect our understanding actions and decisions in an unconscious manner. The most important thing to realize is that it happens at a level below our level of awareness. So it impacts how we see people and as a result how we interact with

people. But it's also important to remember, and for us to understand that we all have unconscious or implicit bias, that none of us are immune to it.

None of us are able to escape our implicit biases. So therefore, it's so important for us, one, to acknowledge and be aware that we do have these biases that are below our level of awareness, and to start to think about how can we dismantle those biases, especially the biases that are held below our level of awareness. I think it's also important for us to talk explicitly about the definition that the state of Michigan has for implicit bias. So Michigan's department of licensing and regulatory affairs adopted a new administrative rule that requires implicit bias training as part of the knowledge and skills necessary for all licensure or registration of healthcare professionals in the state of Michigan. This rule applies to new applicants for licensure or registration, and it requires two hours of implicit bias training within five years immediately proceeding a new license or registration.

So with that being said, I think it's really, really important that we understand how the state of Michigan defines implicit bias. So the state of Michigan defines implicit bias as an attitude or internalized stereotype that affects an individual's perception, action or decision making in an unconscious manner, and often contributes to unequal treatment of people based on race, ethnicity, nationality, gender, gender identity, sexual orientation, religion, socioeconomic status, age, disability, and other characteristics. So now that we have an overarching definition of implicit bias, we have the state of Michigan's definition for implicit bias, as well as the guidelines required for licensed professionals in the state of Michigan. Let's spend some time talking about the different types of implicit bias.

So this list that you see for the different types of implicit bias is not an inclusive list. So there are many, many different types of implicit bias. It's impossible for us to cover every single type of bias that there is. So these are your 10 primary types of bias. And

as I said, there are more, and several of these are similar. In some cases, some of these biases, you'll see them listed by different names or defined by different terms. But for this particular presentation, we will cover the biases that you see on the screen. The purpose of identifying the various types of bias is for us to start to think about bias and how it manifests itself in our day-to-day interactions, not only with our patients, but with our colleagues.

So let's start with affinity bias. So affinity bias, also known as similarity bias is the type of bias that describes our affinity for things that are similar to ourselves. This term is often used in neuropsychology and explains how our brains are wired to subconsciously gravitate toward people or things that are similar to ourselves. For example, we tend to gravitate toward things or people that are similar to our age, similar to our upbringing, we may tend to have an affinity for people that went to the same college or university that we went to. This is not something that we are necessarily aware of or that's at the conscious level, but this is something that we unconsciously do.

We tend to gravitate toward those that are like us, that we identify with that are similar to ourselves. The next type of bias is attribution bias. This type of bias occurs when we attribute a person's actions or behaviors to their character rather than attributing the actions or behaviors to the actual situation. For example, someone cuts you off. It's early in the morning, you're driving, you're on your way to work, you're having a great drive, but someone cuts you off, they turn in front of you. We might automatically attribute that action to the person being rude that you know they're rude and you know they're nasty and they're not a good driver. Rather than us attributing it to the situation.

Maybe this person is late, they're running late for work, they're in a hurry to get to a meeting they're about to miss. So when we think of attribution bias, we are attributing this to that person, to their characteristic, to who they are as a person, rather than

attributing their action or behavior to the situation that is happening in that moment. That is what we know are what we define as a attribution bias. The next type of bias that I want to discuss is beauty bias. So just as the name indicates, it is a bias that's based on looks or based on what you perceive as good looking or beautiful. This type of bias also assumes that what is beautiful is good and or successful.

Another component of beauty bias is weight bias. So weight bias is defined as as negative attitudes toward and beliefs about others cause of their weight. These negative attitudes are manifested by stereotypes and or prejudice toward people who are overweight. So we see beauty bias and weight bias all around us every day, but we don't necessarily call it that or recognize that it's a bias toward the way a person looks, whether it's their physical beauty or the size of their body. So as we think about beauty and weight bias, there was some research done by Davison and Davis in 2019 that indicated that weight bias ranks just below race, gender, and age as the fourth most common form of discrimination in the United States.

And that weight bias also turns out to be common among nearly all types of health providers, including professionals treating overweight people overweight in people with obesity. So this is a very common type of implicit bias that occurs all around us on a day-to-day basis. The next type of bias is conformity bias. So conformity bias is the subconscious effect of peer pressure on one's decision making. This type of bias is based on a famous study known as the Ash Experiment that shows how our decision making can be affected by group peer pressure. So we have this fear of being thought of poorly by our peers, or maybe even ridiculed by our peers, which causes us to conform or causes us to be swayed by others.

And so this is conformity bias where we tend to go with the group rather than possibly going with our own decisions, especially if those decisions differ from the group. So again, this is known as conformity bias. So confirmation bias. So confirmation bias is

based or is that type of bias that we're all guilty of. So first off, all of us are quick to pass judgment. All of us are guilty of that, and sometimes we are guilty of making snap decisions. And so this is the type of bias of when we make snap decisions that are based on perceived truths. And then we spend the rest of our time subconsciously trying to justify our bias. So we see this type of bias happen a lot in interviews.

This is when we've made a snap decision about a perceived truth, and then we spend the rest of our time with that person trying to confirm our bias or confirm the the judgment that we've passed. And so we'll ask irrelevant questions, try to elicit answers that support our initial assumption about the person. We tend to do this because we wanna believe that we are right, that our instincts are intact and that we are right, and that our assessment of the person is correct. But oftentimes, we fall into this trap of confirmation bias where we're not right at all, and we are just trying to prove or justify why we think or have perceived the certain thing about a person.

So the next type of bias is contrast effect. So this is when we're comparing people to one another rather than viewing the person on their own merit. This is the type of bias that often arises in hiring and recruiting, although I must say that this type of bias does arise in healthcare, and it manifests when we unconsciously compare our patients to each other, and we do not view each patient and their situation as unique to them. So it's that comparing and contrasting, instead of allowing each person and each situation to stay in independently on their own, we compare and contrast them to each other. Racial bias. So this is probably one of the more common known biases.

Oftentimes when we think about the different types of biases, and we go through the list of biases, some of these biases like affinity or attribution or conformity bias are not very well known bias. But when we think about biases such as racial bias, it is a very common and well-known type of bias. And this is a personal and sometimes unreasoned judgment made solely on a individual's race. Implicit racial bias can cause

individuals to unknowingly act in discriminatory ways. This does not mean that the in individual is overtly racist, but rather that their perceptions have been shaped by experiences and these perceptions potentially result in biased thoughts or actions. The next type of bias is gender bias, which is also a commonly known type of bias, but gender bias is a tendency to give preferential treatment to one gender over another.

It is a form of unconscious bias that occurs when we unconsciously attribute certain attitudes and stereotypes based on gender. So this type of bias was demonstrated in the initial activity that we did when we opened this presentation. So if you assumed that the surgeon was a man, then you exhibited gender bias, because you did not consider that the surgeon could have been female. Name bias. So this type of bias is another bias that happens frequently, and it is when someone judges a person or makes an assumption about a person based on their name. So this type of bias is often related to race, especially if the name is a non-Western name. So this type of bias also goes hand in hand with having a negative connotation when thinking about somebody based on their name, but then also making assumptions about a person's status and privilege based off of their names.

We especially see this if a person has a double surname, there may be assumptions made about a person's status and privilege based off of that double surname. So name bias is a very real thing, and it is something that we see or the type of bias that we do see in our day-to-day interactions, not only with our colleagues, but with patients and just in our day-to-day interactions with the world around us. The last type of bias is the horns or halo effect. The horn effect is the polar opposite of the halo effect. So this is when something bad about a person negatively grabs your attention and you cannot move beyond it. So therefore, you let it cloud your judgment, and more often than not, your decision making is impacted.

So you may hone in on one character flaw or aspect about a person's person, about a person or their personality that irks you, and you let that one aspect completely drive your thoughts and your decision making as it relates to that person. Whereas the halo effect is the exact opposite of the horns effect. And it's when you forsake all information about a person, you completely look past everything, you're blindsided, and you typically hone in on that one good thing about that person or the one thing that you perceive that makes this person so great, and that is what you focus on and you completely look past everything else. So that's known as the horns or halo effect.

So these types of implicit biases play out in our lives daily. They play out in our interactions with our friends, our family, our colleagues, and unfortunately with the the patients who have entrusted us with their care. So these are micro level biases, although I must say that these biases do infiltrate systems, which we will discuss in the next few slides, is how these personal micro level biases impact our work in healthcare as healthcare providers, as well as how they impact and are embedded in the systems in which we work. So now that we've covered the various different types of bias, I wanna spend some time just really thinking through and sharing some examples of how these biases manifest in our daily lives.

So let's start with gender bias. So we're not gonna go through every single bias that was on the previous slide. We're just gonna go through a couple, but just to highlight how these biases play themselves out in our day-to-day world and in our day-to-day interactions. So as I stated earlier, gender bias is a common type of implicit bias, but when thinking specifically about gender bias, research suggests that we see these bias, this type of bias routinely in regards to women and girls in STEM, for example. So in the school setting, girls are more likely to be associated with language over math, whereas males are more likely to be associated with math over language.

So this reveals a very clear gender related implicit bias that can ultimately go so far as to dictate future career paths. Especially if we are saying or associating girls with language and associating males with math. We may unconsciously be driving girls away from science, away from STEM because we're saying, oh, you're so good at language. So just being mindful of how that gender bias plays out. So even if we outwardly say men and women are equally good at math, it is possible that we still subconsciously associate math more strongly with men without us even being aware that we're making this association. So racial bias, so unconscious racial stereotypes, are a major example of implicit bias. So in other words, having an automatic preference for one race over another without even being aware that you have this bias.

So we can see this type of bias manifest in small interpersonal interactions, although it definitely has broader implications across some of the systems in which we work. So some of the racial bias that some of us may subconsciously hold or have some associations, the angry Black woman or Black individuals are more violent, or Black individuals are violent and dangerous. So as a result, if we do have this perception or we have this racial bias, or you think that, oh, Black individuals are more violent or dangerous, you may find yourself if you're out at night and you're walking on the street, crossing the street at night when you see a Black man or Black person walking in your direction without even realizing that you are crossing the street.

So these are just two examples of how bias play out in our daily lives. And they're just two examples from the long list on the previous slide of all the different types of biases that we have and that we we see impact our relationships and our interactions with others. So as I said, there are several other ways, and these are just two very basic examples. So I wanna shift gears a little bit, and I want to focus on systems and the type of systems, the type of bias that happens at the macro or systems level. So we're gonna move from the personal level, which we've spent the first several minutes thinking through what are implicit, what are implicit biases?

So the different types of implicit bias, how the state of Michigan defines implicit bias. And now I want us to think on a larger level and to think about bias on a macro or systems level and how biases play out in particular systems. So first I want us to focus on the healthcare system. So when we think about the healthcare system and how biases play out, research tells us that healthcare is a setting where implicit biases are very, very present, and that racial and ethnic ethnic minorities and women are subject to less accurate diagnosis, curtailed treatment options, less pain management, and worse clinical outcomes. In addition, research has shown us that Black children are often not treated as children at all when they encounter the healthcare system, and that they are not given the same compassion or level of care that is provided for white children.

So those are just examples of how we see bias in our healthcare system. Another major system in which we see bias is in law enforcement and the legal system. So when we about implicit biases within the law, within law enforcement and in the legal system, we see it manifest in shooter bias. So the tendency among police to shoot Black civilians more often than white civilians, even when they are unarmed. So this particular bias has been repeatedly tested in laboratory settings and reveals that implicit bias against Black individuals is prevalent in in the legal system and in law enforcement. And that Blacks are also arrested at disproportionately higher rates, given harsher sentences, and Black juveniles are tried as adults more often than their white peers, because bias causes Black boys to be seen as less childlike, less innocent, more culpable, and more responsible for their actions and just more as adults oftentimes than their white counterparts.

So these are just two examples of how our personal bias, so the different biases that we talked about earlier, such as the affinity bias, attribution bias, conformity bias, gender, racial, those various different biases that we talked about that occur on a very

personal level. This is an example of how those bias that we carry with us personally when we take them with us, how they ultimately impact systems. So this is just an example of that to show how we go from the micro, from the micro to the macro with these different types of biases. So now that we've talked about and have a solid understanding of implicit bias, what it is, the various types of implicit bias, how implicit bias manifests itself on micro and macro levels, I want us to focus a little bit on how exactly are implicit biases formed.

So as I said earlier, we all have implicit bias. None of us are, and it's important for us to understand that. So don't feel as though you are being targeted or you are the only person who has this implicit bias or maybe thinks this way or has this perception. None of us are immune to implicit bias. We all have them. But I want us to understand how they are formed. So the first way in which implicit bias is formed is based on the way our brains are structured. So it has to do with our brain structure and neural connections. So scientists that we're exposed to about 11 million pieces of information at any given time. That's a lot of information.

But our brains can only consciously process about 40 bits of information, which means our brains only consciously process about 0.00001% of the information that's coming in. So in an effort to make this process efficient, our brains automatically evolve to filter out information that seems familiar. So the evolution of our brain is a means of survival, so that we are not overloaded with information. So what happens is our brain uses preexisting knowledge structures or shortcuts that are related to what is familiar. So our brain has com has compartmentalized things and has developed these knowledge structures of what is likable, what is good, what is safe, what is valuable, what is right, what is competent, what is wrong. And it's created these shortcuts so that every time we interact with a person or a thing or an event, we do not have to go through the entire process of trying to figure out is this good?

Is this valuable? Is this safe, is this wrong? Our brain automatically says, that's good, that's right, that's wrong. And it takes a shortcut. The problem is that our brains have become so good at doing this, they're so efficient at interpreting all the information that's coming in, that's coming very quickly that this happens below our level of conscious awareness, and that we believe that what we see is objective. And we rarely realize that what we see has any impact on the way that our brains, how our brain is interpreting this information, that we automatically make these assumptions, because this is how our brain is structured and wired as a way to keep us able to process all the information that's coming in.

So this is something that's happening below our level of consciousness, below our level of conscious awareness. So that is one of the ways in which implicit bias is formed. It's based off of the way our brain is structured to help us efficiently process all the information that comes into us. But as I said, our brains have gotten so good at doing this that it's become automatic, and we do not necessarily stop to think about it, because our brain automatically takes the shortcut and says, this is good, this is safe, this is right, this is wrong. The next way that implicit biases are formed, or through early socialization and environmental cues or historical basis. So think about the ways in which you were socialized as a child.

Think about historical events or environmental factors and experiences that you've had in your own life. These personal factors help to shape our worldview. They help to shape our perception of the world and how we ultimately interact with the world. This is not something that we can turn off or that we can take off and leave at home when we come to work or when we have to interact with others. Our worldview comes with us wherever we go, and it unconsciously impacts our perceptions and actions. So we cannot leave how we were raised at home. We cannot leave our experiences at home and say, oh, I'm going to work today, so I'm gonna leave these personal experiences at home, or I'm gonna leave my personal childhood upbringing at home.

So we can't just turn it off or take it off, because these are things that are part of our early socialization. They're part of our environment, they're part of our lived experiences, and they come with us. And oftentimes, more often than not, these lived experiences unconsciously impact our perceptions and our actions. So the third way in which implicit biases are formed is through media and advertising. So we're repeatedly exposed to media portrayals of various different things and advertising of various different things that ultimately reinforce our bias. So if you think about some of the media and advertising portrayal of just men and women, we are often exposed to media that portrays females as collaborative, nurturing, homemakers.

And that on the opposite shows men as assertive, competitive, breadwinners. So if we're seeing this day in and day out, beauty bias is another one that we see a lot in media and advertising that helps to shape or impacts how we think of what is seen as beautiful, what is seen as successful. So if we're seeing these images and being on a day-to-day basis, eventually these associations become automatic associations and they become part of our long-term memory. And so again, going back to how our brains are structured, our brain takes a shortcut. So when we encounter these things in real life outside of media and advertising, this is now what we associate as beautiful, nurturing, good, bad, safe, happy.

And so these biases are reinforced and they become part of our automatic thoughts and part of our subconscious thinking. So, these biases reflect what we see and hear in our everyday lives, but not necessarily what we consciously believe about what we see and or hear. So it's so important to note that even though we have these automatic associations and automatic thoughts, it is possible for us to hold unconscious biases that we consciously oppose. So we may have some unconscious associations that we're making about certain people, things, situations that if we were to be asked about

or were to think about consciously, it's likely that we may oppose what we unconsciously think or how we unconsciously perceive those situations.

So let's do a knowledge check. We've covered a lot of information, so I'd like to do a quick knowledge check. So I would like to ask this question. An implicit bias is, A, a conscious bias, B, only related to race. C, an attitude or internalized stereotype that affects someone's perceptions. D, not involved in healthcare. So take a few seconds and jot down your answer. All right, if you chose C, then you are correct. An implicit bias is C, an attitude or internalized stereotype that affects someone's perceptions. So we're gonna move into, we're gonna move from what implicit bias is to how it impacts healthcare. So implicit bias has a detrimental impact on healthcare access, services and overall patient outcomes.

There has been a lot of research done on bias in healthcare and how implicit bias are perpetuated in healthcare systems, as well as some of the barriers that arise as it relates to patients being able to receive healthcare services as well as patients' overall outcomes. So the impact of implicit bias on healthcare results in healthcare workers passing judgment or labeling, having a lack of empathy, sometimes we see it manifest as ambivalence from our healthcare providers. Social determinants or health are largely tied to bias, but not just bias in the healthcare system. Social determinants of health are also tied to biases in other systems as well. A lack of interest in the patient's success or a lack of interest in the patient's adherence to their treatment plan or being successful with that treatment plan, being dismissive of patients needs, and lastly, poor health outcomes.

So this list is not inclusive, but this is a good starting point for thinking about how our personal and systemic implicit biases impact healthcare and especially how it impacts access to healthcare, the healthcare services, as well as patient outcomes. So to put these things into perspective, I want us to walk through some of the research findings

that shed light on how implicit biases play out in healthcare and how they ultimately impact the patients that we serve. So we talked in the beginning of about weight bias. So research that was done by Davison and Davis indicates that women with obesity seeking gynecological cancer screening were interviewed about factors related to their care and how they might feel discouraged from pursuing treatment.

As so patients with an increased BMI indicated several issues that would prevent them from pursuing treatment. Issues such as improperly sized equipment, receiving unsolicited advice about weight, being treated negatively, feeling embarrassed about being weighed, and being treated disrespectfully. So that is highly associated with weight bias. According to a quantitative study from the US, Black women are more likely than white women to receive general anesthesia for ceasarean delivery, but to not receive anesthesia for vaginal delivery. There's also a study that indicates that Black and Latinx healthcare users have lower rates of admission to the cardiology service compared to white patients. When looking at stroke prevalence and treatment among various ethnicities, it was found that Hispanics and Blacks have the highest risk of stroke in the population, but are less likely to be prescribed anticoagulant medications than their white counterparts.

When thinking about end of life care, there was a study done in the US that shows that Black healthcare users receive more burdensome end of life care in comparison to white healthcare users. Another study from the US found implicit racial bias toward whites in the emergency unit and also found implicit racial bias associated with less serious diagnosis in regards to Black and Hispanic healthcare users when the emergency unit is crowded. So another study showed that white male physicians prescribed less pain medications to Black healthcare users compared to white users, and that healthcare professionals perceive Blacks to be biologically different than whites and thus having differential reactions to pain. So these are just a few of the indicators of how implicit bias impacts healthcare access, services and outcomes.

So when we think about the various different bias, different types of bias that we discussed early in the presentation, we can see those different biases play out in some of these very real research reports on healthcare. So we see the weight bias, the racial bias, we see the gender bias, the affinity bias. We see those things play out as it relates to pain management, as it relates to who's getting prescribed what type of medication, as it relates to being considered or your diagnosis or your needs being considered less serious or less severe. So needless to say, these biases have a real major and very detrimental impact on healthcare, on access to healthcare, the services that our patients receive from us as healthcare providers, as well as our patient's overall outcomes.

So there is also substantial evidence that demonstrates that implicit bias in healthcare, it's not new, it is longstanding, and much of the bias that we see is based on historical assumptions that continue to sustain implicit bias in healthcare. And some of those assumptions include that BIPOC patients are seen as biologically different, which plays into the assumption that BIPOC patients, Black patients in particular, have a higher tolerance for pain and therefore require less pain management. There are assumptions that BIPOC patients are less sick and therefore are faking their illness. We see this play out when BIPOC patients' complaints are taken less seriously and when their treatment plans are less aggressive and less targeted. Mistrust, mistrust is especially important, and it's important to note that patients, especially BIPOC patients, enter healthcare with preconceived notions based on historical factors.

So therefore, patients enter the healthcare system, mistrusting the system, as well as the providers within the systems. Patients are often reluctant to trust healthcare providers, because they fear they will be experimented on or experimented or part of an experiment without their consent. This is a longstanding fear, and this fear is understandable, because of historical events such as the Tuskegee Experiment or the

the case of Henrietta Lacks. So patients come into our system with bias against the system, and then that bias is further perpetuated when they get into the system and we as providers are harboring our own implicit biases. And lastly, funding of healthcare services. So when we think about funding, historically, BIPOC individuals have been marginalized in healthcare and have not been in a position to receive adequate healthcare services or adequate funding for healthcare, or for that matter, even adequate insurance that would allow for access to effective and efficient healthcare services.

So all of these things in combination with the systemic implicit bias as well as the personal implicit biases take a major toll on healthcare, and it takes a major toll on how our patients access the healthcare system, the services they receive within the system, as well as their overall outcomes. And as I stated, it also causes patients to come into the system with their own set of biases against healthcare providers and against the healthcare system in general. Just due to some of these historical factors. So now that we have looked at the impact that our system level as well as our personal level biases have on healthcare and the overarching healthcare system, I would like for us to take a little bit of time to do another activity.

So most of us value our health and we value those that we entrust with our healthcare. So the team or group of individuals that we entrust with our health are those that we consider trustworthy, competent, knowledgeable, and the list goes on. So for this activity, I want you to think about your healthcare circle of trust. I want you to think about those that you personally entrust with your healthcare and the healthcare of your loved ones. So take a few seconds and just write down the names of the people that you trust with your health or your healthcare or the healthcare of your loved ones. So take a few seconds and jot down or make a list of your healthcare circle of trust.

All right, so I want you now to look at your list and I'm just gonna name various diversity dimensions and I want you to place a check mark besides those individuals that are on your list. Who are similar or have that same dimension as you. So for example, if you are a male, I want you to put a check mark by everybody on your list that is male. All right, so diversity dimensions, male, put a check mark by everyone on your list that is male. If you are male. If you are white, put a check mark by everyone on your list that is white. If English is your first language and you are English speaking, put a check mark on your list by everyone who is English speaking.

Cisgender. If you identify as a cisgender person, put a check mark by everyone on your list that identifies as cisgender. Latinx. If you identify as lat Latinx, please put a check mark on your list by everyone on your list that identifies in that way. Female, English is a second language, Muslim, educator, nurse, medical doctor, veteran, over 50, Black or African-American. So this is just a short list of diversity dimensions. There are tons more, but I want you to look at your list and see how many people in that circle of trust are like you, because most of us in our circle of trust, we're gonna have people who look like us, talk like us, and identify as us.

So this activity highlights how we tend to gravitate toward and pick those that are the most like us. So if you'll remember from the beginning, the affinity bias. So we are drawn to those that are like us. So if we were to have to really think about our healthcare circle of trust, those that we trust with our health are gonna be the most like us. So I want us to think about our patients and think about who's in their healthcare circle of trust and think about how many of us as providers are gonna be a lot different from our patients. So therefore we're gonna have to earn their trust and we're gonna have to earn the right, the privilege to be a part of their healthcare circle of trust, because it's very likely that many of those in their healthcare circle don't share similarities with them.

And that is very, very important, because we want to be able to have diversity within our healthcare circles of trust, and we wanna be able to respect our patients' diversity and to not allow our implicit biases to prevent us from being able to provide efficient and effective care, simply because we are less similar to our clients. So just something for you guys to think about as we think about how we work with our patients, how we start to recognize our biases and how we start to think through dismantling those biases in a way that will allow us, regardless of our differences, regardless of our diversity factors, to be able to work with our patients as well as our colleagues and our peers in a way that is respectful, in a way that embraces inclusion and in a way that highlights diversity.

So I have another knowledge check. We've covered a lot of information today. We've covered a lot of information about what implicit bias is, how implicit bias develops, and we've talked about how implicit biases impacts healthcare. So for this knowledge check question, implicit and implicit bias impacts healthcare by causing A, lack of empathy, B, ambivalence, C, passing of judgment, D, all of the above. So take a few seconds and answer this question. All right, if you chose D, all of the above, you are correct. An implicit bias impacts healthcare by causing lack of empathy, ambivalence, and it causes us to pass judgment. So D, all of the above. So at this time, I'm gonna turn it over to my colleague Anna Smith, who's gonna move beyond the impact of implicit bias in healthcare to thinking about and discussing interventions to tackle implicit bias.

- Thanks Katrinna. As you mentioned, I'm gonna take over from here and start to talk about some interventions that you can do as an individual to combat and tackle your own implicit biases. The following six interventions that I'm gonna talk about today are representative of a changing body of knowledge on ways to address implicit bias. These interventions are more specific to healthcare practitioners and settings, but these same interventions are consistently talked about in different work settings and

contexts. The interventions are self-reflection and self-assessment, acknowledging and accepting implicit bias, individual responsibility, using neuroscience, practicing self-monitoring and mindfulness and cultural and linguistic competence. Self-reflection is an integral component of the adult learning experience and a practice of many health professionals.

You reflect on various diagnoses, different treatment plans, how your treatment plans are working, how your therapy is progressing, and you change your behaviors based off of those reflections. Adding in self-reflection to analyze and work on your own biases is an important intervention. Those who engage in the process of self-assessment report personal and professional benefits. One of the easiest ways to assess yourself for implicit biases is to take an implicit association test. The implicit association test measures attitudes and beliefs that people may be unwilling or unable to report. The implicit association test may be especially interesting if it shows you that you have an implicit attitude that you did not know about. For example, you may believe that men and women should be equally associated with science, but your automatic associations could show that you, like many others, associate men with science more than you associate women with science.

So the way the implicit association tests work, you'll be presented with two different sets of images and usually two different sets of words. So you may be associating women with work, and you'll press J and Men with home and press H, and you'll go through that for a little while and they'll randomly come up a man or a woman, home or work, and you'll press the appropriate button and then they'll change. And you'll need to associate men with work and women with home. You'll go on again as well. What I found when I took my implicit bias association tests was exactly what I just said. I thought that I would have no bias between men and women and work and home, but I had a bias I didn't know about something that while consciously, I think one thing,

unconsciously, my brain actually has taken in information and made associations that I wasn't aware of.

Even those who are fair-minded and detest prejudice at a conscious level can turn out to have some unconscious biases based on race, age, gender, and other demographic factors. It is really important, therefore, to remember that this measures unconscious bias. Acknowledge and accept implicit biases. Issues associated with culture, race, ethnicity, privilege, social class, prejudice, bias, stereotyping, discrimination, homophobia, institutional racism and oppression. And I'm sure there are more that I could keep going on and on are emotionally charged and difficult to both face and admit. For those of us in healthcare, it may be even harder to accept and you may not view yourself as harboring any ill intent, conscious or unconscious, towards populations and individuals to whom you provide care.

Becoming aware of and unsettled by your own unconscious bias is the first step to addressing it. Sometimes even having a negative reaction to the idea of implicit bias is a starting point, not a point to ignore and pretend that it's not there. You need to instead look inward and work towards acceptance. We all need to work towards accepting that we all have implicit biases, and that in reality, bias is a normal part of human functioning. Even amongst healthcare practitioners, we need to acknowledge that unconscious bias can have a direct impact on healthcare practitioners and their ability to do no harm. We need to acknowledge and accept that biases can negatively impact the day-to-day interactions, including compromising medical decision-making that healthcare practitioners have with their patients.

We need to minimize any feelings we have associated with guilt and blame, because in reality, they only serve to slow and interfere with efforts to address unconscious bias. Instead, what you really need to focus your energy on are intentional actions to recognize and combat your biases on a consistent basis. And finally, we need to

accept that there are solutions to address the complexities of implicit bias. Coming to this class and listening to these interventions show that there are solutions. Individual responsibility. Given the correlation between implicit bias and healthcare disparities, healthcare practices should take action to address this problem, this pervasive problem. It is important for healthcare professionals to assume individual responsibility to better understand and address your own implicit biases.

Things that you can do on an individual basis are you could write a list of beliefs that may lead to your bias thoughts and behavior towards others. So after you've taken the implicit association test, use that test to reflect on what beliefs you might have that could lead to those biased thoughts and behaviors. After finding out that I'm biased towards men and work and women and home, how many different TV shows did I watch growing up where that's all I saw. Even though my mom worked, she was still responsible for most of the household duties. My dad wasn't. Sometimes those things that I saw and heard over and over and over again obviously have impacted my own biases.

Acknowledging that and accepting the responsibility for that is an important first step. Ask one or more of your colleagues to share their views about what they see as biased beliefs or behaviors that you demonstrate. Now, this can be a really hard thing to do, because you have to trust the person that they're gonna tell you the truth and they have to trust that you are gonna be willing to listen and not get upset at them. Make a commitment to combat those biases that compromise the care you deliver to patients and their families. You can participate in implicit bias training, and you're all doing that right now. So you got one thing that you've done. And advocate for the inclusion of implicit bias information in healthcare and professional meetings and conferences, most of the time we're all going to some kind of a professional meeting or conference or some kind of virtual event.

And at the end, a lot of times they give us surveys and they wanna know, what else do you wanna hear about? Start filling out implicit bias, diversity, equity, inclusion. These types of events are a great way to get the information out to everybody. It's now time for a knowledge check. So let's see how well you've been listening so far. I'm gonna read the question, what is the easiest intervention an individual can do to assess their own implicit biases? Take an implicit bias test to understand what their biases are. Avoid seeing patients that are different from yourself. Get an advanced degree in diversity, equity, and inclusion. There are no interventions for implicit bias. It just is what it is.

So the easiest intervention to do is to take an implicit biases test to understand what your biases are. All right, so now we're gonna get into using neuroscience. So a fun little fact that I like to share and I think really helps me is that the human brain can process 11 million bits of information every second, but our conscious minds can only handle 40 to 50 bits of information a second. So think about that, that's a huge disparity. Our brains take cognitive shortcuts and those shortcuts can lead to implicit bias with serious consequences for how we perceive and act towards other people. Our brains really are like little mini computers, or not mini, I guess, that's a seven pound computer that sits on the top of our head, and they take in those 11 million bits of information and they tag them, and they code them, and they box the information up, and they put like information together and unlike information together.

The brain has a unique ability to differentiate between those who are like us and those who are not like us. The mere fact that a person is coded as not like us results in different treatment with those like us being treated better. Implicit bias then can be a function of our brains automatically assigning a person to a group whom we have coded as other and therefore they we have less interest and empathy for that person. We also need to remember that emotional reactions to perceived threats when the other is perceived as dangerous. So we're tagging, we're coding, we're putting people

in boxes, and they're like us and they're not like us. And if we encounter someone who's coded by our brain as not like us and the situation seems dangerous, it's gonna be, you know tho those emotional reactions are gonna happen really, really fast.

At the neural level, the magnitude of implicit preferences for ingroup and against out group correlates with the activation of the amygdala. And as a reminder, the amygdala is a subcortical structure of the brain. It is part of the limbic system or the emotional brain, and it has a major role in the fight or flight response. And also something to remember. It becomes activated in milliseconds. So within milliseconds, that emotional reaction and a perceived threat and there're an other, it just happens just like that. Another thing to remember is that when we're under pressure, stereotyping is easier. It takes time and energy to pay attention to and process information that is unique to each individual patient. When healthcare practitioners are operating under a significant amount of cognitive load, say an ER nurse in an ER with an emergency that comes in, there's limited energy available to attend to the uniqueness of any given patient.

In the spirit of efficiency, well-meaning people and our brains may find that it's easier to stick to the stereotype than to take the mental effort it takes to separate the person from the stereotype and then make the mental corrections for the stereotype that was activated. Controlling the actions from implicit biases will require abstract thought and the activation of the anterior prefrontal cortex, PFC. So this includes the recognition of the influences that of media, education, images that you see, family members, authority figures, peers and social history have on creating and sustaining their implicit biases. It will require that healthcare practitioners recognize the connection between the biases and their verbal or non-verbal actions. This level of awareness and insight allows healthcare practitioners to recognize and acknowledge how frequently implicit biases influence everyday actions.

Practice self-monitoring and mindfulness. So practicing self-monitoring and mindfulness goes hand in hand with several of the previous interventions. So we've identified your biases, we're accepting them, and we're taking the responsibility to reduce our biases. But you need to monitor yourself and you need to use mindfulness to make sure you're not letting your biases influence your thoughts and actions. By practicing self-monitoring, you can monitor yourself and your thoughts and how you relate to your experiences. So we just learned about how in under pressure, the stereotype is easier. If we can practice self-monitoring, maybe in a super stressful situation it might be hard, but the more you do it, the more you're thinking about the way you're thinking and the way you're acting and how it's relating to your patients, you can work to overcome that instinctive reach for the for the implicit bias reaction.

You can also use mindfulness to adopt an orientation towards one's experience in the present moment. Mindfulness is characterized by curiosity, openness, and acceptance. It's important to remember that both of these tools are essential. Since the literature emphasizes that stigmatizing bias rather than acknowledging its existence is counterproductive. The final intervention is cultural and linguistic competence. Culturally and linguistically competent approaches to healthcare have proven effective in addressing disparities in healthcare and health outcomes for some racial and ethnic groups and populations. First, let's discuss the definitions of both of these and then we can look a little bit deeper at them. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system agency or those professions to work effectively and cross-cultural situations.

It's a lot to take in. Linguistic competence is defined as the capacity of an organization and its personnel to convey information in a manner that is easily understood by diverse groups, including persons of limited English proficiency, those who have low literacy levels or are not literate, individuals with disabilities and those who are deaf or

hard of hearing. So going a little bit deeper into cultural competence. There are five essential elements or practices of cultural competence at the individual level. And they include acknowledging cultural differences. They include understanding your own culture, which is the second element of cultural competence at the individual level. And then you need to engage in self-assessment to understand what behaviors and attitudes are a part of your culture, but they might not be a part of others' cultures.

And you need to learn and acquire cultural skills and knowledge that you can begin to see those differences as a part of what makes up an individual. And then the fifth one is that you can begin to view your patient's behavior within a cultural context. So you gotta kind of think about all five of those all together. At the system level or the institutional level there are also five essential skills or interventions and five essential elements, I should say, or practice of cultural competence. They include valuing diversity, having the capacity for cultural self-assessment, being conscious of the dynamics inherent when cultures interact, having institutionalized cultural knowledge, having and having developed adaptations to serve, delivery, reflecting an understanding of cultural diversity.

So those are all at the organizational or system level. I did wanna stop and really talk kind of quickly about cultural humility. It's a topic that we could have a whole hour talk on, and I think we have some to go and and look and they are really great. Cultural humility is really seen as the gold standard of an intervention. We're talking about cultural competence and linguistic competence. But I just wanted to kind of stop for a second and tell you about the gold standard. And there is, there are a few differences. Cultural humility is the ability to maintain an interpersonal stance that is other oriented or open to the other in relation to aspects of cultural identity that are most important to the person.

Cultural humility is different from other culturally based training ideals because it focuses on self humility rather than being other directed, they/them way of achieving a state of knowledge or awareness. So you're not learning just about them, you're trying to focus on your own self humility. It is helpful to see as others see. What they themselves have determined is their own personal expression of their heritage and their personal culture. Cultural humility really was formed by health professionals to learn more about experiences and cultural identities of others to increase the quality of their interactions with clients and community members. Linguistic competence, as a reminder, linguistic competence is the capacity of an organization and its personnel to convey information in a manner that is easily understood by diverse groups, including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities and those who are deaf or hard of hearing.

And two, and that it also responds effectively to the health and mental health literacy needs of population served. There's a lot of evidence that describes the adverse impact on patients with limited English proficiency, especially when interpretation and translation services are not provided in healthcare settings. So when you have a lack of linguistic competence, you're gonna have poor communication. You're gonna see an incomplete or inaccurate health history. There are gonna be more misdiagnoses of health and mental health conditions. There's gonna be a misuse of medications, patients lack of understanding of their own health conditions and recommended treatment. They're gonna be repeated visits to physicians' offices or emergency rooms and there's gonna be a lack of informed consent.

So given that we just talked about the lack of having an interpreter for linguistic competence, I wanted to stop and say that we need to use linguistic interpreters for linguistic competence. And when you're looking for an interpreter, I think especially for those of us in the healthcare professions, it is really important to realize that we have to look for certified medical interpreters. They get an additional set of training, I believe

it's around 40 hours, so that they are properly trained to handle the medical terms and to explain them in the language correctly. In their language correctly to understand what we're having them interpret. And then to explain it correctly. It is really important not to use family and friends of the client or patient.

The ability to be objective and impartial is just really difficult. If you're giving someone bad news, they need to be able to give it and not be overwhelmed by the information you're sharing first to the interpreter. If possible, it would be good to be able to discuss the terms with the interpreter that may be difficult to translate. So as an audiologist, one example I can give you is that high frequency and low frequency, along with high pitch and low pitch, can be difficult to differentiate. If the interpreter isn't exactly sure, they might be telling the patient something incorrectly and then they're not gonna have the understanding needed. The other thing that you need to think about when you're bringing in interpreters is where's the interpreter gonna sit?

Are they gonna sit next to you or behind you? Are you using a live person? That would, those would come into play. But what about using an iPad? If your interpreter is on an iPad, can the patient hold it? Should it sit on the table? Where is it gonna be? You gotta kind of think about all those things ahead of time. And the other thing is sometimes interpretation can happen simultaneously. So as I'm talking, the person is interpreting and speaking just slightly behind me. But you can also have it be delayed. It depends on the language, it depends on your ability to communicate effectively while you have someone else talking right next to you. Sometimes it's a hard thing for people to do.

As well as depending on whether it's interpreting just for language or just interpreting for American sign language, which may be something that you need to do delayed rather than at the same time. Okay, so now we are at another knowledge check. So let's stop, take a breath and think about what is the gold standard when it comes to

culturally based training? So this wasn't a specific intervention that I talked about. I kind of threw it in there at the end, so hopefully you remember. But our options are cultural competence, cultural happiness, cultural humility, and cultural exclusion. So take out your piece of paper, write down the answer, take your best guess, use the commenting tool below, and we're gonna go on and say that it is cultural humility.

Okay, so now we are at a reflection activity time. And this activity I want you to do, I want you to promise me that you're going to watch the local news. You don't have to necessarily listen to the local news. What I want you to, and it maybe it'll even be better if you don't. Put it on mute, but for that half an hour, watch your local news with a piece of paper and a pencil. And what I want you to watch for is who you're seeing and what their, in what situation you're seeing them and and who they are. So a white female news broadcaster, a white male news broadcaster, a young female weather person, are there any people with disabilities?

Are there, what's the diversity makeup of the 30 minute news broadcasts? What stories are they talking about? Are they talking about crime in relation to people of color or disabilities? Are all of the happy stories about white people or the people who are the majority in your neighborhood? Sit down and like I said, spend the next, not not the next 30 minutes, but spend those 30 minutes watching the news and and keeping a running list of everything that you see. And then I want you to really stop and I want you to look through it and think about what that could be telling your brain. Again, your brain is collecting all of that information. Those 30 minutes, we're only picking up parts of it, right?

But our brain is digesting all of it. Everything it sees, everything they don't say that is just implied. Our brain is taking it and it's categorizing it and it's tagging it and it's putting it in its little box. And I want you to reflect on what you saw, the amount of diversity you saw. Did you see how what was talked about could be or could lead to

prejudices that are sitting at the unconscious level that you might not be aware of? Okay, so at this time, I'm gonna step away from the interventions that we just talked about and I'm gonna move on to talk about the goal of implicit bias training. Because we've talked a lot about implicit bias at this point.

We've talked about what it is. We've talked about it's relation to healthcare access. We've talked about different interventions that you can do. But at the end of the day, what is it that Katrinna and I want you to walk away from? Like what's, what's the get at the end? What's the the big deal I want you to walk away from? So we've covered a lot of information, as I said. We've talked about what implicit bias is. We've talked about the various types of bias that you can see and the impacts that they have on healthcare. We've talked about six different interventions that you can utilize to reduce your implicit bias. But it's important, as I said just now, that it's important to clarify what the goal of implicit bias is.

We want everyone watching this course to walk away from this presentation and really have a real sense for the goal of this. And it's important to acknowledge that implicit bias training is an important part of diversity, equity, and inclusion work. And I'm sure you've heard diversity, equity, inclusion, there are now departments in our HR department, DEI, and it's important to acknowledge that these all go hand in hand. So what is the goal? Is it just diversity? We just need to make sure to have more diversity in healthcare and that'll help reduce implicit bias? Is it equity? Is the goal to have equity in healthcare and that can reduce our implicit bias or the goal could be inclusion and we can work to include people that have been historically excluded and people with different backgrounds and that that inclusion will help reduce implicit bias.

When we speak about diversity, equity, inclusion, it's also helpful to start with the definitions as I always like to do. So I'm gonna start there. So diversity, according to the Miriam Webster dictionary, diversity is the inclusion of different races, cultures, et

cetera in a group or organization. Diversity can also be defined as the differences between people. These differences can include race, gender, sexual orientation, religion, background, socioeconomic status, and much more. Diversity when talking about it from a human resource perspective tends to focus more on a set of policies to meet compliance standards. Mo most HR managers have said that diversity in the workplace is not well defined or understood at work. And it focuses much more on compliance and places too much emphasis on gender and ethnicity.

So equity, again, the definition of equity according to the World Health Organization is defined as the absence of avoidable or remediable differences amongst groups of people whether those groups are defined socially, economically, demographically, or geographically. Equity is different from equality where everything is considered equal, equal resources, et cetera. Equity wants to remediate situations and environments so that differences don't become obstacles to access. So the National Equity Project states that to lead to meaningful change, an exploration of implicit bias must be situated as a much larger conversation about how current inequities in our institutions came to be, how they are held in place and what our role as leaders is in perpetuating inequities despite our good intentions.

So as I stated earlier, equity and equality are different. For a long time the idea of equality was seen as the goal. We all want children to have equal access, right? We want an equal representation. Equality really is defined as each individual or group of people given the same resources or opportunities. Whereas equity is defined as each person having a different set of circumstances and being allocated the exact resources and opportunities needed to reach an equal outcome. So equality is kind of equal on the front end. I get a ladder, you get a ladder, whereas equity is looking at, well you're standing on a hill so I'm gonna give her the ladder, so that you're both, the outcome is you're both standing at the same level.

I do tend to tell stories and use pictures when I try to explain topics. And the one that I've always loved using when explaining the difference between equality and equity is the use of an apple tree. So I have a image of a tree, I don't have any apples on it, sorry. And, but I want you to imagine that there's an equal distribution of apples all across the tree. There's apples low, mid, high and there's apples in the middle and all the way to each side. And my daughter and I are going to go pick apples. My daughter and I are about an inch apart in height. So we're, we're practically the same height. And if she's wearing heel, she's probably as tall as I am anyway.

So we go out and we're gonna pick apples. I get one half, she gets one half. So an equal distribution, equal split, equal size people and we are going to pick apples. We're probably gonna end up with about the same number of apples. It might be that there'll be, we'll be one or two off really, but everything in in reality is equal. And when everything is equal, it's easy to see how it's a worthy goal. We want, it's gonna be both equal on the front end and equal on the backend. Now if I take my 10 year old outside in the same circumstances, it's the same tree. We've got the same equal distribution of apples and my 10 year old is about six inches shorter than I am.

Maybe even more than that. I haven't measured her recently. So she gets one half and I get one half. It's never gonna be equal. She's never gonna be able to reach the same number of apples unless I allow her to climb the tree. That would be an accommodation maybe. But I mean that's also kind of a hard accommodation to give because she's 10. Maybe she's a good tree climber, but this might not be a tree you can climb. She could just fall down and hurt herself. So I could give her a ladder and I could say, here you go, this is gonna get you up to my height. You can reach all the same apples on your half that I can reach standing on my half.

That would be giving her something to make the outcome equal to mine. We could also look at it as if it's, again, me and my older daughter we're the same height. But what if

on this hypothetical apple tree, all the apples are skewed on my side with only a few apples skewed on her side. Wouldn't matter that we're the same height, because the way the apples are distributed across the tree aren't equal. So we'd have to come up with a different resource so that she could have equal access. Maybe we both have to pick apples from the same half. I'm not sure what we would do in that case, but that's a different scenario. Those are some different scenarios to explain equity versus equality.

I hope it helps keep it clear in your mind. So let's talk a little bit about health equity, 'cause we're healthcare professionals and we wanna not just know about apple trees, right? We wanna know about how equity involves healthcare and health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. So in a healthcare example, if two people have a diagnosis of diabetes and they need to see an eye specialist and one patient lives in the city and they only use public transportation, because it's too expensive to have a car in the city, maybe.

Maybe they've always lived in the city and they never learned to drive. Hard to say what the reason is. But the other patient lives in the suburbs and they do have access to a car and they can use it independently. And so these two patients are gonna search for eye specialists to go see since they have diabetes and they need to see an eye specialist. And it turns out there are 10 eye specialists in their combined city and suburban locations. Nine out of the 10 clinics are located in the suburbs. One out of the 10 is located in the city. So that one patient that only has access to public transportation might only be able to go to one clinic.

But what if that clinic doesn't see patients for diabetes? They only see glaucoma patients and this patient doesn't have glaucoma yet. And they call and they say, well

this is the only one I can get to. Can you see me? The the eye specialist might say yes, but they might say no. They might say we don't see diabetes patients right now, 'cause we're just specializing in glaucoma. Or yeah, come in, we'll see if you have glaucoma. And they're like, well that doesn't help. Whereas the other patient that lives in the suburbs and has access to a car, they really can see all ten, right? They're not held back from any of those options. So they can call all 10, they can find the best one that works for them.

So that would be an inequitable healthcare solution. And you can understand why there needs to be a benefit or an out. There needs to be an intervention, I'm gonna say. To the one patient in the city, maybe that intervention is that they, that the healthcare facility that does have their, the specialist need to see provides transportation out to them. That would be an equitable solution that gets them to where they need to be. The other person doesn't need it and they can get there on their own. So that would be a way of explaining health equity. So the last one from diversity, equity, inclusion. The last definition I'm gonna talk about, maybe it's not the last definition, but it's the last one of diversity, equity, and inclusion is gonna be inclusion, which is really simply the act of including.

When you're using it in the context of diversity, equity, and inclusion, you're talking about including people who have been historically excluded due to race, gender, sexuality or ability. Okay, so now it's time for our next knowledge check. And I want you to think about what is the definition that I gave for equity. Actually I gave you several. So I'm gonna have you pick one of the definitions of equity. There's only one definition in here. So which one is a definition of equity? Is it the absence of avoidable or remediable differences amongst groups of people? Whether those groups are defined socially, economically, demographically, or geographically? Is it the state of being equal? The action or state of being included within a group or structure?

Or is it including people that have been historically excluded? So the definition of equality, of equity, sorry, the definition of equity, I believe this is according to the World Health Organization, is the absence of avoidable or remediable differences among groups of people. Whether those groups are defined socially, economically, demographically, or geographically. All right, so we left off before our knowledge check talking about inclusion. So now we're gonna talk about inclusive healthcare. Inclusive healthcare accepts, values and views as strength, the differences we all bring to the table. So inclusive healthcare includes respect for diverse cultures, communication styles, languages, customs, beliefs, values, traditions, experiences and other ways in which people identify themselves. So now I wanna combine both equitable healthcare and inclusive healthcare.

We're gonna talk about equitable and inclusive healthcare. And when we talk about equitable and inclusive healthcare, we need to think is the care really accessible? So we talked about that in an equitable healthcare, is it equally accessible for all people? You also need to think about will different insurance coverage dictate what kind of healthcare a patient can receive? So going back to our diabetes patient, what if the only one health clinic that, that the city patient could get to was in, so there was only one clinic that they could go to in the city, but what if the only one their health insurance would pay for is out in the suburbs? And what if that one health clinic doesn't provide any transportation and they can't really go anywhere, because they can't go to the one in the city that they can get to, 'cause their insurance isn't covered and they can't get out to the suburbs, because they don't provide transportation.

And so we need to think about what kind of transportation is required. We need to think about will there be a cost associated with obtaining the healthcare? And it's not just a copay. We need to think about are there parking costs, is there food costs or gas? All of those are are costs that you might, that are kind of the hidden cost, some of the hidden costs of healthcare that you do have to take into account. When my son was in

the hospital, he was in a city hospital and the parking cost was significant and I believe there was even a grant available that cut the cost of the parking down if you were a patient in that hospital and it cut it down to a reasonable level, but only if you were had it validated in the hospital, because otherwise in the city the parking cost could be 25, $30 a day.

Well we were there for five or six days, you know, I mean that's not affordable to a lot of people. And so sometimes that's, you know, something that you have to kind of think about and add in something to make it both equitable and in inclusive. And do you need to have a certain level of knowledge to get the care that you need? The other story I always think about, this is also for my son and it's when he needed ear tubes. As an audiologist, I knew at the time that he needed ear tubes. We had been dealing with the primary care physician for several months to a year. I wanna say we had been there for a full year, he was two.

We started seeing him at nine months when we moved and he just kept having ear infection after ear infection, after ear infection and an internal ear, an external ear infection and a middle ear infection. And the doctor wouldn't refer us. And so I started calling up ENTs going, I know he needs to be referred and Mr ENT, will you please see us? And they didn't, they wouldn't see us without a referral, which was very frustrating. But I also knew that I could call up my insurance company and talk to someone at the insurance company and tell them my story and say, this is what I need. I know I need this. And they found someone that would take me without a referral that was still within my insurance so that we could get the surgery we needed.

And he stopped getting your infections for at least three years before the tubes fell out and he started getting ear infections again. So the other things to consider about equitable and inclusive healthcare is how will I feel when I go to receive care? Will there be empathetic staff and providers? Will there be staff who look like me? Will it be a

welcoming environment? Will assumptions be made about me, my family or my children when I go to receive care? It's always a different situation for my husband and I. When I go with the, with our kids, I'm a white woman and I'm raising three interracial children. And so sometimes I'm not seen as the mother. When my son was a newborn, he looked like a white baby to put it blankly or frankly, I guess to put it frankly.

My husband said he felt nervous going to the pediatrician's office, 'cause here he is a very, he's a large Black man holding a very white appearing baby even though he was a mixed child. And so you do worry about things like that. And if assumptions will be made. Are patients and clients receiving quality care? Is the staff credentialed and up to date on policies and procedures? And are there visible quality metrics and is there adequate staffing and proper safety, security, et cetera? Another important thing to think about is would you recommend the care to others? So what is the goal? I don't think I've answered that question yet. So let's go back and think what is the goal of implicit bias training?

I'm actually gonna talk about something that I haven't talked about yet, but it's taking all those pieces we've talked about so far and when we put them together. So when we take diversity and equity and inclusion and we have all three represented, then we get belonging. Cornell defines belonging is the feeling of security and support when there is a sense of acceptance, inclusion, and identity for a member of a certain group. It is when an individual can bring their authentic self to work. And I always love that statement when you can really bring your authentic self to work. When your patients can bring their authentic self to your clinic and you see them and respect them and accept them.

People of all races, ethnicities, disabilities, genders and abilities will all feel that they belong. And I really think that this is the true goal of implicit bias training. When we really work on our implicit bias and we work on diversity, equity, and inclusion, 'cause

implicit bias is an important aspect of each of those, then we will get to belonging. That is really the goal. And there is a great image I'm gonna show right now that really does show what belonging means. So you've got the image of reality, you got three people trying to see the sunset, but one person's never gonna see the sunset, they can't get over the fence, all they can see is fence.

And one person can peek just a little bit over the fence and one person has a clear view. And that's the reality. Some people have a lot, some people have to struggle and some people, it doesn't matter how hard they try, the reality is they're not gonna be able to see that sunset. And so if we all, if we equally give them a small step stool, the person who can see is probably gonna see even better. The person who can barely see, might be able to see enough to see a little bit more. And the person who can barely see still probably can't see. There's just, it's just not, it's not an equitable solution. So then you look at equity and you go, okay, the person who can see fine doesn't need anything.

The person who can barely see, maybe they need a little step stool, but the person who can't see it all, they need the biggest stool. And so it's gonna be a solution just for them and they're all gonna be able to now see the sunset. And that's an equitable solution. But what about belonging? When you look at the fourth illustration, you see that when you're able to take that fence away, you get to, everybody gets to see the sunset and you get to see the beautiful view the ocean as well. Something you probably didn't even know was there. And so our goal is really in belonging is to remove that fence so that everybody has gets to see the same view.

All right, so at this time we are gonna stop again for a knowledge check. We're wrapping up the hour. What is the definition of belonging? I just talked about it so hopefully it's fresh in your minds. So is it the absence of avoidable or remediable differences among groups of people? Whether those groups are defined socially,

economically, demographically, or geographically. Is belonging the feeling of security and support when there is a sense of acceptance, inclusion, and identity for a member of a certain group? It is when an individual can bring their authentic selves to work. Or C, is it the inclusion of people of different races, cultures, et cetera, in a group or organization or D is it including people that have been historically excluded?

So the correct answer is B, belonging is the feeling of security and support when there is a sense of acceptance, inclusion and identity for a member of a certain group when an individual can bring their authentic self to work. So now we're gonna talk, we're gonna do another reflection activity. And this one is another story that I'm gonna tell you about my five-year-old daughter. And she, like her older brother, needed to have her tonsils, adenoids and ear tubes placed. And this time we were at a different family practice doctor who referred us to ENT. So we went over to ENT. And again, I know enough that I knew that that's where we were at.

Everyone was in agreement, ENT sat us down, talked to us and we all agreed we needed all three. She snored, she was getting repeated ear infections, she was now she was allergic to one antibiotic. And amoxicillin had stopped working. So we were in real danger of having some of running out of antibiotics to treat the ear infections. And so my five-year-old daughter and I, and again I'm a middle-aged white woman, my daughter as the picture indicates was a five-year-old African-American female. Generally they don't look at her and say, obviously your mom is white, but she is. And so we walked down the hall to the surgery schedulers office. And then what I want you to stop and think about is when you have been in to schedule surgery for yourself or for a child, what questions are usually asked?

I know that I was anticipating getting questions about my insurance, about copays. I was anticipating that there might be a certain percentage I had to pay and that it might be upfront or it might be within a few days of surgery. 'Cause sometimes nowadays

they say you're responsible for 20% and we called your insurance company and this is what you're gonna need to pay, but we need it now, not after the fact. So all those things were going through my mind as I walked into and sat down at the schedulers office. My daughter of course didn't think about any of this. She ran off to the toy section in the corner and happily played with some Legos I believe.

And the first question that she asked me was if I was the adoptive mother. And I wasn't really thinking about the mother part, but I stopped in thinking and I was thinking, what does adoption have to do with ear surgery? And I was really confused. And so I thought like, I'm missing something. There's a context I don't understand. She's confused about something or she thinks I'm a different, my daughter's a different patient. And I was like, no. And again, I'm really confused. And so then she goes, am I the foster mother? And I'm even more confused, 'cause now I'm thinking adoption and fostering have something to do with this that I don't know, like maybe they only see parents who are foster and adoptive parents.

Maybe they don't do surgery on, that doesn't make any sense though. Why would that be the case? And I just kind of stumbled and I said biological, like, is that the question you're trying? Like what is the question? I don't understand. And she heard the answer. And so she went on with all the other questions that you normally ask. And we scheduled the surgery and walked away, but it stuck with me. Why was she assuming and thinking that I was an adoptive or foster mother? I wasn't seeing it maybe from her perspective that a white woman walking in with a Black appearing child can't be the biological mother of that child. What she wanted to ask was I the parent or guardian of my daughter in which I would've answered, yes, that's it.

That's a question I would've assumed from a healthcare professional. I would've assumed that that would be one of the first questions. But I've always been asked it in a way that's neutral and that isn't including their own bias. She had a bias towards a

white woman being a foster or adoptive mother of a Black child, maybe her sister adopted several Black children. And that's her frame of reference and that would be a beautiful frame of reference that, but unfortunately it excludes the fact that I'm her biological mother. And it makes it hard for someone to kind of feel comfortable in that situation. You're taking your bias and you're bringing it into a place. It's already kind of nerve wracking for a parent.

You know, she's gonna have to go under and I'm gonna have to worry about it and she's gonna be in pain and there's gonna be pain medication. And so there was, it's a lot of emotions going on. Adding in her own bias is really kind of, it was disappointing and it was real upsetting to me at the time. And it's something to think about. Have you ever been in a situation where based on appearances, based on how you look that particular day, someone makes a judgment about you and how does that feel? And try to think about your healthcare practices to make sure that your own biases are not impacting that patient. We still use that doctor for the ear surgery, but I never went back and even though I had a great experience up till then, it colored my impressions of them going forward, because of that one interaction.

So it's important to think, it's important to really make sure that it's not just the ENT and it's not just the nurse practitioner, it's your scheduling staff, it's your front desk staff, because those interactions happen all along the way. And that really ends our talk for today. Thank you so much for sticking it out. Two hours is a long time to sit and listen about implicit bias or any topic really. I did wanna go over a few resources that we have for you. The Everyone Project is a comprehensive implicit bias training program for health care providers and it promotes awareness of implicit bias amongst primary care physicians and their practice teams and provides resources for instructing healthcare professionals on how to use, how to reduce its negative effects on patients.

The implicit Bias Training guide includes a facilitator's guide that provides an overview of what implicit bias is and how it operates in healthcare settings. The resource also offers a participant's guide that allows learners to follow along with activities that include self-assessments, case study examples, small group discussions, and the development of a post-training implementation plan. In a series of videos that can be shared during training, people who are minorities, LGBTQ or amputees communicate the harms of implicit bias from their perspectives as patients who regularly experience bias. The Implicit Bias Training guide also includes customizable PowerPoint presentations to help family physicians adapt implicit bias training by audience and setting. And they cover an overview of implicit bias, science and health effects of implicit bias, mitigation of implicit bias in clinical practice and the creation of a safe and inclusive learning environment.

And we also have a couple of videos here as well about how to outsmart your own unconscious bias. It's a TEDx presentation and those are always wonderful. I just find them very engaging and short enough to keep your attention span if you wanna watch something really short. And then we also have, we all have implicit biases, so what can we do about it? Also at TEDx. And there are two books here as well that are wonderful resources, "Diversity Beyond Lip Service: A Coaching Guide for Challenging Bias" and "Blind Spot- Hidden Biases of Good People." So if you need some extra resources to take your learning further, please look to these resources. And we have a whole bunch of references that we used today to put together this talk.

So feel free if you need some additional information to our references to get some of that science. All right, and with that, we have finished this presentation and I wanna thank everyone who has watched this course on implicit bias. Both Katrinna and myself find that this topic is one of of importance. Whether you're talking about your everyday life and especially your clinic life, making sure that you know what implicit bias is, the different ways that it can impact your life, the different things that you can

do to learn about what your biases may be, the things that you can do to reduce those biases and just per chance a different way to think about this and to frame what other people may be experiencing that may be different from your experience.

If you do have any questions for me, you can find me and email me. If you have any implicit bias questions, you can reach me at Anna.Smith@Continued.com. And if you have any questions for Katrinna as well, you could reach her at Katrinna.Matthews@Continued.com. Again, we really do wanna thank everybody for attending and hope that this, you can take this information with you, take it home, take it to your clinics, really impart some of this wisdom and some of this information with the people you work with, your family at home, and keep the conversations moving. Keep these ideas going outside of this class that you may have had to take as a requirement, but maybe it'll become a passion for you as well. So thank you very much. Have a good day.