HBPC: Implicit Racial Bias

Resident Reflections and Commitment to Change 1-8

Q1 What was it like to see your result on your implicit bias test? How did that affect your patient encounter? After completing these home visits, what are you noticing in your mind, in your gut or in your heart? What barriers did you face in applying some of these strategies during your home visit? How could you overcome these barriers? What strategies will you try to implement in your clinical practice in the future?

Resident 1:

I was okay with my result of the bias test. After finishing the home visit, my main thoughts were on being less judgmental about how these patients got to their homebound situation. Whether it was the patient's own doing, or the doing of a caregiver holding on to false hope, I noticed that my bias was projecting my own thoughts of quality of life onto my patients.

The biggest barrier to implementing the IMPLICIT acronym was time for me. During the visit, it was easy for me to focus on medicine and being efficient and trying to complete the geriatric checklist that I needed in order to do a thorough home visit. This will be tough to overcome for me especially while learning, but I think taking time (5 minutes) before each visit for self-reflection about my bias will help keep this at the forefront of my mind even during a visit where I am thinking of several other things. The first step of IMPLICIT is introspective, and I think this is a good starting point especially for learners.

The strategy I will be using in the future will be centered on perspective-taking. I tend to use this technique in my life already as an optimist naturally, so I think this is the most effective place to start. I hope to transition to using the "slow

28 down" technique once I become more efficient in the room so that I don't miss
29 opportunities to address my bias because I am rushing.
30
31 **Resident 2:**
32 My implicit bias test showed that I have no automatic preference for white or
33 black people, but I am pretty sure that is not true as a white person. I did not
34 know many black people until I had graduated college, and even then it was not
35 in the context of the US. I went abroad and lived with black people, so while it
36 helped decrease my innate fear and confusion around black people it did not
37 decrease the racial tension I feel with African Americans. I know I feel guilt,
38 anger, and frustration when I interact with African Americans. It makes these
39 interactions much more fraught than my interactions with people of other races. I
40 guess I just need to learn how to feel uncomfortable.
41 For instance, on the home visit I had a hard time identifying with the patient, and
42 with the caregiver who were both black. There were many factors in this,
43 including class, race, disability, ageism, and my own family structure. I am sure
44 this biased my interactions with them, including how I spoke more loudly to the
45 patient than I needed to after seeing her niece speak quietly to her. I inwardly
46 assumed that the patient had very few resources, and was surprised to find her
47 with a decent pension and good family support.
48 Part of learning to feel uncomfortable is leaning into it, and being mindful that it is
49 not going to overtake me. I loved reading about how mindfulness decreases
50 biases. It makes sense to me that if I was less in my head, less stressed, and
51 more focused on being the best human I can be I would be less biased. While I

do believe that white people are racist due to societal teaching, I think we have the capability to not be. I think we get closer to that when we meditate. It makes me frustrated that medicine as it is currently practiced often does not allow or actively discourages mindfulness.

For instance, being on ICU drove home how in a place where physicians need to be the most mindful – in decreasing bias, in having difficult conversations, and in not missing errors – it is one of the most difficult to be mindful. We are asked to divide our attention, where human suffering is commonplace, and where there is no time to discuss or process.

Luckily, I am only on ICU for 1 month. On the other hand, I do feel like clinic can be frenzied as well, leading to biases and a lack of mindfulness. There are time constraints, so many expectations to manage, and a certain level of quality to meet. I like the idea of coming up with a phrase or brief moment of closure at the end of each patient encounter that could increase mindfulness.

Resident 3:

I actually feel my Implicit Bias test results might be counter-intuitive if one was to guess what they would have been (taken twice- once without bias towards one race vs the other, the second time with mild bias toward blacks). In terms of how this affects my clinic visits, honestly on my particular day of home visits perhaps not a whole lot. But had it been home visits with white patients, that might have been different. I've found myself frustrating and sometimes angry with many white patients because of their irrational attachment to a certain political persuasion, but also does not support the well-being of many of my low-income

76 patients. Further, several have proven to express racist sentiments that further
77 creates a divide in our communities. After having enough of these encounters, it
78 starts to wear on my subconscious in ways that aren't helpful to me as a
79 healthcare provider because I've noticed it has started to develop a gut reaction
80 aversion to certain types of white patients. It's hard for me to even write that last
81 statement- I don't want to have a negative mindset towards anyone before I've
82 really even met them. And yet in some way I do, although it's not in the way one
83 might typically expect since it is incongruent with my own race. For now, I think
84 the best I can to is to recognize that the bias is there in a different way than most,
85 and by acknowledging that, begin to consciously counter those gut reactions that
86 could impair my ability to provide equal care to all my patients.
87
88 **Resident 4:**
89 I was quite surprised to see my results from the implicit bias test. The Harvard
90 test didn't show that I have much bias at all either towards white or black.
91 Perhaps because these are topics we've discussed so much as a residency, I felt
92 like I would have a significant bias. Maybe the test doesn't pick up mine, or
93 maybe while I've thought about these things, I've actually been pretty successful
94 cancelling them out. It was certainly interesting to see.
95 To be honest, I'm not sure that the testing truly affected my encounters that
96 much. I think these are topics that have been talked about for good amounts of
97 time, and what may have been implicit, has been revealed. When these beliefs
98 are in the open, you can process them and see the, for the cognitive distortions
99 and stereotypes they are. Then you can go about your business of caring for the

100 person in front of you. I suppose this represents the learn to slow down and

101 individuation strategies. Those 2 strategies appear to be the most important to

102 me. They are certainly some of the easier strategies for me to practice. When I

103 find myself thinking something that is coming from a stereotype or bias, rather

104 than what I know about the actual patient in front of me, I can stop for a moment,

105 note that fact, and then treat the patient as an individual.

106

107 **Resident 5:**

108 The results of my implicit bias test were less surprising to me this time as it was

109 consistent to what I have tested in the past. However, when I first took the

110 assessment I was surprised. Like many others I had hoped that my results would

111 have been equivocal without a bias in either direction, but they show I have a

112 slight bias towards African Americans. This is not surprising as I am biracial but

113 identify more as African American. I have been very involved in the black

114 community and social justice work for many years in attempt to educate others

115 on systemic racism and inequality. Knowing the results of my IAT has made me

116 question if my white peers view me as only “pro black” and not as someone who

117 would stand up for them. As we have had difficult conversations and momentum

118 in our residency around race I often hear from several people that they are

119 offended and feel hurt by pro-minority efforts. This has influenced

120 how vocal I choose to be and how I word things when in their presence but has

121 not affected my patient encounters. I do know that I feel that I can be more of

122 myself with African American patients, and I’m not sure that will ever change. I

123 feel that I can relate to them more and have a better understanding of their

124 background which makes the social part of our appointments much easier. I don't
125 think these undertones were evident in today's home visits and I felt very
126 comfortable with both patients (one black, one white). Reflecting on this, I do
127 wonder if my discomfort is more a matter of socioeconomics versus race. This
128 places an unfair overgeneralization on our patients regarding SES and race
129 though, so this is something I am working to overcome. For the pneumonic, I
130 want to work on "Individualization" to help correct my bias. I think that reminding
131 myself to connect with an individual rather than assuming things about
132 their background will aid me in this.
133

134 **Resident 6:**
135 I was aware of my implicit bias, but I did not expect it to be that significant. I really
136 appreciated getting to visit my own patients at their home- I noticed that my
137 patient's house was nicer than I anticipated, which again shows my bias I
138 constantly challenge myself when negative thoughts about patients cross my
139 mind to see if my biases are influencing those thoughts.
140

141 **Resident 7:**
142 When I chose medicine as a vocation I was drawn to the writers and thinkers
143 who saw the stories of each human in front of them. People like Anton Chekov
144 and William Carlos Williams and even Somerset Maugham and his depiction of
145 the physician/artist in "Of Human Bondage". As I decided to go on the path of
146 medicine I read a lot of different modern accounts of life as a physician. Though
147 none of them of course can fully prepare you for what it is like--I read Danielle

148 Ofri, Rita Charon, Atul Gawande, and Pauline Chen. The stories from their lives
149 still follow me where I go. But I don't often get a chance to think about the stories
150 of my patients. When I think of bias I think there are many layers to it. Some of
151 them are even imposed by the medical system itself. No matter how humble we
152 may be there's something about our training that often sets up a power dynamic
153 that we walk into and don't always know how to get out of. One of those biases is
154 that we know something more about the person's body than they do. And
155 sometimes this is true but other times it can be disempowering to deny people
156 what they are feeling. As a psychiatrist I think we maybe do this more often than
157 we'd like to imagine.
158 For example, when we tell someone whatever symptom they are having is not a
159 side effect but maybe really a stress response... Home visits can absolutely take
160 you one way or another. They can move you deeper into a sense of your
161 "knowing" and being right. Or they can open your eyes to the intricacy and
162 intimacy of human life. The key, likely, is to apply mindfulness. To see clearly--
163 the life of the person in front of you. The home that they have created wherever
164 they may be. To not enter with the judging or fixing mind. The mind of the doctor
165 who knows what is right for the patient--but rather the openness of wanting to
166 understand or to appreciate what they have. During my visit with XXX I made
167 efforts to focus on what they were doing well and how to help them stay safe,
168 without trying to fix things. To stay mindful and present. To not "wish time
169 forward" when conversations skipped from topic to topic. Our presence was
170 healing to them. The visit was healing. It offered a social outlet and a catharsis. I
171 also could see the fragility of their situation but that they had a tenacity and

172 independence that could be maintained with the right supports. In thinking about
173 it I notice that there are perhaps a lot of judgments that come up about the clutter
174 or the bigness or the house or the danger of falls--and those are things that I
175 should think about as a doctor, but also as a doctor I have to weigh and balance
176 what will make them happiest. Staying mindful is one way to do this and offering
177 compassion and empathy. I think the barrier most of the time to mindfulness in all
178 of life is the hurry we feel--the hurry to move from thing to thing, to get it done, to
179 be right, to be efficient. So if we are deliberate and do not hurry we may be able
180 to apply that bare attention and see when are thoughts are moving too fast or
181 see when we are judging more than listening. I would like to be the kind of
182 physician who creates a space for folks to be heard and truly works with them to
183 improve their situation—a friend recently told me: Empathy is planting five seeds
184 and not being upset when one of them doesn't grow. All of us are in different
185 places in life and on our journey and really we all just have to help each other
186 along, using the skills that have been given us. I love home visits because they
187 feel more effective. I also loved being able to walk to our home visit and take the
188 time to talk with the medical student and share observations.
189
190 **Resident 8:**
191 It is important to recognize the various multitudes of implicit biases that we may
192 harbor, especially as physicians providing care to diverse populations. I feel so
193 appreciative to be part of a residency program that has committed to the
194 integration of excellent cultural humility training. In reading on ways to confront
195 and combat our own biases, I found the IMPLICIT acronym to be useful. In

196 particular, the tools of "Mindfulness, Perspective Taking, and Individuation"
197 seemed to be especially helpful for bringing more humanism to patient
198 encounters. These tools help me view the patient as a unique person, rather than
199 in the context of whatever preconceived biases I may have. When revisiting
200 results of the implicit bias test, I tried to reflect on why my sentiments may have
201 developed and ways I can be more mindful. I also reflected on other biases I
202 might bring to these tele-home-visits, such as the notion that older patients may
203 be more resistant to change. During the home visits, I became aware of a slight
204 bias regarding "old white smokers", and certain assumptions I may make. During
205 our discussion with patient XXX, I noticed some of these biases surfacing. In my
206 pre-charting, I already formed assumptions about him as a middle aged
207 chronically-ill man who smokes, and probably has no interest in quitting. In
208 addition, there were probably some nuanced notions about his mental health.
209 However, the tools of "perspective taking" and "individuation" were critical for
210 keeping these biases at bay.
211 For example, I tried to stick to open-ended non-assuming questions as much as
212 possible, and learned that the patient was actually willing to cut back on his
213 tobacco use and was setting reasonable goals. In addition, I was also surprised
214 to learn that he enjoyed spending his time serving coffee to clients at a local
215 social service agency. Approaching each patient as a unique individual and
216 working to reduce assumptions can lead to greater outcomes and greater
217 satisfaction for both parties involved. Moving forward, I will continue to try to
218 implement strategies of the IMPLICIT acronym in my own practice. During these
219 difficult and stressful times, it is especially important to "learn to slow down" -

220 pausing and reflecting before our interactions to reduce reflexive reactions. In
221 addition, pausing to take the perspective of another can likely prevent some
222 clinician frustration in the setting of stress. My goal in the coming months is to
223 implement more mindfulness prior to and during my clinical encounters; taking
224 even 30-60 seconds to stop and think before making a phone call or entering a
225 room can help build stronger rapport and lead to a better encounter. I will
226 continue to remind myself to simply listen before assuming, and to ask non-
227 biased questions to help uncover important information.
228

229 **Q2** From 1 (minimal commitment) to 10 (maximal commitment), how committed
230 are you to making this change?

231 **R1:** 50
232 **R2:** 98
233 **R3:** 90
234 **R4:** 72
235 **R5:** 100
236 **R6:** 88
237 **R7:** 90
238 **R8:** 90
239

240 **Q3** As a result of completing this home visit experience, I commit to:

241 **R1:** taking five minutes before each visit to address my own self bias and to use
242 perspective taking during the visit to help address my bias

mindfulness

243 **R2:** - I will use mindfulness between patients - I will work on my messaging to

244 decrease bias and make patients feel heard

Assumptions
Introspection

245 **R3:** Go into each patient encounter free of any assumptions that a patient will be

246 resistant or disinterested in my recommendations

Self-
Reflection
Mindful

247 **R4:** Spending more time in reflection, becoming more mindful of my thoughts

Individuation
Selfaware

248 **R5:** reminding myself each day before clinic/inpatient to connect with each

249 patient as an individual rather than the social/racial group that they identify

Selfawareness

250 **R6:** challenge my assumptions about patient's living situations

Mindful
Deep breath/
slow down

251 **R7:** Bring mindful attention to each patient, taking a deep breath before I enter

252 and listen to what they have to say.

slow down

253 **R8:** take a pause of 30-60 seconds before each clinical encounter to be mindful,

perspective-
taking
person-centered

254 slow down, and aim to take the perspective of the patient I am about to interact

255 with.

Slow down
Pauses range from "deep breath", 30-60 s, 5 min, reminder

Table 2 of article