Contributions of Systemic and Scientific Racism to Disparities in Patient Care in the Healthcare Field of Black Americans through a Neuroscience and Psychology Lens



By
Elizabeth Debich Student
May, 2021

Allegheny College

Department of Neuroscience and Psychology Program

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A Senior Comprehensive Project in Partial Fulfillment of the Requirements for a Bachelor of Science Degree from Allegheny College

I hereby recognize and pledge to fulfill my responsibilities as defined in the Honor Code and to maintain the integrity of both myself and the College community as a whole.
Pledge
Elizabeth Debich

Approval by the Senior Thesis Committee:

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Dr. Conklin 2nd Reader

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Abstract

Racism is physically bad for everyone's health. In comparison to sixteen different industrialized countries all Americans live shorter and more immunocompromised lives, in comparison to their counterparts across the world (Gilligan, 2015). However, experiencing scientific and institutional/systemic racism in the past and present has been found to produce lasting and long term effects on the quality of patient care received by Black Americans. America's prior medical history has influenced modern day research in irreparable ways. There are three main pathways that are responsible for strengthening implicit biases and maintaining negative health outcomes, which are prolonged discrimination, the physician-decision route, and the physician-patient route (Penner et al. 2014). This review looks at ways in which physicians can combat their implicit biases. The main goals of this literature review are to a.) research medical history and how it led to modern day health disparities in patient care b.) understand why health disparities in patient care persist and potential acute interventions c.) apply a psychological and neuroscientific lens to pre existing literature d.) create bias training workshops applying the literature and my background in social neuroscience and psychology.

Development of Racial Attitudes Over Time

Jones defines racism as "the exercise of power against a racial group defined as inferior" (Jones & Neblett Jr., 2019). Discrimination, predjudice, and sterotypes are key components that make-up racism. Discrimination is the differentional treatment of members of such out groups either by individuals or social instututions (Jones & Neblett Jr., 2019). Discrimination involves strictly behavioral components that involves taking action. Prejudice consists of negative attitudes held toward members of racial outgroups, which usually hold a negative connotation and are marked by negative feelings (Myers and Twenge, 2019 ; Jones & Neblett Jr., 2019). Prejudice, unlike discrimination must involve an affective, cognitive, and behavioral component. However, people don't always act on their prejudices. Prejudice results from targeting an aspect of our social identity, which can include, but is not limited to things like our nationality, racial and ethnic identity, gender, sexual orientation, religion, appearance, disabilities, weight, diseases, and our professions. Common forms of prejudice include racism, sexism, ageism, classism, homophobia, nationalism, religious prejudice, and xenophobia. Stereotypes are very similar to prejudice, but stereotypes make overgeneralizations and simplifications about a group as a whole, rather than holding prejudicial attitudes towards an individual for being a member of a specific group (Myers and Twenge, 2019).

Prejudice is thought to be maintained by five different theories. Scapegoat theory, also called Frustration-aggression theory, was initially proposed by five scientists at Yale (Dollard, Miller, Doob, Mowrer, and Sears, 1939) and further expanded upon. It frames prejudice as a defense mechanism, in which people who are frustrated can deflect their feelings onto another

more disadvantaged group for the problems they face, even when these problems stem from much larger uncontrollable structural changes. A prime example of this can be seen in times of economic anxiety. When the job market tanks, people often blame other racial and ethnic groups for the lack of jobs that are available, stating that if it weren't for immigration there would be more jobs available for the white majority. A second theory that maintains prejudices is known as the authoritarian personality theory, which was proposed by sociologist Theodor Adorno and his colleagues (1950). This theory sees prejudice as the result of a personality type, that of authoritarianism. A third theory that promotes prejudicial attitudes is culture theory, which touches upon the idea that "Everyone's a little bit racist." We are products of our environment and we live in a prejudiced culture, so we should just accept it. We learn through a cultural osmosis, which can most visibly be seen through the fact that history textbooks are primarily written from a Euro-Caucasian viewpoint. The fourth theory involves the social distance scale, which measures how closely people are willing to interact with minorities, which is similar to the idea that larger the geographic distance, the more likely a person is to think that people are more different from themself. Social distance can be a predictor of the likelihood that a person may hold stereotypical or prejudiced views about a group. The last and final theory is race conflict theory which describes how social inequalities develop as the result of varying power dynamics between different racial and ethnic groups. It centers around that idea that if "Whites are the superior race" the power of the majority should be maintained. This is one of the main justifications for maintaining slavery and the events that occured after (CrashCourse, 2017).

Two pertinent forms of prejudice that contribute to institutional/systemic and scientific racism that have emerged are: modern symbolic prejudice and aversive prejudice. While these two types of prejudice have distinct differences they show that these biases result from white

American's internal struggle with competing ideas and beliefs toward Black Americans (Todd et al. 2011). Modern symbolic prejudice avoids blatant derogation of outgroups. People who exhibit symbolic prejudice often view themselves as anti-racist and will deny that they hold racist attitudes, however their feelings and beliefs reflect cultural stereotypes of outgroups. They harbor unconscious negative feelings, attitudes, and beliefs toward Black and indigenious people as well as people of color (BIPOC). They believe that because prejudice is not overtly expressed like it was in the 1950s and 1960s that prejudice is no longer a societal problem and no longer exists. They attribute inequalities and differences in the racial status quo to individual and cultural factors, rather than their direct experiences with people of those groups. In doing so they also neglect to acknowledge the institutional/systemic forces which are one of the main driving forces behind preserving white dominance, instead attributing it to individual and cultural factors. White Americans view the violation of traditional and conservative American values as well as the expression of Black individualism as reason to express unconscious negative attitudes towards the black, indigenious, and people of color (BIPOC) community (Nelson, 2006; Myers and Twenge, 2019; Whitley & Kite, 2010).

People who exhibit aversive prejudice recognize prejudice as bad, but they do not recognize themselves as prejudiced individuals. Instead of acknowledging their prejudices they avoid them. People who exhibit aversive prejudices feel uncomfortable with interacting with members of minority groups and so try to ignore their existence and avoid contact with them. When they have to engage in interracial interaction people who exhibit aversive prejudices, often face a social dilemma in which they struggle with their conscious explicit attitudes, their commitment to egalitarian values, and unconscious implicit attitudes, their learned negative views of Black Americans. They try to be polite and correct when they do have contact with

members of minority groups, but oftentimes their underlying attitudes seek out into their interactions. People who hold this prejudice can be defined as “aversive racists”, generally hold low explicit prejudicial attitudes and high implicit prejudicial attitudes. Aversive racists feel threatened when their egalitarian self image is targeted. These implicit attitudes tend to creep out as biased responses that manifest themselves into pro-white bias. (Nelson, 2006; Myers and Twenge, 2019; Penner et al., 2010; Whitley & Kite, 2010).While both of these theories differ, they share the underlying idea that pro-white biases are dominant. Pro-white bias is a problem, in a well known study conducted by Clark & Clark in 1950 when Black and white children were presented with a baby doll, Black children prefered the white baby doll, exhibiting a pro-white bias.

Regardless, of the type of prejudice people hold, they can be expressed either explicitly or implicitly. Explicit racial bias consists of open outward displays of racism with deliberate intent to treat one race as superior, whereas implicit racial bias is an unconscious and more subtle form of racism, in which individuals are usually unaware of their discriminatory bias. (Stevens and Abernethy, 2018).

The Implicit Association Test (IAT), was developed by Tony Greenwald in 1995, as a way to assess implicit attitudes, stereotypes, and self concepts. It is the most credible and reliable measure in current use for measuring implicit racial bias and has been featured in over 450 published studies. The IAT is a cognitive test based on reaction time between relative association strength between two pairs of concepts, a target concept such as race (White American vs. Black American) and an evaluation (good vs. bad) (Sabin et al., 2009). Many people had never heard the term implicit bias let alone the IAT until the 2016 presidential election when Mike Pence attacked Hilary Clinton’s statement stating that, “I think implicit bias

is a problem for everyone, not just police. I think, unfortunately, too many of us in our great country jump to conclusions about each other. And therefore, I think we need all of us to be asking hard questions about, you know, why am I feeling this way?...” (Clinton, Hillary. Debate. First Presidential Debate. Hofstra University. Long Island, NY. 26 Sept. 2016.) Implicit bias develops early in life from repeated reinforcement of social stereotypes and as the result of being raised in a culture of subtle racism (Stevens and Abernethy, 2018). Studies show that children across the world as young as three years old can begin to exhibit implicit pro-white biases (Bigler and Liben, 2006, Baron and Banaji, 2006). Due to its early development implicit racial bias has a permanent and lasting effect which makes it difficult to unlearn. The formation of implicit bias occurs through associative learning, similar to classical conditioning in which a neutral stimulus is paired with a positive or negative stimulus and as a result elicits a behavior (Smith and Decoster, 2000). Implicit bias has the ability to affect decision making, behaviors, and even perceived perceptual differences (Kreuger, 1992). Given that most of our interpersonal judgements are made on the basis of small observable segments of behavior, which are called “thin slices,” those lasting less than 5 minutes, I think it is important to look at the automatic judgements that result from implicit bias (Ambady et al. 2001).

Daniel Kahneman’s contribution to behavioral psychology, shows us how two types of information processing systems, called system one and system two, can contribute to the expression of implicit and explicit biases (Kahneman, 2011). These two systems work together simultaneously, however approximately 95% of how we think, respond, and make decisions is driven by system one processing.

System one allows us to make more automatic, quick, efficient, impulsive, and unconscious decisions. System one involves the activation of the limbic system and subcortical

regions, areas more involved in processing emotions. Using system one processing allows us to use mental heuristics, such as the availability heuristic, which involves the use of immediate examples that come to a person's mind rather than more factually correct information. For example, when discussing travel plans a person may immediately think that they don't want to fly because planes are more dangerous than cars. However, the opposite is true. We know that on average flying is safer than driving and that on average a person is 19x less likely to die on a plane than in a car. However, plane crashes because they are less common occurrences are more publicized by news media sources, which makes people think the opposite. People draw on the information that is most available to them. Another example of a mental heuristic could be the affect heuristic, in which a person may let their emotional state drive heavily influence their thought processes. For example, they may be extremely upset with the welfare system and don't understand why people can't just get jobs. This feeling may lead people to make the assumptions that Black Americans are on welfare because they are lazy. This is obviously not true and the majority of people on welfare are white Americans, but people often let their emotions influence how they feel about a particular group. When we make judgements like these, we fail to consider other reasons why white and black Americans might be unable to get a job and get off of welfare, such as disabilities, unstable living conditions, employment diuscrimination, or disrupted familial structure, along with a plethora of many other factors. Other commonly used heuristics we often use include the representativeness heuristic and anchoring heuristic amongst others. Mental heuristics like these aren't always a bad thing even though these examples do a good job of demonstrating that they can be. They allow us to take shortcuts to conserve brain power and energy, so that we can go about our everyday lives. Imagine pausing and making deliberate decisions. to do something as simple as turn the porch light off every night, to walk to the

mailbox, or to eat breakfast. We would be mentally exhausted by doing the bare minimum every day.

Contrary to popular belief both systems can be biased and make mistakes in their thought processes, however more of these biases and snap judgements stem from system one strictly because of our heavy reliance on it (Myers and Twenge, 2019, Stevens and Abernethy, 2018). When we use mental heuristics and shortcuts like these they often result in the fundamental attribution error (FAE) (Ross, 1977). The FAE results in a person discounting the situation, by overestimating the effect of the dispositional effects, like an individuals traits and attitudes, rather than the power of other situational influences, like how institutional support can cause these problems by furthering discrimination (Myers and Twenge 2019). System two enables us to construct slow, deliberate, reliable, and thoughtful thoughts, behaviors, and actions in response to stimuli. It involves the activation of areas used more in thought and planning such as the prefrontal cortex (PFC). When people engage in system two processing they take more time to use their cognitive capabilities to stop and think about what they are about to say or do. Most of our social information processing, however, involves the use of system one. Unconscious decisions controlled by mental processes and driven by environmental factors determine the course of our everyday life more often than conscious intentions and deliberate choices. (Bargh & Chartrand, 1999).

These two forms of racial prejudices in particular contribute to scientific and systemic/institutional racism we see in healthcare. Racism results from targeting a person's racial or ethnic identity and as a result can exist on individual, institutional, scientific, and cultural levels. Racism is a result of,

> [T]he transformation of race prejudice and or/ethnocentrism through the exercise of power against a racial group defined as inferior, by individuals and institutions with the intentional or unintentional support of the entire race or culture (Jones and Carter, 1996 pg. 3).

Cultural racism is the belief that one race is superior to another on the basis of culture, heritage, language, and traditions. This often manifests in the form of images and ideas in contemporary culture, such as negative depictions and stereotypes as seen in the news, television, and social media. Institutional/systemic racism is the manipulation of social institutions in order to promote racist objectives. Examples of this type of racism include, racial profiling, predatory lending, and race related disparities in healthcare. Individual racism is the belief that another racial group is inferior and the interpersonal behaviors that maintain those beliefs. Individual racism consists of both overt and blatant actions, such as racial slurs, or covert or subtle actions, such as microaggressions. Microaggressions are stressful encounters which people undergo while performing mundane tasks (Jones & Neblett Jr., 2019). While the overt and blatant racial injustices of the past may have declined, the prevalence of present day racism has not decreased, but rather shifted form. Racism has been described as, " [similar to a] virus that has mutated, racism has evolved into different forms that are not only more difficult to recognize, but also combat (Dovidio & Gaertner, 1998, p. 25)." While present day racism is more subtlely disguised within the fabric of society than past racism, that of which was exhibited in the early 1950s and 1960s, it is no less deadly and can lead to equally aversive consequences (Nelson 2006, Myers and Twenge 2019).

Medical Gaps and Mistrust Generated By Scientific Racism

Scientific racism is the belief that pseudoscience is the basis for justification for promoting racial inequalities. Scientists conduct methodologically flawed experiments, which can be directly or indirectly influenced by their cultural beliefs, values, and expectations. Certain values and beliefs if they carry over into the experiment have the ability to contribute to experimenter bias (Paludi & Haley, 2014). The lasting effects of scientific racism have impacted the modern day medical and healthcare field by generating mistrust in these systems amongst Black Americans. A hallmark of scientific racism is the unethical medical experimentation that enslaved people endured in the antebellum south, that continued to grow and progress in order to support the power dynamic that became known as the plantation owner - physician relationship. Despite the belief that plantation owners and physicians had a shared interest in preserving enslaved people's health, it was for amoral reasons that sought to promote their financial and economic livelihood and aligned with the political interests of both parties. Enslavement could not have remained a prominent institution in the South without the help of the owner-physician relationship. Slavery, which was initatiated by plantation owners, maintained instututional racism, while physicans promoted scientifc racism, which complimented institutional racism nicely and created a power dyiad targeted at African Americans. Scientific and medical justifications from physicans who claimed they were more than certified to assess and study African Americans exploited the bodies of minds of African Americans and allowed for white justification of the profitable institution of slavery and continued support. To give context, at this time almost 90% of the South was made up of enslaved American blacks in 1865, a vast majority of whom underwent inhumane, usually ineffective, excruciatingly painful, and crude procedures, which is documented by physician's memoirs, medical journals, and planters' records (Washington, 2006).

Owners determined when enslaved people needed to receive medical care and oftentimes administered medicine to them themselves, due to the costs of receiving medical care from a physician. The therapeutic line was blurred initially when physicians and owners used whipping as a treatment for the malingering enslaved person. Prescribing physical violence as treatment for the malingering enslaved person is only one example of scientific racism amongst the multitude of ways in which physicians endorsed false beliefs by exploiting the black body and mind. Physicians identified differences that were nonexistent between African Americans and Caucasians and posted scientific publications to gain attention and fame in the medical community. An example of this is, "Crania Americana," a study that was published by Samuel George Morton (1839) that supposedly showed that skull measurements indicated different racial types, which were categorized as Caucasian, Mongolian, Malay, American, and Ethiopian. Morton found that African Americans had smaller skull measurements in comparison to Caucasians. He used this finding to make the generalization that Caucasians had a bigger brain because they had more cranial space and as a result they were deemed as more intelligent. Cartwright followed suit, with his publication of "The Diseases and Peculiarities of the Negreo Race" (1851), which was followed by his discovery of mental illnesses in African Americans that were mainly categorized by a lack of enthusiasm for slavery which were based off of extensive "biblical and scientific findings." He discovered a multitude of imaginary diseases such as drapetomania, dysesthesia aethiopia, and cachexia africana. Drapetomania was categorized by enslaved people exhibiting escape behaviors. Dysesthesia aethiopia focused on the desire of enslaved people to destroy their owner's property and possessions. Cachexia africana was diagnosed based on one's tendency to eat nonfood substances such as clay, chalk, and dirt. His prime recommendation to treat these so called mental ailments were corporal and

physical punishment to work the desires out of their system. Scientific publications like these two contributed to the culture of scientific racism and maintained institutional racism (Washington, 2006). These beliefs constructed by physicians in the 18th and 19th century have carried over today into modern day medicine. Around 73% of people without medical training, endorse at least one false belief about African Americans, which then contributed to the fact that they provided lower pain ratings for Black versus white patients in vignettes, showing an interaction between false beliefs and race. Even more surprising, approximately 50% of participants with some medical training (i.e. medical students and residents), reported at least one of the false beliefs to be true, they too provided lower pain ratings for African Americans (Hoffman et al., 2015).

Nineteenth century influx of medical experimentation furthered these problems, in which enslaved people were taken advantage of and routinely bought for the sake of medical progress. The beliefs about African Americans induced by physicians a century earlier provided adamant justification for abusive medical experimentation.

Medical remedies, including medications, dosages, and surgical experiments of the time became daily practice among enslaved people and were extremely controversial with an equal chance of finding a cure-all or imminent death. Enslaved people were given metabolic poisons as medicine, with no regard to dosage, such as arsenic, mercury, opium, morphine, and cocaine derivatives. For example, mercury contributed to injury of the nervous system, mental deficits, hair and tooth loss, kidney and heart disease ,lung injury, and respiratory distress. In pregnant women this also contributed to infant mortality. If these substances didn't kill them, it frequently induced chemical pneumonitis and lung injury (Washington, 2006, 25-52).

However, one of the most well known examples of experimentation on enslaved people is seen within the highly controversial work of Marion J. Sims, a man often regarded as the modern father of surgical gynecology. Dr. Sims embodies the dual face of American medicine, while he saved countless women from debility, he also performed unethical and brutal medical experiments on enslaved women (Washington, 2006, p. 61,69). Dr. Sims sought out to repair tears to the vesicovaginal fistula, which resulted due to complications in childbirth. Tears to the vesicovaginal fistula result in constant discomfort from a continuous stream of urine and (occasionally feces) running down their legs at almost all times. Women with tears to their vesicovaginal fistula also oftentimes suffer from infertility, loss of vaginal function, damage to the pubic bones, neuromuscular damage to their lower extremities, recurring pelvic and urinary tract infections, diminished self esteem, damaged body image, as well as depressive symptoms and suicidal ideations. From 1845 -1849 Dr. Sims experimented on Black enslaved women, with his first patient being Anarcha, a woman whom he conducted 30 different operations on before he was able to fix the hole in her bladder. Sim's silver sutures he patented for the surgical procedure, was a significant medical contribution that prevented women from infections, but it came at a cost (Washington, 2006, p. 69). Much like many historical accounts there are two versions of Dr. Sims' work, while some praise him for his medical accomplishments, others feel that his claim to fame was achieved by unethical experimentation on powerless unconsenting Black enslaved women. Two articles, one by Wall, 2005 and one by Ojanuga, 1993, showcase the power of perspective.While no one knows the whole truth regarding Dr. Marion Sims' work, it is important to note that these discrepancies amongst historical accounts only creates further mistrust in the medical system, much like that seen in the Tuskegee study.

While the Tuskegee Study of Untreated Syphilis in the Negro Male (Pesare et al., 1950) , a study conducted by the United States Public Health service from the 1930s to the 1970s, was thought to be the root of medical mistrust amongst the African American community, studies show that mistrust is more likely to stem from historical and patterns of negative interactions with the healthcare system. The Tuskegee study is oftentimes regarded as the "catch-all" as to why African Americans distrust medical care, which based on the results of the study by Brandon et al., 2015 is far from true. Based on phone interviews, researchers found approximately % of white and Black participants were even aware of the Tuskegee study, with no significant racial differences in awareness. However, based on answers to the survey researchers did find that the Black race was a significant predictor for medical mistrust even after controlling for demographic variables, awareness of the study, and insurance status. African Americans believed that those who were aware of the study were 130% more likely to believe that a similar study could happen again. The Tuskegee study is not the only reason for widespread medical mistrust and I think that in order to firmly grasp the reasons for medical mistrust people have to delve deeper into historical events, personal accounts and experiences, and occurrences of negative patterns of interactions (Brandon et al., 2005). Between unjust historical events, fabricated scientific publications, and contradicting legislative rulings, it is not surprising that these abuses fed iatrophobia, the fear and negative feelings that Black Americans hold towards the medical/healthcare systems. Hospitals and clinical hospitals for enslaved people, were backyard shacks in which there was a lack of thoroughly thought out "research experiments", which frequently resulted in spontaneous and unrecorded research. (Washington, 2006, p. 57). Not only were enslaved people wary of the medical system because of these injustices, but also because Western medicine had no parallels to the spiritual and community based healing

remedies typically used in African American communities (Washington, 2006, p. 56). It has been speculated that there are transgenerational effects that can be passed down from generation to generation from these injustices (Jones & Neblett Jr., 2019).

Physician's Implicit Bias

A majority of our multitude of short interactions drives much of our interpersonal interactions in life, and can be hugely affected by biases. One aspect of our everyday life that contains critical brief human-human interactions can be seen in the healthcare industry. It has been found that implicit biases held by healthcare workers, such as physicians, regarding the BIPOC community vary based on the physician's gender and race. For example, it has been found that female physicians typically exhibit less implicit and explicit biases towards people of color than male physicians. In the same study, out of a sample of 2,535 MDs of varying races, black physicians were the only race to exhibit little to no implicit bias in the healthcare setting, based on Race Attitude Implicit Association Tests (IAT) scores and explicit self report measures examining racial attitudes on a Likert scale (Sabin et al. 2009). Due to these findings, many researchers favor the idea of introducing system-focused approaches at the institutional level, such as the collaboration between insurance companies, health care policy makers, and hospital employees/staff to work together to reduce biases and racial disparities across patient care. However, even in universal healthcare systems implicit biases held by healthcare workers towards people of color lead to racial and ethnic disparities (Saha et al. 2008). Since, universal healthcare still suffers from these disparities in patient care standardizing medical treatment for diseases may not prove to be the best route to prevent or minimize the effects of implicit biases,

which leads us to look elsewhere for other potential targets responsible for the development of racial disparities.

There are currently three main pathways that are responsible for strengthening implicit biases and maintaining negative health outcomes. If these pathways are not targeted and addressed they can further facilitate racial disparities in patient care. I would like to address the effects of prolonged discrimination, the physician-decision route, and the physician-patient route (Penner et al. 2014).

Prolonged discrimination can lead to the development of chronic illness and disease due to an increased negative stress response both physiologically and psychologically. The aversive effects of racism can start as early as the gestational period, with prenatal effects that can last a lifetime (Gee et al., 2012;Harrell et al., 2011). Stress neuorbiology framework proposes that experiences of chronic racial discrimination can lead to physiological changes due to the activatation of stress hormones, such as cortisol and neurotransmitters, like dopamine which can impact functional brain networks (PFC) in turn leading to structural and network activity changes (Jones & Neblett Jr., 2019). Another example of physiological changes as a result of chronic stress is seen in patients who also experience higher incidences of hypertension, diabetes, respiratory problems, cardiovascular disease, and depression (Penner et al., 2015). It is known that prejudice and discrimination are responsible for maintaining racial disparities in the healthcare system because when various other determinants of health are controlled for such as socioeconomic status (SES), as well as other social, economic, and political processes health care disparities still persist (Bravemen, 2012).

A report from The Institute of Medicine called *Unequal Treatment* (2003) also shows that, “Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers

may contribute to racial and ethnic disparities in health care." The prevalence of racial disparities as well as their underlying causes of prejudice and discrimination in the healthcare system are not understood to their full extent, which can be detrimental to patients in terms of recieving equitable health care access, treatment, and care. One report found that a mere 39% of female physicians and 26% of male physicians agreed that patients received unfair treatment due to race on a very or somewhat often basis (The Kaiser Family Foundation,2002), demonstrating the lack of understanding surrounding the perpetuation of health care disparities.

The physician-decision route can influence the physician's decisions about the medication and treatment patients are prescribed especially when physicians are under the influence of variables such as clinical uncertainty, physician fatigue, a high workload, stress, changing environments, time crunches, and pressure (Chisolm-Straker & Straker, 2017; Penner et al. 2014). Prescribing pain medication is one area in which clinical uncertainty is common, because it is subjective. One study found that physicians with low pro-white bias agreed to prescribe Black Americans five more days of oxycodone, the recommended treatment in this situation, whereas physicians high in pro-white bias did not agree (Sabin et al. 2012). It is clear that patients may receive different diagnoses due to a physician's potential racial biases. Another study done by Green et al. 2007 found that physican's implicit bias contributed to different treatment for thrombolysis for Black and white patients. Physicians were more likely to diagnose Black (40.1%) than white patients (29.8%) with coronary artery disease (CAD) and that white patients (58.2%) compared to Black patients (42.7%) were more likely to be offered thrombolysis treatment for myocardial infarction (Green et al. 2007). As antiBlack bias increased, recommendations for thrombolysis treatment decreased. Racial biases are prevalent in pain perception and treatment as well. Scientists in a study by Mathur et al., 2014 asked

participants, in response to vignettes about patients' pain, to rate pain perception, empathy, helping motivation, and treatment suggestion, while a rapid (implicit condition) or static picture (explicit) of an African or European American's face was presented. They found that the participants who were in the implicit condition perceived and responded more to pain in European-Causians rather than African Americans. However, participants in the explicit condition, received and responded more to pain in African Americans. There was also a main effect for gender found in the study, showing the females perceived and responded more overall to patients regardless of their race. There was also a race effect, which showed that overall African Americans were more perceptive and responsive to the pain of others overall (Mathur et al., 2014). Decisions regarding health care can not only mean the difference between living in pain, but also the difference between life and death.

Effects on Patient Care

The physician-patient route shows us that poor interactions can negatively affect patients and enable future distrust of the healthcare system. Face to face interracial interactions can lead to feelings of anxiety, discomfort, and unease which may cause a person's implicit biases to "creep out," which ultimatley leads to racial anxiety (Blascovich et al. 2001,Stephan & Stephan, 1985,Trawalter et al. 2009). This is a problem given that face to face interracial interactions are unavoidable (Todd et al. 2011) and that approximately 75% of medical interactions in the healthcare system occur between patients and physicians of a different race (Penner et al. 2007). While explicit biases are less prevalent, it only places more importance on a physician's implicit nonverbal behaviors. When someone is concerned about appearing outwardly racist it can lead to the expression of avoidant nonverbal signals (Myers and Twenge, 2019). Studies have revealed that white Americans who hold negative implicit attitudes towards Black Americans exhibit less nonverbal friendliness during interracial interactions which can be seen through the expression of

more avoidance oriented behaviors (e.g., gaze aversion, increased interpersonal distance) and less approach oriented behaviors (e.g., smiling, leaning forward) (Todd et al., 2011; Dovidio et al. 2002 ; Fazio et al. 1995 ; McConnell & Leibold, 2001). When people have positive evaluations they tend to express more approach related motor responses, whereas when people have negative evaluations they express more avoidance related responses (Feltman and Elliot, 2012). Most inconsistencies in nonverbal behavior and implicit racial biases in the health care system can be easily detected by Black Americans which then can lead to reticence, the illusion of distrust, and less harmonious relationships (Todd et al, 2011). Approach oriented nonverbal behaviors can work to the advantage of both the physician and the patient and create a better relationship between the two. For example, patient satisfaction has been found to be related to the expressiveness of the physician which includes the incorporation of nonverbal behaviors such as spending less time reading medical charts, leading forward more, nodding more, using more gestures, a closer interpersonal distance, and more gazing (Hall et al. 1995). In addition, physicians with better nonverbal communication skills not only have higher levels of patient satisfaction, but suffer less medical malpractice litigations (Ambady et al. 2002).

The quality of care received and rated by patients is also impacted by their physician's gender. Female physicians obtain higher patient satisfaction ratings across various measures of patient care in comparison to their male counterparts (Bertakis et al. 2003). For example, patients under the care of female physicians were found to have and enjoy more collaborative relationships, longer visits, and more discussions centered around social and emotional issues (Roter and Hall 1998). Female physicians were also rated higher on their nonverbal behaviors as well, such as increased gazing at the patient rather than the medical chart, less interpersonal distance, and the use of a softer tone of voice which were predictors of higher patient satisfaction

ratings (Schmid et al. 2008). During both regular and clinical visits, female physicians were also rated as more participatory by patients (Cooper-Patrick et al. 1999). Female physicians as a whole are liked more by patients than male physicians in healthcare settings (Hall et al. 2002). This finding may be partially due to the fact that women in general are perceived to be more understanding, helpful, and kind (Eagley, 1994). "The women are wonderful effect," a theory proposed by Eagley in 1994, demonstrates that most people like women more than men because of the light women have been painted in and the gender roles that reinforce these perceptions. While this is a psychological theory, I believe that it may play a role in the findings listed above and throughout the healthcare setting. It is an area that should be further investigated.

All three pathways are extremely important and offer potential areas in which racial health disparities can be improved upon. If these structures remain unchanged, patients who experiece discrimination in the healthcare field will continue to face problems such as delays in timely treatment, interuptions in the continuity of care, and mistrust and avoidance of the health care system (Sabin et al. 2012).While biases do not change overnight, multiple acute interventions have been proposed that have the ability to help implement small beneficial changes into the healthcare system, which then have the potential to facilitate large scale social and institutional changes that can lead to the end goal of equitable and improved patient care. Sadly, we will not be able to eliminate racial bias any time soon, but by developing specific skills and techniques we can limit its impact.

Strategies to Combat Implicit Bias: Acute Interventions

One form of acute intervention that has been discussed in the literature is the use of perspective taking. Perspective taking allows us to reduce racial health care disparities by targeting varying levels of physicians implicit biases. As mentioned earlier there are three common pathways in which disparities can develop; perspective taking focuses on targeting the

physician-patient route. By “putting yourself into someone else’s shoes,” people are better able to actively engage in the contemplation of others' psychological experiences which can lead to the use of more system two thinking. Research shows that taking the perspective of a model Black target or someone who fits the mold of a model citizen, such as Martin Luther King Jr., produces more positive group based activation rather than negative activation. However, one must be careful not to enforce model minority stereotypes in doing so. Perspective taking has the ability to create more positive interracial evaluations as a result. By taking the perspective of a Black target people are able to heighten their motivation to at the very least try to be unbiased. (Devine, 1989, Plant and Devine,1998). Through a series of five experiments examining the effectiveness of perspective taking on automatic evaluations of black verses white Americans researchers found that participants in the perspective taking condition which involved the use of a narrative essay task, led to more favorable automatic interracial evaluations, the use of more approach rather the avoidance behaviors, and interpersonal behaviors as demonstrated by IAT scores and other tasks (Todd et al. 2011). In comparison to Vorauer et al.’s study perspective taking appears to only be beneficial for short periods of time (approximately 3 minutes in this study).Vorauer et al.’s study did not show significant results for perspective taking during 15 minute interactions.

I thought a useful application of this could be used during primary care office visits. While the average visit for patients is approximately 17.4 minutes, with median length of visits being around 15.7 minutes, during which the physician spends a median of 5.2 minutes while the patient typically spends 5.3 minutes talking, with a median time of 55 seconds of silence (Tai-Seale, 2007). If the patient is talking for 5.3 minutes then perspective taking for the

physician could be useful given that the structure of visits in the healthcare system involves physicians and patients usually talking in blocks of time.

Another form of acute intervention involves the use of education, not only amongst medical school students, but the general population as well. Implicit bias is today's modern prejudice and has the potential to unconsciously affect individuals with the best intentions, including medical professions (Myers and Twenge, 2019). Research has found that even just exposing participants of studies to the IAT and explaining their results has the ability to generate more overall awareness surrounding the issue of implicit bias in the healthcare system. After taking an IAT meant to examine how implicit bias can affect thrombolysis predictions amongst physicians, 74.8% of participants said that they felt that taking the IATs was a worthwhile experience. 76.1% of participants also agreed that they felt that just learning about implicit bias held the potential to improve patient care (Green et al. 2007)

The prejudice habit model also supports the effects education can have by demonstrating that while people often view biases as "habits of mind," low prejudiced people are better able to suppress prejudicial behaviors and actions and engage more of system two processing, which is responsible for making conscious, deliberate, and more reliable complex decisions. Education can aid in making people consciously aware of their unconscious biases, which may cause people to better combat and control their automatic unconscious thoughts. Devine's work emphasizes the importance of finding the motivation to control prejudice by mastering intact cognitive control capabilities (Devine 1989). There are regions of the brain that have been implicated in their role of regulation in racial bias such as the ACC and diPFC. However, in correspondence with Devine's work the racial bias can be taxing to their functioning resources, leaving one's cognitive ability impaired after an interracial interaction (Amodio et al. 2006,

Kubota et al. 2012). Further work conducted by Devine et al., 2012 combined various other strategies such as stereotype replacement, counter stereotypic imaging, individuation, perspective taking, and increasing opportunities for contact to "break the prejudice habit," that her previous work had focused on extensively. Using these debiasing techniques for 4 weeks resulted in lower IAT scores, which is indicative of lower levels of implicit bias, with effects lasting up to 4 weeks after the initial IAT test during follow-up. This is one of the first successful studies in this area and has been replicable. A replication study was conducted by Forscher et al. in 2017 in which they tripled the sample size of the original experiment and results aligned with the original study showing that results persisted two weeks after.

Communication is an extremely important and often overlooked facet of the physician-patient relationship. According to the Accreditation Council for Graduate Medical Education interpersonal and communication skills is one of the six core competencies and an area that many faculty members find challenging to teach (Al-Temim et al. 2016). Embodying a caring communication style involves expressing empathy, utilizing statements of reassurance and support, providing positive reinforcement, having a carefree and fun attitude, exhibiting courtesy, and using psychosocial talk, all of which can improve the physician patient relationship drastically (Beck et al. 2002). Empathy, in the context of the healthcare system, is the ability of the physician to understand and share the patient's personal experiences without bonding with them. It is thought that inducing empathy is a way to improve the physician-patient relationship, by implementing more empathy measures and training into the healthcare system we have the potential to improve racial interactions and attitudes toward stigmatized groups. Empathy has the ability to cross over emotional,cognitive, and behavioral dimensions (Moudatsou et al. 2020) and has been correlated with higher patient satisfaction as well as adherence to treatment, and

psychological adjustments to illness (Cousin et al. 2012). This is an important finding given that recent studies show that after the second year of medical school, medical students exhibit decreased empathy scores that persist throughout the rest of their schooling and can even seep into their careers. Ironically this is when students are the most involved with patient care activities and interactions (Hojat et al. 2009). Perceiving pain in others activates the pain matrix in the observer, this shared neural representation can lead to the expression of empathy or personal distress for the patient. When watching visual animated stimuli of needles being injected into various body physicians, in comparison to the control group, showed significantly less brain activation on fMRI scans in regions such as the anterior insula somatosensory cortex, periaqueductal gray, and anterior cingulate cortex areas associated with pain processing. The experienced acupuncturists instead showed more activation in the medial and superior prefrontal cortices and the temporoparietal junction, areas which are involved in emotion regulation and theory of mind. This finding suggested that experts who are constantly exposed to painful/ pain inducing situations may have developed a regulatory response to others' pain to mediate personal distress. This however, suggests they are also less empathetic in response to others pain (Cheng et al. 2007). A lack of empathy in the healthcare system can also lead patients to feel dehumanized and deindividuated (Haque & Waytz, 2012). Knowing that adequate expression of empathy is an important component of facilitating a caring communication style in the physician patient relationship could imply that empathy training may be another useful form of acute intervention to improve patient care. In a randomized controlled trial, resident physicians who underwent empathy training over the course of four months they showed a greater changes from their pre to post patient related CARE scores, a ten question survey that measures empathy in the physician-patient relationship, indicating that empathy training can improve the quality of patient

care (Riess et al. 2012). Implementing having patients take the survey for the CARE measure of empathy pre- and post- visit could enlighten physicians as to how well they actually express empathy during their visits and leave room for personal improvement.

Research also demonstrates that how people view empathy, as a skill or trait, can effectively predict how likely a person is to engage in empathy (Rataka, 2018). People who view empathy as a skill that can be improved upon, have a more malleable definition of empathy and exhibit higher levels of self-reported empathetic concern in challenging situations. This finding demonstrates that empathy in comparison with other variables in the caring communication style may be easier to manipulate, which could increase empathy's positive effects in patient satisfaction. While women are perceived as more empathetic, studies have found that when incentive or motivation (e.g., money, feedback) is provided, gender differences on empathic accuracy tasks are eliminated (Klien and Hodges 2001). Based on this finding empathy may be one variable involved in the embodiment of a caring communication style that could be manipulated, without enhancing pre-existing gender biases in the healthcare field. Something like using pre- and post- CARE measures could provide the feedback physicians need to express more empathy during visits.

While some of these interventions may seem taxing or time consuming, they may be able to prevent further racial disparities in the healthcare system from developing, leading to the end result of better patient care for members of the BIPOC community. The healthcare system prides itself on its ability to provide affordable quality care and I think that it is time that they live up their promises and provide affordable quality care for everyone. Before people set out to change or improve people's preexisting implicit biases they need to be aware of a vast array of psychological and neurological underpinnings surrounding biases. While the adverse and

negative consequences of implicit biases in the healthcare system have been recognized their root cause has not been thought about. The healthcare system is not the only domain in which this research is important and pertinent, as many of the same problems arise in the education system and the workplace.

Bias Training

Workshop A: Back to the Basics; Understanding and Applying Race Based Terminology

Training (Facilitator Copy)

A. Session 1

Goals / Learning Objectives:

- Understanding and applying basic terminology
- Being able to differentiate the difference between prejudice,racism,sterotypes,bias, and discrimination
- Understanding the framework of out social processing centers (system one and two)
- Identifying and differentiating between four different types of racism
- Creating a safe space and facilitating interactive and engaging conversation with peers

This bias training is applicable to anyone who deals with...
Age • Body habitus • Color • Disability • Economic status • Gender identity • Immigration status • Mental health • Nationality • Race/Ethnicity • Religion • Sexual orientation • Healthcare • Medicine

9:30 am : Meet and Greet (Coffee and Donuts)

10:00 a.m. Introductions (Sample Questions, can be changed to fit the facilitator's preferences)

- Name
- Where do you call home?
- If you could eat only one food for the rest of your life what would it be ?
- Fun fact about yourself

10:30 a.m. Get to Know Your Instructor

On a piece of paper, write down what you think that my...

- Age
- Job
- Hobby
- Marital Status
- Religion
- Vehicle of choice
- Pets

Is…

Have a couple volunteers discuss what they think the answers to these categories are

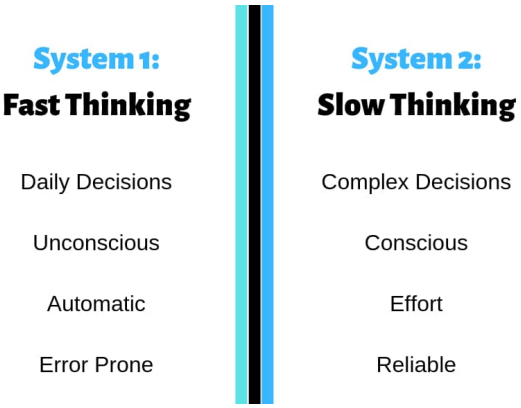
10:45 a.m. Segue into Snap Judgements

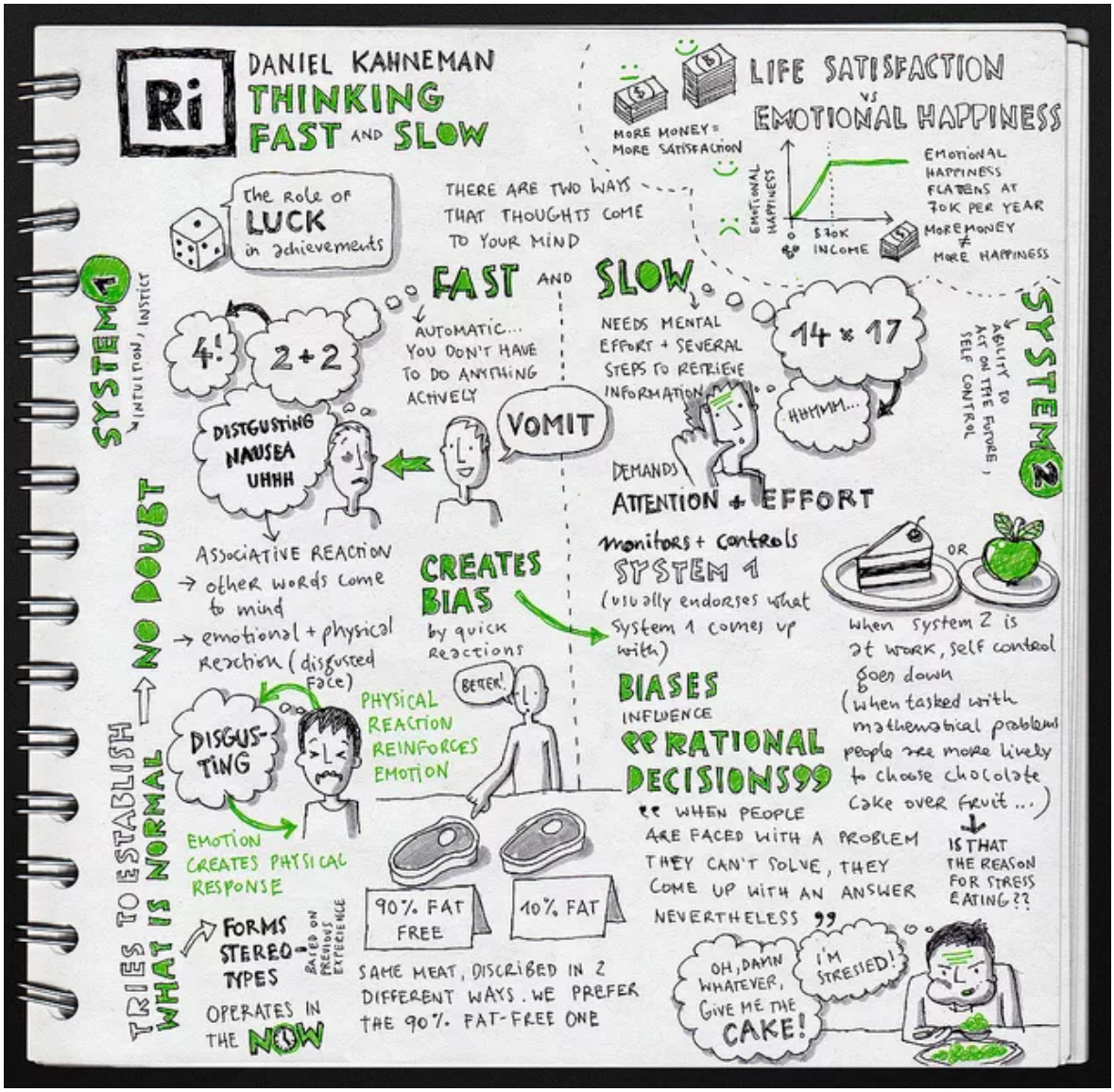
Talking Point: Now that you have decided who you think I am, let's talk about what the "reality" is. There's almost always a major gap between perception and actuality. Most of our interpersonal judgements are made on the basis of small observable segments of behavior, which are called "thin slices," those lasting less than 5 minutes (Ambady et al. 2001). We form first impressions from facial expressions, which is one of the reasons why first impressions can make such lasting impressions on us (Zebrowitz, 2017) By making these "snap judgements," we carry assumptions (and indirectly prejudice) about most people based on the way they look.
***Instructor will then provide the correct answers to these questions

Talking Point: Why do we make snap-judgments?

- System 1 and 2 social processing centers! Daniel Kahneman, made this contribution to the field of behavioral psychology, which he then popularized in his bookThinking, Fast and Slow in 2011. These systems work simultaneously and are meant to complement each other.
    - Explain images then proceed to discussing next bullet point
        - Most of our decisions are made by system one. Without these social processing centers we would be mentally exhausted by just doing the basics everyday. Can you imagine using a slow and deliberate thought process every time you have to flip on a light switch? Scratch your leg ? Walk up the street? However, as we've seen earlier using only system one judgements can get us in more trouble typically and there are certain times where we need to imply more of system two thinking. BUT system one and two can both make mistakes!

Thinking, Fast and Slow: By Daniel Kahneman




Ri
DANIEL KAHNEMAN
THINKING FAST AND SLOW
LIFE SATISFACTION vs EMOTIONAL HAPPINESS
MORE MONEY = MORE SATISFACTION
EMOTIONAL HAPPINESS
$70K INCOME
EMOTIONAL HAPPINESS FLATENS AT 70K PER YEAR
MORE MONEY ≠ MORE HAPPINESS
The role of LUCK in achievements
THERE ARE TWO WAYS THAT THOUGHTS COME TO YOUR MIND
SYSTEM 1
INTUITION / INSTINCT
FAST AND
AUTOMATIC... YOU DON'T HAVE TO DO ANYTHING ACTIVELY
SLOW
NEEDS MENTAL EFFORT + SEVERAL STEPS TO RETRIEVE INFORMATION
SYSTEM 2
ABILITY TO ACT ON THE FUTURE / SELF CONTROL
4!
2+2
14 * 17
HMMM...
DISTGUSTING NAUSEA UHHH
VOMIT
DEMANDS ATTENTION + EFFORT
ASSOCIATIVE REACTION
→ other words come to mind
→ emotional + physical reaction (disgusted face)
CREATES BIAS
by quick reactions
monitors + controls SYSTEM 1
(usually endorses what System 1 comes up with)
OR
when System 2 is at work, self control goes down
(when tasked with mathematical problem people are more likely to choose chocolate cake over fruit ...)
IS THAT THE REASON FOR STRESS EATING??
BIASES INFLUENCE "RATIONAL DECISIONS"
" WHEN PEOPLE ARE FACED WITH A PROBLEM THEY CAN'T SOLVE, THEY COME UP WITH AN ANSWER NEVERTHELESS "
TRIES TO ESTABLISH WHAT IS NORMAL
NO DOUBT
DISGUS-TING
PHYSICAL REACTION REINFORCES EMOTION
BEHER!
EMOTION CREATES PHYSICAL RESPONSE
FORMS STEREO-TYPES
BASED ON PREVIOUS EXPERIENCE
OPERATES IN THE NOW
90% FAT FREE
10% FAT
SAME MEAT, DISCRIBED IN 2 DIFFERENT WAYS. WE PREFER THE 90% FAT-FREE ONE
OH, DAMN WHATEVER, GIVE ME THE CAKE!
I'M STRESSED!

System 1	System 2
Unconscious reasoning	Conscious reasoning
Mostly involuntary	Mostly voluntary
Mostly linked to emotions ("gut feeling")	Mostly detached from emotions
Implicit	Explicit
Automatic	Controlled
Low Effort	High Effort
Large Capacity	Small Capacity
Rapid	Slow
Default process (suppressed by System 2, intense concentration)	Inhibitory (suppressed by clearing mind, meditation)
Association (A↔B)	Implication (A→B)[1]
Contextualized	Abstract[1]
Domain-specific	Domain-general
More subjective, Value-based	More objective, Fact/Rule-based
Evolutionarily old	Evolutionarily recent
Nonverbal	Linked to language
Includes recognition, perception, orientation.	Includes rule following, comparisons, weighing of options.
Modular Cognition	Fluid Intelligence

Is this a system one or two decision?

- (1) Multiplication Facts
- (2) Deciding where to apply to graduate school
- (1) Putting on your clothes in the morning
- (2) Planning a vacation to Aruba
- (1) Driving to work
- (2) Starting a new construction project

11:00 a.m. Activity: Brainstorm, What's the first thing that comes to mind when you hear the words?

- 5 minute brainstorm (fold a piece of paper into four sections and write what you think they are under each section)
    - Racism
    - Prejudice
    - Discrimination
    - Bias - (Explicit and Implicit)
- 5 minute Share Out - Call on participants who choose to offer what they think each one means/components/associations

11:10 a.m. Video: Stereotypes, Predjudice, and Discrimination (Crash Course Sociology Video #35)
https://courses.lumenlearning.com/wm-introductiontosociology/chapter/stereotypes-prejudice-and-discrimination/ (~11.5 minute video)

11:20 a.m. Clarification and Elaboration on Predjudice,Stereotypes,Discrimination, and Bias
What did we learn here?

- Prejudice = Beliefs,Thoughts, Feelings, or Attitudes held towards a person of a different social group
    - Ambivalent prejudices - mix of both positive and negative attitudes, depending on what the situation calls for
    - White Americans evaluations of Black Americans who are presented positively or negatively tend to be more extreme than evaluations of similar white individuals
        - Example: Your neighbor whom is a Latinx American is convicted of possession, even though it was planted, you may react by saying you knew he was always a part of drug ring or that he was always very secretive and suspicious
        - BUT if your neighbor were white, you may defend them by saying that they were a good neighbor or that they would never do anything like that
    - Aversive prejudices - feeling uncomfortable interacting with people of minority groups
        - Example: In the grocery store, choosing to check out with the white clerk instead of black clerk, to avoid feelings of discomfort
    - Hostile prejudices - negative attitudes towards members of the outgroup
        - Example: “Why do handicapped people always get better parking spots?” -Taking the spot, because you hate the privileges they receive as a result of their social group
    - Benevolent prejudices - positive attitudes towards members of the outgroup (typically chivalrous acts towards women)
        - Example: The idea that men have a duty to protect women. While this doesn’t sound like that bad of a statement, it implies that women are weak and can’t protect themselves
        - (Whitley & Kite, 2010)
- You may not act on your attitudes
- Prejudices must contain an …
    - Affective Component
    - Behavioral Component
    - Cognitive Component
- What maintains prejudice/why does it exist?
    - Scapegoat Theory/Frustration Aggression Hypothesis

    - Authoritarian Personality Theory
    - Culture Theory
    - Race Conflict Theory
    - Social Distance Theory

- Stereotypes
    - Simplified over generalizations about groups of people
- Examples: Women can't drive, Blondes are ditzy, Gingers have are hot tempered, Tattoos are unprofessional, Men don't ask for directions

11:30 a.m. Video : Prejudice Versus Discrimination

Real Life Example : Sexist CEO - reference khan academy video - helps better define the distinction between prejudice and discrimination

- https://www.khanacademy.org/test-prep/mcat/individuals-and-society/social-interactions/v/prejudice-vs-discrimination (~2.5 minutes)

- Discrimination = Action
    - Only involves the behavioral component
    - Think things like racial slurs, unequal employment opportunities, and arrest rates for crimes

11:40 a.m. Podcast: NPR, We Are Repeating The Discrimination Experiment Every Day, Says Educator Jane Elliott (~3 minute segment)

Blue eyed Brown eyed experiment

- https://www.npr.org/sections/live-updates-protests-for-racial-justice/2020/07/08/888846330/we-are-repeating-discrimination-experiment-every-day-educator-says

11:45 a.m. Video: 12 Cognitive Biases Explained - How to Think Better and More Logically Removing Bias

- https://www.youtube.com/watch?v=wEwGBIr_RIw (~10 minutes)

12:00 p.m. Video: Implicit Bias Check Our Bias Wreck Our Bias

https://www.pbs.org/video/pov-implicit-bias-check-our-bias-wreck-our-bias/ (~3 minutes)

12:05 - 12:45 - Lunch

12:45 - 1:30 - Activity: Jigsaw Learning (Pt 1 - Individual and Cultural Racism Groups)

- Each small group, composed of 4-5 participants is given one of the four types of racism and is asked to learn about and to teach others about it. After each presentation, the facilitator will discuss further topics that may not have been touched upon. Groups will be given approximately 20 minutes to develop their presentation and then 7-10 minutes to present.

Presentation Objectives/Goals :

Create an informal presentation that is approximately 7-10 minutes long and addresses the following...

- Address what is said form of racism : Provide a definition
- How can it adversely affect people?
- Why is this type of racism a problem?
- List three modern day examples of how this type of racism applies or occurs in today's society

Cultural Racism

- "Images and ideas in contemporary culture"
- Negative depictions and stereotypes of BIPOC in TV, books,newspaper, and the exclusion of BIPOC in textbooks, course curriculum, and the media
    - Token Black Characters

Individual Racism

- Belief that another racial group is inferior and the interpersonal behavioral enactments that maintain these beliefs
    - When someone is concerned about appearing outwardly racist it can lead to the expression of avoidant nonverbal signals (Myers and Twenge, 2019). Studies have revealed that white Americans who hold negative implicit attitudes towards Black Americans exhibit less nonverbal friendliness during interracial interactions which can be seen through the expression of more avoidance oriented behaviors (e.g., gaze aversion, increased interpersonal distance) and less approach oriented behaviors (e.g., smiling, leaning forward) (Todd et al., 2011; Dovidio et al. 2002 ; Fazio et al. 1995 ; McConnell & Leibold, 2001).
    - Most inconsistencies in nonverbal behavior and implicit racial biases in the health care system can be easily detected by black Americans which then can lead to reticence, the illusion of distrust, and less harmonious relationships (Todd et al, 2011). Approach oriented nonverbal behaviors can work to the advantage of both the physician and the patient and create a better relationship between the two.
    - **Video of common types of nonverbal behaviors**
      https://www.verywellmind.com/types-of-nonverbal-communication-2795397

1:30 - 1:40 p.m. - Break

1:40 - 2:20 p.m. - Activity: Jigsaw Learning (Continued Pt 2 - Institutional/Systemic and Scientific Racism Groups)

Institutional/Systemic Racism

- "Manipulation of societal institutions in ways that achieve racist objectives or limit the access and rights of a group"
    - Social determinants of health

Video: Systemic Racism Explained (~4.5 minutes)

- https://www.youtube.com/watch?v=YrHIQIO_bdQ

Scientific Racism

- "The pseudoscientific belief that empirical evidence exists to support or justify racism"
- Discuss studies briefly such as Tuskegee, Marion Sims, etc.

2:20 - 2:30 p.m. Facilitated Discussion: How Much Did You Learn?

- Come up with scenarios and have participants decide what categorie(s) they belong in by voting with colored cards

Training (Participant Copy)

A. Session 3

Goals / Learning Objectives:

- Understanding and applying basic terminology
- Being able to differentiate the difference between prejudice,racism,sterotypes,bias, and discrimination
- Understanding the framework of out social processing centers (system one and two)
- Identifying and differentiating between four different types of racism
- Creating a safe space and facilitating interactive and engaging conversation with peers

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- Name
- Where do you call home?
- If you could eat only one food for the rest of your life what would it be ?
- Fun fact about yourself

10:30 a.m. Get to Know Your Instructor

On a piece of paper, write down what you think that my...

- Age
- Job
- Hobby
- Marital Status
- Religion
- Vehicle of choice
- Pets

Is…

10:45 a.m. Segue into Snap Judgements

11:00 a.m. Activity: Brainstorm, What's the first thing that comes to mind when you hear the words?

- 5 minute brainstorm (fold a piece of paper into four sections and write what you think they are under each section)

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- Prejudice
- Discrimination
- Bias - (Explicit and Implicit)

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- https://www.npr.org/sections/live-updates-protests-for-racial-justice/2020/07/08/888846330/we-are-repeating-discrimination-experiment-every-day-educator-says

11:45 a.m. Video: 12 Cognitive Biases Explained - How to Think Better and More Logically Removing Bias

- https://www.youtube.com/watch?v=wEwGBIr_RIw (~10 minutes)

12:00 p.m. Video: Implicit Bias Check Our Bias Wreck Our Bias
https://www.pbs.org/video/pov-implicit-bias-check-our-bias-wreck-our-bias/ (~3 minutes)

12:05 - 12:45 - Lunch

12:45 - 1:30 - Activity: Jigsaw Learning (Pt 1 - Individual and Cultural Racism Groups)

- Each small group, composed of 4-5 participants is given one of the four types of racism and is asked to learn about and to teach others about it. After each presentation, the facilitator will discuss further topics that may not have been touched upon. Groups will be given approximately 20 minutes to develop their presentation and then 7-10 minutes to present.

Presentation Objectives/Goals :

Create an informal presentation that is approximately 7-10 minutes long and addresses the following...

- Address what is said form of racism : Provide a definition
- How can it adversely affect people?
- Why is this type of racism a problem?
- List three modern day examples of how this type of racism applies or occurs in today's society

1:30 - 1:40 p.m. - Break

1:40 - 2:20 p.m. - Activity: Jigsaw Learning (Continued Pt 2 - Institutional/Systemic and Scientific Racism Groups)

2:20 - 2:30 p.m. Facilitated Discussion: How Much Did You Learn?

Bias Training Workshop

Workshop B : Scientific Racism and Medical Mistrust

Training (Facilitator Copy)
Workshop B, Session 2

Goals / Learning Objectives:

- Learn about the historical events that facilitated medical mistrust among African Americans
- Learn how to build a repertoire of information in order to make informed decision about your stance on something
- Learn how to consider multiple perspectives
- Understand the importance and implications of performing ethical research
- Examine additional factors that contribute to medical disparities in patient care for Black Americans vs. white Americans
- Develop plans to fix mistrust in the healthcare system

9:30 am : Meet and Greet (Coffee and Donuts)

10:00 am Opening Activity: Facts about Tuskegee - What do you know ?

*****Survey: Taken From Brandon et al., 2005, with the exception of question #3**

- In what decade did the study begin?
- Answers:
    - 1890s
    - **1930s**
    - 1950s
    - 1970s
- In what decade did the study end ?
    - 1930s
    - 1950s
    - **1970s**
    - 1980s
- Where did the study take place?
    - **Macon County, Alabama**
    - Ionia County, Michigan
    - Knox County, Tennessee
    - Rankin County, Mississippi
- How many men were in the study ?
    - 75
    - 200
    - **400**

    - 1,000
- Which organization conducted the study?
    - **U.S. Public Health Service**
    - Tuskegee Institute
    - John Hopkins
    - US Army
- Did the researchers give the men syphilis or did they already have it ?
    - Gave it to them
    - **Already had it**
- Do you think it is possible for a study like this to happen today?
    - **Yes**
    - No

Talking Points:

The Tuskegee Study of Untreated Syphilis in the Negreo Male is thought to be the root of medical mistrust amongst members of the African American community, however studies show that mistrust is more likely to stem from other historical events and continuous patterns of negative interactions with the healthcare system. The quiz you just took is from a research study centered around mistrust and theTuskegee study, which is oftentimes regarded as the "catch-all" as to why African Americans distrust medical care, however based on the findings of this study that is far from true. Based on phone interviews, researchers found approximately ⅘ of white and Black participants were even aware of the Tuskegee study, with no significant racial differences in awareness. However, based on answers to the survey researchers did find that the Black race was a significant predictor for medical mistrust even after controlling for demographic variables, awareness of the study, and insurance status. African Americans believed that those who were aware of the study were 130% more likely to believe that a similar study could happen again. The Tuskegee study is not the only reason for widespread medical mistrust and I think that in order to firmly grasp the reasons for medical mistrust people have to delve deeper into historical events, personal accounts and experiences, and occurrences of negative patterns of interactions (Brandon et al., 2005).

10:30 a.m. Understanding the Historical Timeline Activity (15 minutes)

- Have participants break into small groups of 2-3 participants to construct what they think to be the correct historical timeline of events regarding medical ethics cases, scientific publications, and legislative rulings that facilitated mistrust amongst African Americans

Events (Listed in Correct Chronological Order Below)

*****MAKE SURE TO OMIT DATES AND TO REARRANGE THE ORDER OF EVENTS BEFORE BEGINNING!**

Talking Point: This activity is meant to be challenging, but it is meant to help you better under a timeline of historical events,scientific publications, and legislative rulings that led to the present day mistrust among African Americans and the medical system. On this list there will be events that you may not have heard of or recognize. To the best of your ability organize these events in chronological order. For events that span across a range of time, use the point that you believe this event started.

- Publishment of “Crania Americana; or, A comparative view of the skulls of various aboriginal nations of North and South America. To which is prefixed an essay on the varieties of the human species” by Samuel George Morton (1839)
- Marion J Sims: Vesicovaginal fistula Surgery (1845-1849)
- Fugitive Slave Act of 1850 required citizens to assist in the return of escaped enslaved people to their owners
- Samuel Cartwright’s development of the mental illness “ drapetomania”
    - “The Diseases and Peculiarities of the Negreo Race” (1851)
- Kansas-Nebraska Act repealed the Missouri Compromise, allowing slavery in the northern territories (1854)
- *Dred Scott v. Sanford* (Missouri) declared that all blacks—enslaved people as well as free—were not and could never become citizens of the United State (1854-1857)
- Civil War (1861- 1865)
- Emancipation Proclamation (1863)
- Thirteenth Amendment to the U.S. Constitution abolished slavery (1865)
- Civil Rights Act (1866)
- Extension of Citizenship to African Americans 14th Amendment (1868)
- Fifteenth Amendment to the U.S. Constitution granted African American men the right to vote (1870)
- *Plessy v. Ferguson* (Louisiana) upheld the constitutionality of a Louisiana statute that required railroads to provide “equal but separate accommodations for the white and colored races” (1896)
- Tuskegee Study (1932-1972)
- Henrietta Lacks: Hela Cells (1951)
- Brown Vs Board of Education (1954)
- Emmett Till Case (1955)
- Ionia State Hospital : Diagnosis of African Americans with schizophrenia for their civil rights ideas (1960’s)
- Dr. Thomas Hamiliton’s Experiments on John Brown “Fed” (add more to this!)

Discussion Questions:

- By raise of hands, how many of you knew about all these events?
    - Ask for volunteers to discuss what happened during the course of a couple of the events
- What domains do you think are impacted by these events aside from healthcare?

10:45 a.m.Video: The US medical system is still haunted by slavery (~8 minutes)

- Based on the findings in the book the Medical Apartheid
    - https://www.youtube.com/watch?v=IfYRzxeMdGs

10:55 a.m. Large Group Discussion :

- What changed after these historical events?
- How did people change?
- What can we do to fix medical mistrust ?
- How did these events shape the modern day physician-patient relationship?

11:10 a.m. Video: Baltimore hospitals work to repair frayed trust in black communities (~10 minutes)

- https://www.pbs.org/newshour/show/baltimore-hospitals-work-to-repair-frayed-trust-in-black-communities

11:20 - 11:30 a.m. - Break

11:30 - 12:15 p.m. - Perspective: Marion J. Sims (A Case of Medical Ethics)

- Split the participants into two groups, each group will read a short article discussing a different perspective about the controversial and unethical work conducted by Dr. Marion J Sims. Ideally about 15-20 minutes should be allotted to reading and thinking about the discussion questions and 20-25 minutes should be devoted to in depth discussion
    - Group 1 will read "The medical ethics of Dr. J Marion Sims: a fresh look at the historical record (Wall, 2005)
        - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563360/
    - Group 2 will read "The medical ethics of the 'Father of Gynaecology', Dr J Marion Sims (Ojanuga,1993)
        - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1376165/

After reading, participants will be asked about these questions before discussing in mixed small groups of 4-5 participants, comprised of 2-3 people from Group 1 and 2-3 people from Group 2

- **Discussion Questions to Consider:**
    - Prior to reading this article did you know anything about Dr. Sims? If so, what was the perspective you were exposed to ?
    - Was the work of Dr. Marion J Sims ethical in any way?
    - How has the ethical code of conduct for medical professionals in the United States changed since the 1800s?
    - Do you think that Dr. Sims should be applauded for his medical contributions or scorned for his unethical experimentation on enslaved women? Or both?
    - The statue of Dr. Marion J Sims was removed in 2018 from Central Park and relocated, do you agree with this?

- **Talking Point:** Oftentimes as people, we fail to consider both sides to every story. It doesn't help that the things we learn in school growing up are taught from one perspective and are limited. We neglect to put ourselves in someone else's shoes, and evaluate the situation from a different perspective. Seeing both sides of the story, on the

other hand makes it hard to know what to believe, and oftentimes it creates mistrust. The work of Marion J Sims is extremely controversial and unethical regardless, but this activity was meant to teach you that the ability to look at things through a different lens is an invaluable skill. This activity also was meant to facilitate healthy discussion about topics that make a lot of people uncomfortable.

12:15-12:55 p.m. - Lunch

12:55 - 1:10 p.m. What Changed After Tuskegee?

Talking Point: Two years after the end of the Tuskegee study the National Research Act was signed into law, and the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was created. This commission was tasked with identifying the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects. It was also tasked with developing guidelines that should be followed to assure that such research is conducted in accordance with these ethical principles. As a result, the commission drafted what came to be known as the Belmont Report, a foundational document for the ethics of human subjects research in the United States.

The Belmont Report (https://www.unlv.edu/research/ORI-HSR/history-ethics)	
Principle	Application
Respect for Persons ● Individual should be treated as autonomous agents ● Persons with diminished autonomy are entitled to protection	Informed Consent ● Subjects to the degree they are capable, must be given the opportunity to choose what shall or shall not happen to them ● The consent process must include three elements ○ Information ○ Comprehension and, ○ Voluntariness
Beneficence ● Human subjects should not be harmed ● Research should maximize possible benefits and minimize possible harm	Assessment of risks and behaviors ● The nature and scope of risks and benefits must be assessed in a systematic way
Justice ● The benefits and risks of research must be distributed fairly	Selection of Subjects ● There must be fair procedures and outcomes in the selection of research subjects

1:10 p.m. Video: Crash Course, Henrietta Lacks, the Tuskegee Experiment, and Ethical Data Collection: Crash Course Statistics #12 (~6.5 minutes)

***Stop at 6:19

- https://www.youtube.com/watch?v=CzNANZnoiRs

1:20 p.m. Two Case Studies on the Importance of Informed Consent from (Marco, 2004)

Case One: A 56-year-old female presents to the emergency department with chest pain, and is found to have an acute myocardial infarction. She meets all inclusion criteria for a research study to evaluate a novel therapeutic modality for treatment of acute myocardial infarction. The research assistant approaches the patient, who is suffering from ongoing pain and anxiety.The research assistant presents a six-page informed consent document for signature to the patient, who willingly signs the document in triplicate.

Case Two: A 24-year-old male presents with a laceration to the forearm. He meets inclusion criteria for a research study to evaluate the efficacy of a newly developed suture material. His primary language is Spanish, although he speaks some limited English. He cannot read in any language. The research assistant approaches the patient and requests his signature on an informed consent document to participate in the research protocol. Due to the brevity of the discussion, the research assistant was unaware of the patient's illiteracy and the patient willingly signed the document.

Questions:
What is wrong with each of these scenarios?
Why aren't they correctly following the ethical guidelines for informed consent?
What could the research assistant change in order to make this an ethical procedure?

TABLE 1: BARRIERS TO ADEQUATE INFORMED CONSENT

Acute medical or traumatic conditions
Impaired decisional capacity
Impaired cognition
Psychiatric illness
Intoxication with illicit or pharmaceutical agents
Language barriers
Pain
Anxiety
Speech or hearing deficits
Illiteracy
Time constraints
Inadequate communication skills
Lack of understanding of voluntariness

1:45 - 2:00 p.m. Wrap Up : We talked about all these changes we made so racism should be gone BUT it's not !

- Mistrust contributes to poorer healthcare outcomes, BUT what other factors further medical disparities?
- After Tuskegee: A timeline of continued medical injustices

Social Determinants of Health

- Economic Stability
    - SES - socioeconomic status
    - Insurance
- Education Access and Quality
- Healthcare Access and Quality
- Neighborhood and Built Environment
- Social and Community

Other

- Implicit/ Explicit Biases
- Physician-Patient Relationship
    - Discordant Relationships
    - Lack of Joint Decision Making
    - Ineffective Communication and Listening

Training (Participant Copy)
Workshop B, Session 2

Goals / Learning Objectives:

- Learn about the historical events that facilitated medical mistrust among African Americans
- Learn how to build a repertoire of information in order to make informed decision about your stance on something
- Learn how to consider multiple perspectives
- Understand the importance and implications of performing ethical research
- Examine additional factors that contribute to medical disparities in patient care for Black Americans vs. white Americans
- Develop plans to fix mistrust in the healthcare system

9:30 am : Meet and Greet (Coffee and Donuts)

10:00 am Opening Activity: Facts about Tuskegee - What do you know ? (Survey)

10:30 a.m. Understanding the Historical Timeline Activity (15 minutes)

10:45 a.m.Video: The US medical system is still haunted by slavery (~8 minutes)

- Based on the findings in the book the Medical Apartheid
    - https://www.youtube.com/watch?v=IfYRzxeMdGs

10:55 a.m. Large Group Discussion :

- What changed after these historical events?
- How did people change?
- What can we do to fix medical mistrust ?
- How did these events shape the modern day physician-patient relationship?

11:10 a.m. Video: Baltimore hospitals work to repair frayed trust in black communities (~10 minutes)

https://www.pbs.org/newshour/show/baltimore-hospitals-work-to-repair-frayed-trust-in-black-communities

11:20 - 11:30 a.m. - Break

11:30 - 12:15 p.m. - Perspective: Marion J. Sims (A Case of Medical Ethics)

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After reading, participants will be asked about these questions before discussing in mixed small groups of 4-5 participants, comprised of 2-3 people from Group 1 and 2-3 people from Group 2

- **Discussion Questions to Consider:**
  - Prior to reading this article did you know anything about Dr. Sims? If so, what was the perspective you were exposed to ?
  - Was the work of Dr. Marion J Sims ethical in any way?
  - How has the ethical code of conduct for medical professionals in the United States changed since the 1800s?
  - Do you think that Dr. Sims should be applauded for his medical contributions or scorned for his unethical experimentation on enslaved women? Or both?
  - The statue of Dr. Marion J Sims was removed in 2018 from Central Park and relocated, do you agree with this?

12:15-12:55 p.m. - Lunch

12:55 - 1:10 p.m. What Changed After Tuskegee? : A Discussion about Ethics

1:10 p.m. Video: Crash Course, Henrietta Lacks, the Tuskegee Experiment, and Ethical Data Collection: Crash Course Statistics #12 (~6.5 minutes)

***Stop at 6:19

- https://www.youtube.com/watch?v=CzNANZnoiRs

1:20 p.m. Two Case Studies on the Importance of Informed Consent from (Marco, 2004)

Case One: A 56-year-old female presents to the emergency department with chest pain, and is found to have an acute myocardial infarction. She meets all inclusion criteria for a research study to evaluate a novel therapeutic modality for treatment of acute myocardial infarction. The research assistant approaches the patient, who is suffering from ongoing pain and anxiety.The research assistant presents a six-page informed consent document for signature to the patient, who willingly signs the document in triplicate.

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discussion, the research assistant was unaware of the patient's illiteracy and the patient willingly signed the document.

1:45 - 2:00 p.m. Wrap Up : We talked about all these changes we made so racism should be gone BUT it's not !

- Mistrust contributes to poorer healthcare outcomes, BUT what other factors further medical disparities?

Workshop C: Why Implicit Bias is Bad Training (Facilitator Copy)

A. Session 3

Goals / Learning Objectives:

- Understand what implicit bias is and why is it a problem
- To promote and raise awareness about the aversive impacts of implicit biases, especially in the healthcare field
- Identify how implicit bias affects the physician-patient relationship
- To utilize education as a method to reduce disparities in healthcare outcomes and promote equal access to healthcare resources and treatment
- Improve recognition and management of personal biases
- Increase self awareness and effectively use strategies to "slow down"
- Eliminate the negative connotation and myths associated with implicit bias
- Outline how to apply potential techniques for mitigating the effects of implicit bias

9:30 am : Meet and Greet (Coffee and Donuts)

10:00 am : Opening Activity: The Tag Game (adapted from Fowler 2006)

- **Repeat 3 times x 5 minutes per session = 15 minutes**
- **15 minutes + 5 minutes of prep = (20 minutes)**
    - **Preferred or optimal group size is ~ 15 -20 participants, but it can be performed with a minimum of 6 participants**
        - **Have badges pre cut/pre made prior to session**

      Participants will each be given a badge that is different shape, size, and color that will be placed somewhere between their waist and neck. Once the badges are distributed, participants will be told to form groups without talking, without any criteria to use to form the groups. Once the participants form groups they will talk to each other for the remainder of the five minutes, before they will be instructed to break up and form into different new groups. This will be repeated three times for 5 minutes each time. Inadvertently, participants will in most cases form groups based on the shapes, colours, or sizes of their badges. Participants neglect to realize that they do this. They also rarely intentionally form groups that are diverse and representative.

      This activity is meant to elicit discussion about social categorization in a powerful and non-confrontational way. The activity brings about the idea of the "us" vs "them" categorisations, and ingroup vs outgroup biases. This activity also is meant to generate conversation about diversity and the places it lacks such as in the workplace. It should also be mentioned how important cultural competency is as well as ways in which people can improve the recognition, support, and value of diverse perspectives and experiences.

10:20 a.m. - 10:30 a.m. Discussion : Development of Ingroup and Outgroup bias

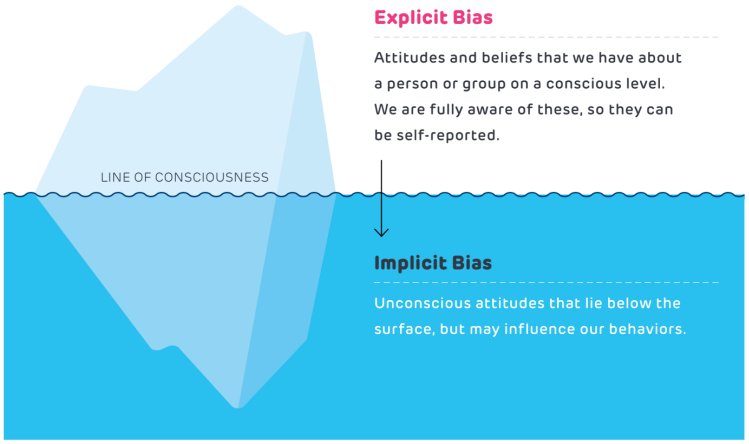
- **What did you learn from this activity?**
- **How do ingroup and outgroups form?**
    - **Talking Points:** Social psychology shows us that people tend to define themselves in terms of their social groupings or categorizations. A person's social identity is derived from their membership or involvement in these social groups or categorizations (Tajfel & Turner, 1979).Social psychology also has taught us that people tend to like people that are similar to them (Myers & Twenge, 2019). As a result people are often quick to denigrate others who don't fit into those groups. These groups can be as simple as preferring a certain brand of shoe or as complex as involving things like sex,age,race/ethnicity. This can turn ugly when you embody the "us" versus "them" dichotomy.
- **Where do we lack diversity? Why is it important to form diverse groups ?**
    - **Discuss the findings from:**
        - Interracial Roommate Relationships study: (Shook & Fazio, 2008)
        - Increasing Opportunities for Contact: This strategy involves seeking opportunities to encounter and engage in positive interactions with out-group members. Increased contact can ameliorate implicit bias through a wide variety of mechanisms, including altering the cognitive representations of the group and directly improving evaluations of the group (Pettigrew, 1998; Pettigrew & Tropp, 2006; Devine et al., 2012).

10:30 - 11:00 a.m. What is Implicit Bias? Brainstorm and Share Out

10 minute brainstorm, 10 minute discussion in small groups, 10 minute group session

- **On a piece of paper write down ideas you have about …**
    - **1. What you know about implicit bias ?**
        - **Talking Point:** Many people had never heard the term implicit bias until the 2016 presidential election when Mike Pence attacked Hilary Clinton's statement stating that, "I think implicit bias is a problem for everyone, not just police. I think, unfortunately, too many of us in our great country jump to conclusions about each other. And therefore, I think we need all of us to be asking hard questions about, you know, why am I feeling this way?..." (Clinton, Hillary. Debate. First Presidential Debate. Hofstra University. Long Island, NY. 26 Sept. 2016.)
    - **2. What do you think implicit bias is ?**
        - **Talking Point:** It might be easier to start with what implicit biases aren't. Having implicit biases isn't meant to make you feel bad, but to make you aware that everyone is a little biased. Just because you may have an implicit association between Black and bad or Black and violent doesn't make you racist. The IAT is meant to help you identify potential biases and figure out ways in which you can overcome them. As people, a vast majority of our thoughts and actions are unconscious and out of our immediate control. It helps to think of bias as an iceberg, in which implicit biases are attitudes and beliefs that float below our line of consciousness oftentimes unbeknownst to us.

- **3. Why do we care about implicit biases?**
  - **Talking Point:** As we discussed last session medical mistrust deters many African Americans from receiving the care they need. Taking the first step to get help is a big deal. Oftentimes, while African Americans may seek help, they experience discrimination in the form of implicit biases held by their physicans, which can in turn hinder there ability to recieve treatment.



  - **Pull up & Discuss: Myths about Implicit Bias**

***Adapted from: https://www.workforce.com/news/5-myths-unconscious-bias-6-ways-reduce

  - **Myth 1: Since everyone is biased we don't need to worry anymore about conscious bias or bigotry and we can move on from that tired conversation about racism/sexism, etc.!** We are not "post-racial." Individual acts of verbal, physical and emotional violence against people due to their real or perceived group membership are still relatively common. One of my least favorite statistics is that the number of active hate groups in the U.S. has increased by 56 percent — to over 900 — since 2000, particularly since President Obama took office in 2008.
  - Although everyone is biased, biases are not equal in their impact at a group level. Negative unconscious biases held by a numerical majority or power-dominant group have a disproportionate ability to do harm to numerical minorities or power non-dominant groups.
  - **Myth 2: I don't have any unconscious biases.** It's frightening to think we may not be 100 percent aware or in control of what we think and do. But brain science shows that if you're a human being, your brain operates through biases. Homo sapiens evolved to constantly and unconsciously make immediate decisions based on limited data and pre-existing patterns. We are descended from the more skittish members of our species, so we're hypersensitive to anything the old parts of our brain deems dangerous. Biases have thus served us for eons, and continue to do so, but are not effective in helping us interact effectively with diverse humans in today's workplace. Bias elimination is not only ineffective, it's impossible — the focus should be on bias reduction (see myth 5), choosing behaviors more mindfully, and mitigating any negative *impacts*

of those behaviors. Check out “Blind Spot: Hidden Biases of Good People” for a fascinating read.

- **Myth 3: Since unconscious bias is unconscious, there’s nothing I can do about it**. Excellent suggestions abound about how to mitigate the effect of negative unconscious bias in talent management and hiring practices through awareness, calibration and effective behaviors. However, there seem to be few evidence-based strategies to *reduce* harmful negative biases in the first place other than these

- **3. Where have you heard the term implicit bias?**
- **4. Why might implicit bias be a problem?**
- **Talking Point:** Implicit biases affect our behaviors
  - For example, (These examples were taken from the Perception Institute verbatim), it may affect the....
- The speed and likelihood of shooting an unarmed person based on race
- Employment callbacks relative to equally qualified white applicants
- The rate of referring otherwise similar Black and white patients with acute coronary symptoms for thrombolysis
- Why Black defendants with stereotypically Black features receive longer sentences, and why stereotypically Black defendants are more likely to be sentenced to death in cases involving white victims
  - In addition, implicit bias can play a dynamic role in education and healthcare as well as affect racial anxiety and stereotype threat
- **5. Does implicit bias matter in the “real world”?**
- **6. How is implicit bias measured?**
  - **Talking Point:** The IAT (Implicit Association Test) is the most commonly used test at the moment, but it is not without its flaws - We will discuss this further in more detail during the remainder of this session and you will get a first hand experience at taking the IAT

11:00 - 11:10 - Break

11:10 - 11:15 - Activity: Rapid Fire Association

When I say this “word,”write down the first thing that comes to mind?

For example, if I say “Peanut Butter”, most of you will say “Jelly” in response

- Salt and Pepper
- Bacon and Eggs
- Bonnie and Clyde
- Batman and Robin
- Green Eggs and Ham
- Law and Order
- Barbie and Ken
- King and Queen

- Spaghetti and Meatballs
- Cat and Mouse
- Hansel and Gretel
- Biscuits and Gravy
- Guns and Roses
- Burt and Ernie
- Rum and Coke
- The Birds and The Bees
- Soup and Salad
- Black and White

11:20 - 11:25 a.m. - Show PBS Implicit Bias: Peanut Butter,Jelly, and Racism Video Clip

- https://www.pbs.org/video/pov-implicit-bias-peanut-butter-jelly-and-racism/

Talking Points: You guys may be wondering why I made you do this exercise and watch this video…as many of you have probably gathered association is a BIG part of how the IAT works

11:25 - 11:40 a.m. Activity: Project Implicit - IAT (after explanation have them go into separate rooms- eliminates group pressure/ helps with focus - look into test taking effects)

Explanation and Overview of…

What is the IAT ?

- The IAT (Implicit Association Test) is the most popular test used to measure implicit biases. The test works by asking you to pair two concepts, like those seen in the association activity we did earlier. The idea is that the more closely a person associates the two concepts, the easier it is to respond to them together as a single unit. So, if *eggs* and *bacon* are strongly associated, it should be easier to respond faster when you are asked to give the same response, by pressing a specified key, to these two. If *eggs* and *tofu* are not so strongly associated, it should be harder to respond fast when they are paired. This gives a measure of how strongly associated the two types of concepts are. The more associated, the more rapidly you should be able to respond.

Refer to resources for additional questions:

- https://implicit.harvard.edu/implicit/uk/background/faqs.html
- https://implicit.harvard.edu/implicit/iatdetails.html
- https://implicit.harvard.edu/implicit/selectatest.html

Discuss the different types of IATs

- Gender- Science
- Transgender (Transgender– Cisgender People IAT)
- Arab-Muslim (Arab Muslim - Other People IAT)

- Gender - Career
- Religion (Religions IAT.
- Weight (Fat - Thin IAT)
- Age (Young - Old IAT)
- Sexuality (Gay - Straight IAT)
- Presidents (Presidential Popularity IAT)
- Skin-tone (Light Skin - Dark Skin IAT)
- Disability (Disabled - Abled IAT)
- Asian American (Asian - European American IAT)
- **Race (Black - White'IAT) - Explain the one they'll be taking today**
- Weapons (Weapons - Harmless Objects IAT)

11:40 - 11:50 a.m. - IAT Wrap-Up and Discussion

Talking Points:

What do your results mean?

- The labels 'slight', 'moderate' and 'strong' reflect the strength of the implicit preference based on how much faster you respond to White Faces + Good / Black Faces + Bad versus Black Faces + Good / White Faces + Bad.
- You can take the IAT multiple times and it is likely that your results may change, if you continue education, increase awareness, and participate in interventions
  - If you were to take it again today your results would not be drastically different
- Reliability
- Fair share of problems

11:50 - 11:55 a.m. Show PBS Implicit Bias: Snacks and Punishment Video Clip

- https://www.pbs.org/video/pov-implicit-bias-snacks-and-punishment/

11:50 - 12:30 p.m. - Lunch

12:30 - 1:00 p.m. - Implicit Bias in the Healthcare Field Five Question Quiz - (MythBusters Activity)

True or False....

Statement 1: Black patients have higher pain tolerances than white patients

- **Talking point:**

False, pain is a subjective measure, and oftentimes Black patients are underprescribed medication

  - White patients are over prescribed pain medications in comparison to Black patients
  - In studies participants rate pain perceptions lower for Black patients

Statement 2: White patients are more susceptible to cardiovascular disease

- **Talking Point:**

False, Stress and prolonged discrimination have increased the vulnerability for cardiovascular disease

Statement 3: Black female patients experience higher maternal death rates than white female patients

- **Talking Point:**

True, stems from medical history

Statement 4: Female physicians exhibit less explicit and implicit bias than male physicians (Sabin et al. 2009).

- **Talking Point:**

True, your physician's gender has the ability to influence the health care you receive. In addition to having less implicit biases, female physicians also obtain higher patient satisfaction ratings across various measures of patient care in comparison to their male counterparts (Bertakis et al. 2003), such as experiencing…

- more collaborative relationships (Roter and Hall 1998)
- longer visits (Roter and Hall 1998)
- more discussions centered around social and emotional issues (Roter and Hall 1998)
- higher ratings on their nonverbal behaviors, such as increased gazing at the patient rather than the medical chart, less interpersonal distance, and the use of a softer tone of voice which are predictors of higher patient satisfaction ratings (Schmid et al. 2008)
- more participatory regular and clinical visits (Cooper-Patrick et al. 1999)

Female physicians as a whole are liked more by patients than male physicians in healthcare settings (Hall et al. 2002). This finding may be partially due to the fact that women in general are perceived to be more understanding, helpful, and kind (Eagley, 1994). “The women are wonderful effect,” is the idea that most people like women more than men because of the light women have been painted in and the gender roles that reinforce these perceptions.

Your physician's race can also impact the healthcare you recieve. 75% of medical interactions in the healthcare system occur between patients and physicians of a different race (Penner et al. 2007), and while studies show that patients are more comfortable with a physician of their same race or ethnicity, as of 2018, only 17.1% of physicians are identified as Asian, 5.8% are identified as Hispanic, and 5.0% are identified as Black or African American (AAMC, 2018).Black physicians exhibit little to no implicit racial biases

Statement 5: Most people, even those that identify as African American have a slight pro white bias (Clark & Clark, 1947).

Talking Point: Discuss that this study was a turning point for Brown Vs. Board of Education. The study found that when Black and white children were presented with the choice to choose from either a Black or brown baby doll, both children chose the white doll, showing a pro-white bias, even in young children.

Wrap-Up Questions:

- Were you surprised to hear that any of these were true/false?
- Why do you think you thought this was true/false ?
- Where did you hear this information ?
- Why do you think that these myths aren’t addressed and are maintained in the healthcare setting?

So what if I told you that 73% of people believe at least one of these myths to be true? What about 50% of physicians or medical school students believe at least one of these?

1:00 - 1:30 p.m. Wrap-Up and Takeaways
Talking Point: Okay? So Implicit biases are bad, but what can we do about them?

Techniques to reduce implicit bias:

- Interracial Contact
    - https://www.pbs.org/video/pov-implicit-bias-make-friends-tackle-bias/
- Breaking the Prejudice Habit
- System 1 & 2 Processing
- Education,Knowledge, & Awareness
- Perspective Taking
- Empathy

Knowing the ways people are likely to react to implicit biases
https://theoatmeal.com/comics/believe - Backfire effect
Feelings of Cognitive Dissonance
Denial
Acknowledgement

- How to get people to listen
- How to change someone's mind/opinion
- Power of perspective

Training (Participant Copy)

A. Session 3

Goals / Learning Objectives:

- Understand what implicit bias is and why is it a problem
- To promote and raise awareness about the aversive impacts of implicit biases, especially in the healthcare field
- Identify how implicit bias affects the physician-patient relationship
- To utilize education as a method to reduce disparities in healthcare outcomes and promote equal access to healthcare resources and treatment
- Improve recognition and management of personal biases
- Increase self awareness and effectively use strategies to “slow down”
- Eliminate the negative connotation and myths associated with implicit bias
- Outline how to apply potential techniques for mitigating the effects of implicit bias

9:30 am : Meet and Greet (Coffee and Donuts)

10:00 a.m. - 10:20 a.m. : Opening Activity: The Tag Game

10:20 a.m. - 10:30 a.m. Discussion : Development of Ingroup and Outgroup bias

10:30 - 11:00 a.m. What is Implicit Bias? Brainstorm, Small Group Discussion, and Whole Group Discussion

Brainstorming Questions:

- **On a piece of paper write down ideas you have about …**
    - 1. What you know about implicit bias ?
    - 2. What do you think implicit bias is ?
    - 3. Where have you heard the term implicit bias?
    - 4. Why might implicit bias be a problem?
    - 5. Does implicit bias matter in the “real world”?
    - 6. How is implicit bias measured?

11:00 - 11:10 - Break

11:10 - 11:15 - Activity: Rapid Fire Association

When I say this “word,”write down the first thing that comes to mind?

11:20 - 11:25 a.m. - Show PBS Implicit Bias Video Clip

- https://www.pbs.org/video/pov-implicit-bias-peanut-butter-jelly-and-racism/

11:25 - 11:40 a.m. Activity: Project Implicit - IAT (Explanation & Taking Test)

Feel free to find any place in the building to take the IAT and please return to this room when you are finished

Directions:

Go to the Website: https://implicit.harvard.edu/implicit/selectatest.html

Select **The "Race (Black - White'IAT)"**

11:40 - 11:50 a.m. - IAT Wrap-Up and Discussion

11:50 - 11:55 a.m. Show PBS Implicit Bias: Snacks and Punishment Video Clip

- https://www.pbs.org/video/pov-implicit-bias-snacks-and-punishment/

11:55 - 12:30 p.m. - Lunch

12:30 - 1:00 p.m. - Implicit Bias in the Healthcare Field Five Question Quiz - (MythBusters Activity)

1:00 - 1:30 p.m. Wrap-Up and Takeaways

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