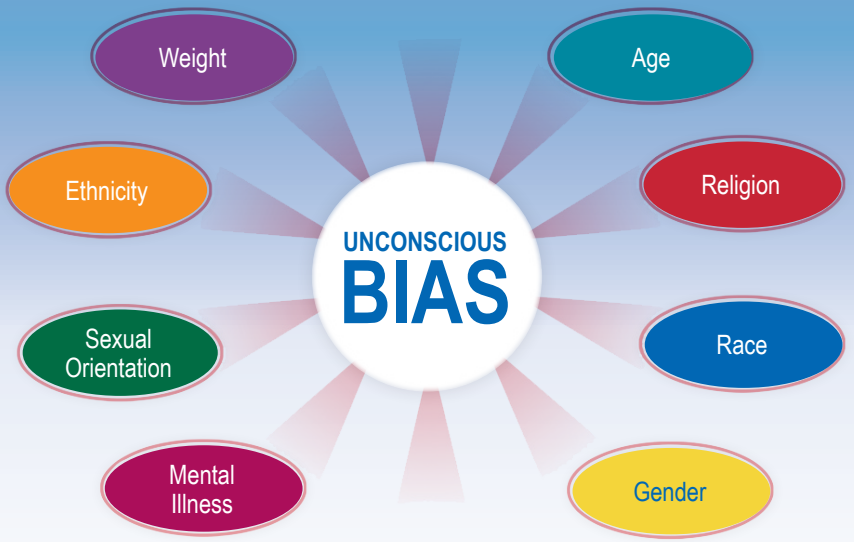
Yes, UNCONSCIOUS BIAS: IT IS REAL!



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UNCONSCIOUS BIAS: *Yes*, IT IS REAL!

INTRODUCTION

Are you guilty of unconscious bias? Take a minute and think about your conscious biases—what are they? You know they exist. We are all biased, but can we identify whether they are unconscious or conscious biases? It is more difficult to identify the unconscious biases. The information that follows demonstrates how healthcare professionals may impact patient outcomes through unconscious bias.

What bias is and the types are identified, as well as examples of how unconscious bias impacts healthcare providers and patients. Groups of patients that have the tendency to experience unconscious bias will be described, and the impact of biased attitudes on these patients will be discussed. Interventions that may prevent or mitigate unconscious bias will be evaluated.

Although healthcare providers strive to provide high quality care to their patients, their efforts may be impeded by comments and attitudes, and stimulated by subconscious judgmental thoughts, which lower the value of the encounter. Even though some biases occur without a person's awareness, it is unacceptable for patients to be subjected to unfair treatment that impacts them physiologically, psychologically, and propagates healthcare disparities.[1]

WHAT IS BIAS?

Opinions about ideas, people, and groups influence decisions and contribute to our uniqueness and social identity. Each social identity has emotional significance, and is intricately associated with self-esteem that can empower or make someone vulnerable.[2] There are circumstances when a person's opinion or belief manifests in an attitude that other ideas, individuals, and groups are not as valuable as their own. Although a person may not consider these opinions harmful, favoring a person or group to the detriment of others results in unfair treatment, and it is considered a "bias".[3, 4]

Biases are exhibited in both personal and professional settings, and their expression often arise from perceived threats, fears, misunderstandings, or stereotypes5 that are influenced by a person's background, personal experiences, or cultural environment. When someone feels threatened or uncomfortable, they are more likely to create boundaries to distinguish themselves from others.

Most people envision bias as a person having negative feelings toward another person or group. However, research dating back more than 40 years found that many biases are a function of favoritism toward one's own group, than negative opinions toward others.[5]

Factors that create bias include:

- Age
- Gender, gender identity, or gender expression
- Ethnicity, race, national origin
- Sexual orientation
- Weight
- (Dis)Ability
- Socio-economic status
- Political affiliation
- Religion
- Marital status
- Military background

TYPES OF BIAS

As shown in table 1, bias can be expressed directly as an explicit bias, or indirectly as an implicit bias. Explicit biases are attitudes that are deliberately formed at the conscious level, and are easy to self-report.

Explicit bias requires that a person is aware of his/her evaluation of a group, believes that evaluation to be correct in some manner, and has the time and motivation to act on it in the current situation.[6] On the other hand, implicit biases are attitudes that are involuntarily formed at the unconscious level and are typically unknown to us.

Table 1. Examples of Implicit and Explicit Biases

EXAMPLES OF BIAS	
Implicit (Indirect) Bias	**Explicit (Direct) Bias**
Sitting further away from a person perceived as gay than an individual perceived as heterosexual.	Telling a joke based on stereotypes.
Asking an Asian nurse colleague for assistance calculating medication dosages because you assume she is better in math.	Using derogatory slurs or name-calling to identify someone.
Avoiding or excluding others of a specific group or identity.	Stereotyping all people of a specific group or identity.
Not examining your hiring practices and recognizing the lack of diversity in your department.	Imitating someone's cultural norms or practice.
Dismissing an addicts' pain as drug-seeking behavior.	Prohibiting someone's holiday decoration because you do not share his or her beliefs or faith.

UNCONSCIOUS (IMPLICIT) BIASES

It was historically believed that patterns of discriminatory behavior were always conscious. It was also widely accepted that good people do the right thing and are inclusive, and bad people do not do the right thing and cause biases. A "good person" versus "bad person" paradigm of diversity developed, and the strategy to eradicate bias was to identify the "bad people" and fix them. However, it is now known that implicit bias is prevalent and creates hundreds of seemingly illogical scenarios in which people make choices that appear to be driven by overt prejudice; although they are not. While research and anecdotal reports support that explicit bias is alive and well, explicit bias toward ethnic and racial groups and women has decreased considerably. Implicit bias continues to be common and persistent.[7]

Unconscious biases—also referred to as hidden, automatic, or subconscious—are a universal element of life that governs many important decisions that people make. They generally occur without the person's awareness, and can be triggered rapidly by situational cues such as an individual's accent, skin color, or attire. A few key characteristics of unconscious biases include:[7]

- They are pervasive, and everyone has them, even if they are avowed to impartiality (i.e. clergy, judges).
- They are not necessarily aligned with professed or endorsed beliefs.
- They align with a person's own in-group or faction.
- They are malleable and can be progressively unlearned.

UNCONSCIOUS BIASES IN HEALTHCARE

Some clinicians are unaware unconscious bias exists in the health industry and are skeptical of evidence that supports disparities.[9] For this reason, it is important that healthcare providers participate in on-going education about the existence for clinician bias, engage in discussions about the pervasiveness of disparities, and learn how bias can influence clinical decision-making and behavior.

Unconscious biases silently influence perception and behavior making them challenging to control; thus presenting a significant concern in the healthcare environment for HCPs, patients, and their family members. In fact, striking results from studies examining bias among clinicians revealed that HCPs make choices that discriminate against one group in favor of another on a frequent basis without realizing it.[10] Some biases displayed by clinicians can be traced back to personal experiences and background, while other biases stem from the proclivity to blame patients for their health issues when they have behaviors, customs, or traits the HCP considers aberrant or abnormal.[1]

Understanding the power of unconscious bias has emerged as a priority, and the healthcare industry and advisory organizations have made a concerted effort to promote cultural competence, fairness and justice, in an attempt to address it. In fact, numerous state, federal, and national organizations have published reports supporting the need for a more pervasive culturally competent culture to address the significant levels of discrimination toward patients and HCPs, as well as health inequities in our health systems.[11, 12]

This undertaking is important, because the presence of bias can stifle progressive efforts and stymie diversity, recruitment, retention, and the morale of the organization. If healthcare professionals are not taught to recognize and address instances of unconscious bias, the hiring, promotion, and professional development process will continue to be jeopardized;[13] thus advancing the progress of some while hindering others. When biases are not managed within organizational structures, the attitudes will extend into patient care. Since the Institute of Medicine's (IOM) conclusion on the adverse impact of unconscious bias on the care of racial and ethnic minorities,[14] subsequent studies have also corroborated the correlation between unconscious bias in HCPs and health disparities. These disparities manifest as inferior clinical care, mistrust in the clinician-patient relationship, and patients' reduced willingness to seek needed medical care.10 The proceeding section will discuss some of the groups of people who are common victims of subtle discrimination and disparities.

Unconscious Bias Involving Weight

Obesity describes the range of weight that is greater than what is considered healthy for a given height. It is a growing health risk in the United States with two-thirds of American adults classified as overweight.[15] Obesity is commonly stigmatized. This

stigma restricts the delivery of health services, employment opportunities, educational achievement, and impairs family relations, and various aspects of personal well-being. Considerable empirical evidence suggests these negative events occur, because people routinely react to obese individuals with disgust, anger, blame, and general dislike.[2] On one hand, societal messages perpetuate slim figures, and shames body types with excess weight.[16] On the other hand, the promotion of fast, high-calorie, and inexpensive meals makes it easy to maintain a poor diet, which can promote a sedentary lifestyle.[17]

Obese people are not only stigmatized by the population at large, but research reveals that many obese patients find themselves confronted by weight-based bias from HCPs.[2] On average, healthcare providers including those that specialize in bariatric care[18], exhibit a strong unconscious bias toward obese patients similar to that of the general public. They are more likely to assume that obese patients are unintelligent, unsuccessful, lazy, lack self-control, and will not be compliant with treatment plans compared to average weight patients.[19] A physician communication study, published in 2013, supported this notion. The study examined recordings of outpatient visits of nearly 40 primary care providers (PCPs) and 208 patients. The findings indicated that the PCPs were 35% less likely to express concern, empathy, or collaboration with overweight and obese patients than with average weight patients.[20]

Unconscious Bias Involving Mental Illness

Nearly 20% of our adult population experiences a mental health disorder in any given year, and in 2014, this accounted for 43.6% of adults. The National Institute of Mental Health estimates one in five Americans will experience a diagnosable mental condition at some point in their lifetime.[21] Stigma and implicit bias against these individuals is of notable concern. Some common beliefs about people with mental illness are:[22]

- They have unpredictable behavior.
- They are violent or dangerous.
- They are going through a phase.
- They cannot recover.

Because of these misconceptions and generalizations, many patients experience symptoms that are misdiagnosed or under-diagnosed. A recent study published in 2016

compared care management processes among patients with depression with other chronic illnesses (e.g., asthma, diabetes and congestive heart failure). The study found that physicians are more likely to engage in care strategies and standard protocols for chronic physical illness than mental illness. Physicians are also less likely to follow up with patients who have depression or help them manage their illness. Additionally, mental health insurance may not be provided to the same extent as medical insurance coverage, which may also be the product of unconscious bias at a structural level.[23]

Unconscious Bias Involving Race and Ethnicity

Minorities have an earlier onset of illnesses, greater severity and more rapid progression of diseases, higher comorbidity, and increased mortality rates than Caucasians.[1] Unconscious biases are a factor in these types of medical-related disparities, contributing to the broader challenge of persistent disparities in health status. Experts have extrapolated three primary drivers that produce tendencies of unintended discrimination by clinicians:[24, 25, 26]

- Preconceptions about minorities
- Clinical uncertainty as it relates to minority patients
- Beliefs and stereotypes about the health behaviors and patterns of minorities

HCPs often relay their bias unintentionally through their word choices, tone, and body language. For example, refusing to recognize a patient's cultural norms as a factor to help with treatment decisions signals to the patient that their background is not considered important. Implicit attitudes can be intensified when a provider is confronted with limited time, capacity, and opportunity to completely assess circumstances fully. These conditions are common in many healthcare settings and are ripe for the triggering of stereotypes and further disparities.[27, 28]

In a review of core measure outcomes shown in table 2, the Agency for Healthcare Research and Quality (AHRQ) substantiated that minority patients are provided less or inappropriate care than Caucasians. Healthcare services evaluated included access and barriers to care, and screening and preventive care. Fewer than 20% of disparities faced by these groups show evidence of narrowing.[29]

Compared to Caucasian patients, ethnic and racial minority patients are not as likely to be provided appropriate cardiac medications, undergo bypass surgery, or receive kidney dialysis. Conversely, ethnic minorities disproportionately receive undesirable procedures such as limb amputations for diabetes and other conditions.[14]

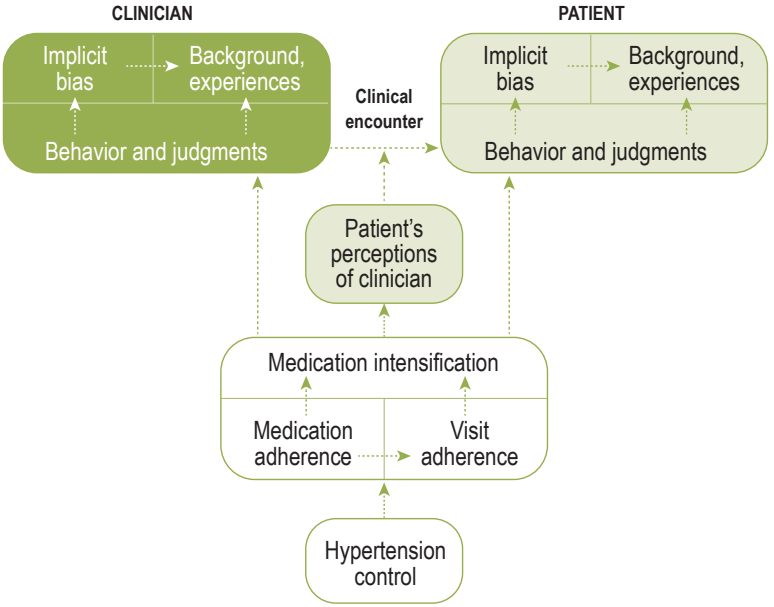
Table 2. Review of Clinical Outcomes from AHRQ.[29]

POPULATION GROUP	RECEIVED INEFFECTIVE, INAPPROPRIATE OR NON-STANDARD CARE IN….
Hispanics and Latinos	60% of clinical measures
African Americans, Native Americans, and Alaskan Natives	40% of clinical measures
Asians	20% of clinical measure

A study, where approximately 80% of the physician sample was Caucasian, found that male physicians prescribed twice the amount of analgesia to Caucasian patients than African American patients suffering from back pain and renal colic. Female physicians prescribed higher doses of analgesia to African American patients than to Caucasian patients. According to these findings, the researchers infer that unconscious bias may cause male and female physicians to respond differently to gender and/or racial cues.[30]

Unconscious bias not only affects clinical decision-making, but it can also limit interpersonal communication. Numerous studies have shown that clinicians with higher implicit ethnic and racial bias have poorer interpersonal interactions with minorities.[3] Figure A illustrates the pathways whereby unconscious bias can affect the patient-clinician relationship.[31] Unconscious bias in communication may be expressed through simple aspects such as speed of speech, tone of voice, body language, or neglecting important conversation altogether.[31] Consider a scenario where a Caucasian nurse has imposed his or her implicit bias during an encounter with an overweight Latina patient who has been prescribed antihypertensive medications but has uncontrolled blood pressure. The nurse has been subconsciously influenced and perceives the patient to be noncompliant and unlikely to adhere to a higher dose of medication. Due to this distorted perception, the nurse believes that the best decision is to not “bother” the patient’s physician to request more intense treatment.

Figure A. Conceptual model of the influence of implicit bias on hypertension control.[31]



Although scientific evidence supports that many societal and behavioral factors generate ethnic health disparities, it cannot be overlooked that missed opportunities in communication and treatment of minorities as a result unconscious bias within health systems contribute to disparities.[1]

Unconscious Bias Involving Gender

In most countries, people are socialized to believe that men are the stronger gender. Although it is true, there are biological differences in physical strength and pain pathways between men and women, these differences are often framed negatively for women. Consequently, HCPs may assume that women are more difficult to manage from a pain standpoint, may take longer to recover and require longer hospital stays, and necessitate more post-discharge follow-up.[32] Gender bias is especially evident where common disease conditions are managed by specialists in reproductive health, pain management, cardiology and surgery.

Numerous studies confirm that women are less likely to receive medical interventions to manage pain and are more likely to be told that their symptoms psychosomatic. The 2014 National Pain Report survey of 2,400 women highlighted the following feelings of gender bias:[33]

- 90% of women with chronic pain felt they were discriminated against by the healthcare system.

- 84% indicated they have been treated differently because of their gender.
- 65% felt providers took their pain less seriously.
- 49% indicated providers are less inclined to prescribe opioids because of their gender.

Another example of how bias affects women is in the area of cardiac health. Many HCPs assess female patients based on cardiac symptom presentation in men although symptoms in women present very differently. As a result, women suffering with cardiac conditions are being dismissed and sent home from hospitals, because HCPs are not adequately trained to recognize the unique signs and symptoms of cardiac dysfunction in women.[34]

> "There are many factors that influence the patient-physician interaction and relationship. But the factor that may be the most powerful may be one we know surprisingly little about in the health care setting: unconscious bias."
>
> **—MARY O'CONNOR, MD**
> **MAYO CLINIC**[8]

In the present context, gender bias also includes transgender men and women. Although many studies combine transgender research with research on sexual orientation, it is important that it is understood that one's gender identity is exclusive of their physical or emotional attraction.[35] [36] There are anecdotal reports and limited peer-reviewed studies of transgender patients and their experience with negative behaviors from HCPs. Often these negative behaviors are fueled by personal values and widespread lack of understanding about the health needs of transgender men and women. The list below may be helpful in understanding how HCPs might unconsciously show bias:[37]

- Discussing gender identity in the context of sexual orientation.
- Assuming that gender identity is the cause of the patient's presenting health issue or focusing on their identity instead of their medical condition.
- Avoiding or minimizing gender identity.
- Making stereotypical assumptions about transgender patients.
- Attempting to over identify with transgender patients.
- Assuming that all transgender people need psychotherapeutic treatment.

A survey of transgender patients, administered by the National Center for Transgender Equality, found that 28% of respondents reported high levels of postponing medical care

due to previously experienced discrimination within the healthcare system. Female-to-male respondents reported higher rates of unequal treatment and Latino/a respondents reported the highest rate of unequal treatment of any racial category at over 30%. Fifty percent of the participants reported that their HCPs did not show knowledge or interest in caring for them.37 In addition to the work conducted by organizations that exclusively champion gender minority rights, Healthy People 2020 (part of the United States Public Health Service infrastructure) released a call to action for more in-depth research on the medical and psychological needs within the transgender community as a means to promote optimal health and wellness.[38]

Unconscious Bias Involving Sexual Orientation

Lesbian, gay, and bisexual men and women are members of distinct groups. However, they face similar obstacles due to societal attitudes that are partial to heterosexual people. For the purposes of this discussion, the collective term LGB will be used to identify any or all three populations.

As sexual minorities, LGB men and women have unique medical and emotional needs that are typically unaddressed or disregarded.[39] Research has shown that LGB patients are often the recipients of substandard assessment, treatment, and follow up of their health issues.[37] As a result, sexual minorities were more likely to have generally poor physical and mental health and less likely to receive treatment. Furthermore, LGB patients also find themselves in circumstances where their HCPs have a general lack of knowledge, interest, and/or comfort level to sufficiently care for them.[40] Studies of unconscious bias between heterosexual HCPs and LGB patients determined the following three beliefs commonly create barriers to care:[41, 42]

- **Heterosexism**—the belief in the superiority of heterosexuality
- **Homophobia**—feelings of trepidation against sexual minorities
- **Heteronormativity**—the supposition that heterosexual relationships are the norm within society

A study of heterosexual and sexual minority HCPs showed that many HCPs seem to be biased toward patients who have the same sexual identity.[43]

THOUGHT QUESTIONS

You decided to go out to dinner at your favorite "pub" and there is a choice of seats. On one end of the bar there is a guy with several tattoos and piercings and on the other end is a business man. You chose the seat close to the business man.

1. *What were your thoughts as you chose your seat?*
2. *Is this implicit or explicit bias?*

LIMITATIONS IN RESEARCH

Research involving unconscious bias in healthcare is still developing. Current studies have limitations in accounting for the numerous variables that impact the way bias affects clinical decisions. For example, researchers have not determined if participants in published studies occasionally made benevolent—although stereotyped—tassessments of minority patients; such as being less aggressive in seeking minority patients' consent for certain medical procedures due to a desire to foster a sense of empowerment relative to treatment decisions.[44, 45]

A second limitation is that existing research does not discuss the level of professional experience and degree of exposure to cultural competence education for participants. Also, disparities exist for a range of ethnic and racial groups, and yet current explorations primarily focus on African Americans as targets of implicit bias.[31] Lastly, some researchers have proposed that studies do not account for how various minority groups differ in help-seeking behavior. IOM data suggest that racial differences in attitudes and preferences for treatment are slight, and cannot completely justify disparities in healthcare.[46]

PATIENTS' RESPONSES TO BIAS

Experiences with unconscious bias can lead to consequences; such as stress and other acute reactions, which may diminish the quality of a healthcare appointment, regardless of HCP skill.[8] Unconscious bias can also cause patients to avoid or cancel medical appointments altogether. This avoidance leads to missed opportunities for early disease detection (e.g., pap smears, mammography) among groups with a higher proclivity to experience bias verses others.[47]

Previous hurtful interactions with HCPs are a critical factor of healthcare avoidance. A study of morbidly obese women found that 36% had experienced disrespectful treatment or negative attitudes from HCPs in the past.[48] Repeated encounters with weight-based bias can cause patients to tolerate and internalize unconstructive attitudes directed toward them. This makes them vulnerable to significant rates of depression, anxiety, and social isolation.[2] Isolation may not be relegated to social settings, but may also impact the healthcare setting where obese patients may be fearful of disrobing or being weighed in front of a perceived judgmental HCP. Bias may also have implications for unintended changes in eating behaviors, leading some patients to increase their consumption of food in response to stigmatization; thus interfering with attempts to lose weight[17] and potentially contributing to co-morbidities of obesity.

Ineffective communication and the disparity in adequate treatment provided by HCPs to minority patients contribute to a lack of trust and compliance on the part of the patient. Although nurses and other HCPs may be unaware of their own biases, patients often sense their implicit attitudes. A survey of African-American and Latina

Unconscious bias not only affects clinical decision-making, but it can also limit interpersonal communication between providers and patients.

breast-cancer survivors uncovered that 36% of the patients surveyed believed that they experienced discrimination due to their ethnicity and that it lowered their quality of care.[49] Repeated experiences of unconscious bias could lead patients to bring their own implicit biases to the clinical encounter, further confounding communication and treatment goals.[31]

Harmful or insensitive communication can be especially damaging to minority patients who already feel stigmatized for seeking treatment for an illness. Minority patients may also find it difficult to directly respond to biased remarks due to power dynamics. Instead, they may elect to distance themselves from the clinician, become reluctant to disclose personal information, and perhaps treatment early. The consequence is that patients may never overcome the illness or condition for which they initially sought help. To that end, the degree of harm experienced as a result of the biased encounter is immeasurable. It is important to note that in these studies, physicians, nurses, and other HCPs reported that they did not intended to discriminate against or demean any patients. Unfortunately, patients sensed the underlying disapproval that was projected on them, and responded accordingly.

Women may feel that biases against them make it difficult to convince HCPs to take their symptoms seriously. For this reason they may become hesitant to speak up about their medical concerns. This type of complex interchange between gender and the healthcare system is problematic and places lives at risk.

MEASURING UNCONSCIOUS BIAS: THE IMPLICIT ASSOCIATION TEST[50]

As would be expected, unconscious bias cannot be measured through a self-reported survey. Instruments, such as the Implicit Association Test (IAT), have been developed to uncover the automatic association of a person's attitudes and beliefs that they may be unwilling or unable to articulate. The IAT is web-based tool where respondents categorize words or images into two pairs of concepts (e.g. good and bad, athletic, clumsy). The respondents' pace in sorting the items determines the strength of association. Conditions with faster responses indicate a stronger association.

Table 3. Types of Implicit Association Tests (IAT)[50]

RACE IAT	This IAT requires the ability to distinguish faces of European and African origin. It indicates that most Americans have an automatic preference for White over Black.
WEIGHT IAT	This IAT requires the ability to distinguish faces of people who are obese and people who are thin. It often reveals an automatic preference for thin people relative to fat people.
PRESIDENTS IAT	This IAT requires the ability to recognize photos of the current president and one or more previous presidents.
ARAB-MUSLIM IAT	This IAT requires the ability to distinguish names that are likely to belong to Arab-Muslims versus people of other nationalities or religions.
AGE IAT	This IAT requires the ability to distinguish old from young faces. This test often indicates that Americans have automatic preference for young over old.
DISABILITY IAT	This IAT requires the ability to recognize symbols representing abled and disabled individuals.
GENDER-SCIENCE IAT	This IAT often reveals a relative link between liberal arts and females and between science and males.
SKIN-TONE IAT	This IAT requires the ability to recognize light and dark-skinned faces. It often reveals an automatic preference for light-skin relative to dark-skin.
RELIGION IAT	This IAT requires some familiarity with religious terms from various world religions.
NATIVE IAT	This IAT requires the ability to recognize White and Native American faces in either classic or modern dress, and the names of places that are either American or Foreign in origin.
WEAPONS IAT	This IAT requires the ability to recognize White and Black faces, and images of weapons or harmless objects.
SEXUALITY IAT	This IAT requires the ability to distinguish words and symbols representing gay and straight people. It often reveals an automatic preference for straight relative to gay people.
GENDER-CAREER IAT	This IAT often reveals a relative link between family and females and between career and males.
ASIAN IAT	This IAT requires the ability to recognize White and Asian-American faces, and images of places that are either American or Foreign in origin.

The Five Sections of the IAT[50]

Part 1: The respondent sorts words relating to concepts (e.g., fat people, thin people) into categories. If the category is "thin people" and an image of a slender person appears on the screen, the respondent would give an affirmative response with a keystroke.

Part 2: The respondent sorts words relating to the evaluation (e.g., good, bad). If the category is "good" and a pleasant word appears on the screen, the respondent would give an affirmative response with a keystroke.

Part 3: The categories are combined and the respondent is directed to sort both concept and evaluation words. For example, the categories on one side of the screen would be "Fat People/Good" and the categories on the opposite side would be "Thin People/Bad"

Part 4: The placement of the concepts are interchanged. If the category "Fat People" was previously on the left side of the screen, it will be moved to the right side.

Part 5: The categories are inverted from phase 3 and 4.

In terms of scoring, if the respondent categorizes words faster when "Thin People" and "Good" share a response key, the conclusion would be that they have an implicit preference for thin people relative to heavier people.

THOUGHT QUESTIONS

The fact that the guy with the tattoos and piercings is a member of the Navy Seals and the business man is transgender is unknown to you.

1. *Is this how you imagined the two men?*
2. *Does the additional information above change your perspective?*
3. *If you imagined the situation differently from above, what prompted the assumptions that you made?*

COUNTERACTING UNCONSCIOUS BIAS

Interventions to reduce bias should focus on individualism.[9]
Evidence indicates that with adequate motivation, effort, and resources, we are able to focus on the distinctive attributes of others, rather than on the groups they belong to thus forming false impressions.[51]

This applies to both implicit and explicit biases. A multilevel approach beginning with acknowledgement of personal biases, accepting that bias influences patient care, and participating in on-going education to mitigate bias is recommended by experts. It may not be possible to elude automatic bias altogether, but after HCPs become aware of their overt and hidden biases it should spark internal motivation and commitment to correct behavior and attitudes.

It is also important to openly discuss the negative impact that unconscious prejudice has on the disparate care and outcomes some patients receive. Partnership building between HCPs and patients should be encouraged, with an expectation that interactions will be more open and cooperative. The thought is that collaboration will help the HCP and patient see each other as members of the same team, versus members of a different group. Tools and methods to help HCPs modify their attitudes, sharpen their skills and increase their knowledge about how to care for patients with greater sensitivity should be made available. Communication tools, such as the LEARN model below, can assist HCPs strategically create meaningful encounters with patients.[52] Organizations should also have a plan for on-going education and forum for open dialogue. This will allow HCPs to routinely share their feedback about bias issues in the organization and allow organizations to formulate and implement effective intervention strategies.[53]

L	E	A	R	N
Listen with empathy and understanding to the patient's perception of the problem.	Explain your perceptions of the problem (practice active listening).	Acknowledge and discuss the differences and similarities.	Recommend treatment.	Negotiate treatment.

It is easy to blame physicians, leaders, and peers who openly express harmful and biased attitudes. In a utopian world HCPs would view every patient and colleague as an equal. Unfortunately, this is not the case. It is important to acknowledge that no one can escape the concept of unconscious bias, and it is inevitable that people will discriminate against others based on their differences or in-groups to some degree. However, if HCPs are made aware of their implicit biases and how they may affect the quality of care received by patients, it provides them with the opportunity to improve them before they are expressed through verbal communications, tone of voice, and body language.

GLOSSARY

Bias	An attitude that projects favorable or unfavorable dispositions towards people. Biases may be conscious (explicit) or unconscious (implicit).
Confirmation Bias	The tendency to search for, interpret, or recall information in a way that confirms one's beliefs or hypotheses. It is a type of cognitive bias and a systematic error of inductive reasoning. People display this bias when they gather or remember information selectively, or when they interpret it in a biased way.
Cultural Competency	A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.
Discrimination	Behavioral manifestation of bias, stereotyping, and prejudice. It is the manner in which others are treated.
Explicit Bias	An attitude that somebody is consciously aware of having. Research has found that implicit and explicit biases are often diverging. For example, a person may consciously express a neutral or positive opinion about a social group that they unconsciously hold a negative opinion about.
Health-Disparate Populations	Populations with a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population. As such, racial and ethnic minorities (i.e., African Americans, American Indians and Alaska Natives, Asians, Hispanics, and Native Hawaiians and Other Pacific Islanders), low socioeconomic status, and rural persons, are currently designated as health disparate populations.
Health Literacy	The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
Implicit Bias	A positive or negative mental attitude towards a person, thing, or group that a person holds at an unconscious level.
Psychosomatic	A physical disorder that is caused by or notably influenced by emotional factors.

Prejudice	Refers to a positive or negative evaluation of another person based on their perceived group membership.
Prejudice as Prejudgment	Forming an opinion before becoming aware of the relevant facts of a case. Often it is used to refer to preconceived judgments (usually unfavorable), toward people or a person because of gender, political opinion, social class, age, disability, religion, sexuality, race/ethnicity, language, nationality, or other personal characteristics.
Stereotype	A shared set of beliefs, fixed impressions of a group.
Stigma	A mark of disgrace that sets a person apart and brings feelings of hopelessness, shame, and blame.
Transgender	A term used to describe people whose gender identity differs from the sex the doctor marked on their birth certificate.

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