

# The Impact of Implicit Bias in the Pandemic Age: Protecting our Pediatric Patients

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May 13, 2020

In the midst of a global public health crisis, medical providers find themselves on the frontline of unprecedented circumstances caring for patients as they fight the coronavirus disease 2019 (COVID-19) pandemic. Pediatricians are faced with the reality that COVID-19 positions marginalized groups of children and youths at an increased vulnerability to health care inequities. These at-risk groups include children and youth who are ethnic and racial minorities, immigrants, LGBTQ, homeless, in foster care, as well as those who have medically complex health conditions and/or mental health and substance use disorders (1, 2, 3). Now more than ever, health disparities have the potential to result in fatal health outcomes and healthcare professionals have the power to advocate for and protect their young patients. Given the urgent and pressing impacts of the current pandemic, Tsai and Kesselheim offer a timely and critical dialogue in this issue of Pediatric Blood & Cancer, focused on the effects of provider implicit bias that contribute to health disparities.

Tsai and Kesselheim underscore the well documented literature on implicit bias in pediatric medical oncology and note the limited research in pediatric hematology-oncology, despite the complexities that exists in prognosis and treatment plans for this clinical population. Additionally, the case examples are thoughtful, transparent self-reflections from the authors personal clinical experiences with implicit bias in the field of pediatric hematology-oncology. The authors then outline a plan of action towards mitigating implicit bias in healthcare. They first emphasize the importance of acknowledging implicit bias, which is ubiquitous in human nature and exists under many circumstances. Subsequently, upon acknowledgment of existing implicit bias, providers should cultivate self-awareness via medical education in order to have the autonomy and ability to identify and detect implicit bias that negatively affect patient care. Moreover, the authors deduce that diversifying the medical team, both demographically and interprofessionally, can optimize detection of implicit bias. The authors go on to conclude that more research is needed in the specialty field of hematology-oncology to identify how implicit bias specifically affects provider's ability to communicate complex diagnoses, prognoses, and treatment options.

Derived from social psychology research, implicit bias refers to unconscious, unintentional, and automatic positively or negatively skewed classifications people make based on their own experiences and demographic background which then influences behavior and perceptions. The Institute of Medicine published a pivotal report illuminating how implicit bias can negatively influence patient care and may lead to health disparities (4). Examples of implicit bias affecting health outcomes include biases toward race, weight, sexual orientation, socioeconomic status, age, marital status and history of drug use (5, 6). There are two paths that may explain how implicit bias amongst medical providers may contribute to health disparities (5, See Figure 1). Path A suggests provider judgements and decisions regarding patient care can result in health disparities. Path B proposes that implicit bias amongst providers can lead to ineffective communication which affects the providers ability to cultivate a trusting relationship and environment. Patient's distrust with their providers affects their willingness and ability to adhere to treatment recommendations which subsequently leads to health disparities. Moreover, this model also explains the conduit for interaction effects between path A

and B. That is, compromised judgment leading to poor medical decisions may strengthen the probability of poor communication and distrust in the provider-patient relationship or the inverse. Also imperative to the discourse of health disparities and bias, not discussed by Tsai and Kesselheim, is the notion of “privilege” that, unlike minorities, many non-minorities may experience in their rise to becoming a medical professional as well as their medical decision making (7). Such privilege can inadvertently bias providers to behave in ways that illuminate implicit bias. Therefore, the ability to acknowledge privilege is essential to increasing one’s proclivity to recognize their implicit biases. The authors provide vignettes that pointedly describe the importance of self-awareness. Practicing self-awareness promotes the ability to detect implicit biases that may affect patient care and result in unintentional health disparities. Moreover, central to the author’s argument, it is fundamentally important to identify and implement practical steps to address provider implicit bias.

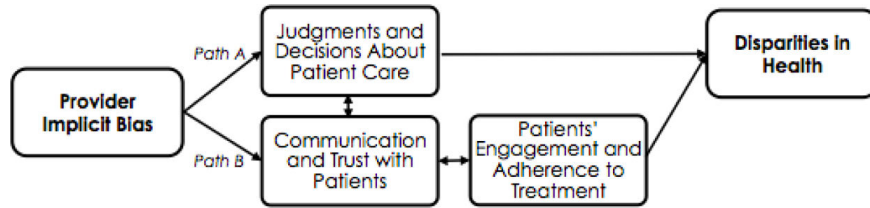
The use of research to inform best clinical practice by implementing skills training is key in addressing health disparities related to provider implicit bias. A potential barrier to successful training and education on provider implicit bias is limited support from institutional leadership (8). Committed leadership on curricula related to implicit bias at an institutional level is likely to reflect long-term systemic change (9, 10). Furthermore, providing a nonjudgmental and safe environment for providers to address difficult content is also key in fostering self-awareness that is more likely to result in long-term change (10). Considering the role of power dynamics in practice and training is also fundamental for cultivating a safe environment for self-disclosure and self-awareness and bringing about systemic long-standing modifications. Tsai and Kesselheim highlight the importance of building demographically diverse and interdisciplinary medical teams. Purposeful team development can also reveal and mitigate any systemic workforce and recruitment biases (11). Having various perspectives while discussing a treatment plan can combat implicit bias. For example, if a complex case is presented at morning rounds with a team that is homogeneous in background and trainings there is potential for groupthink that is anchored in one or two individuals’ implicit biases. Specific to complex cases in pediatric hematology-oncology this can be critical especially during a pandemic that is particularly impacting vulnerable populations, who are often less likely to be represented among medical decision makers. A diverse team can provide insight for culturally competent care as well as provide important perspectives that could optimize diagnostic and treatment outcomes.

As a clinician, it is not an easy task to be open to becoming vulnerable to exploring self-awareness as it relates to implicit bias. It is also our ethical duty to do no harm. Acknowledging implicit bias as a catalyst to health disparities while implementing effective skills training to address implicit bias is crucial to protecting our most vulnerable pediatric patients.

## References

1. Silliman Cohen RI, Adlin Bosk E. Vulnerable youth and the COVID-19 pandemic. *Pediatrics* . 2020; doi: 10.1542/peds.2020-1306
2. Cholera R, Falusi OO, Linton JM. Sheltering in place in a xenophobic climate: 12 COVID-19 and children in immigrant families. *Pediatrics*. 2020; doi: 10.1542/peds.2020-1094
3. Wong CA, Ming D, Maslow G, Gifford EJ. Mitigating the impacts of the COVID-19 pandemic response on at-risk children. *Pediatrics* . 2020; doi: 10.1542/peds.2020-0973
4. Smedley BD, Stith SY, Nelson AR, Smedley BD, Stith SY, Nelson AR, editors. Unequal treatment: confronting racial and ethnic disparities in health care. Institute of Medicine. National Academies Press; Washington, D.C: 2002. doi.org/10.17226/12875
5. Zestcott C, Blair I, Stone J. Examining the presence, consequences, and reduction of implicit bias in health care: A narrative review. *Group Processes & Intergroup Relations* . 2016;19(4):528-542. doi:10.1177/1368430216642029
6. DelFattore J. Death by Stereotype? Cancer Treatment in Unmarried Patients. *New England Journal of Medicine* . 2019;381(10):982-985. doi:10.1056/nejmms1902657
7. Hall J, Carlson K. Marginalization. *Advances in Nursing Science* . 2016;39(3):200-215. doi:10.1097/ans.0000000000000123

8. Dehon E, Weiss N, Jones J, Faulconer W, Hinton E, Sterling S. A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making. *Academic Emergency Medicine*. 2017;24(8):895-904. doi:10.1111/acem.13214
9. Pereda B, Montoya M. Addressing Implicit Bias to Improve Cross-cultural Care. *Clin Obstet Gynecol* . 2018;61(1):2-9. doi:10.1097/grf.0000000000000341
10. Sherman M, Ricco J, Nelson S, Nezhad S, Prasad S. Implicit Bias Training in Residency Program: Aiming for Enduring Effects. *Fam Med*. 2019;51(8):677-681. doi:10.22454/fammed.2019.947255
11. Hall W, Chapman M, Lee K et al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *Am J Public Health*. 2015;105(12):2588-2588. doi:10.2105/ajph.2015.302903a



**Figure 1:** *Model of paths through which provider implicit bias may contribute to health disparities\**

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