Module one: Understanding and addressing implicit bias

Denis Grennell
Kaumātua, Health Quality & Safety Commission

E ngā waka, e ngā mana, e ngā karangarangaranga maha o te Kupu Taurangi Hauora o Aotearoa.

Nau mai haere mai, whakatau mai ki ēnei akoranga tokotoru. Hei akoranga i whakapakiri i te hauora o te iwi Māori e mauiui ana i tēnei whenua o Aotearoa.

Mā ngā tākuta hoki kia turuhia e rātou ki ō rātou nei mahi hei whakapakiri ake, hei whakapai ake mō te hunga Māori.

Nō reira, tēnā koutou, tēnā koutou, tēnā koutou katoa.

Anton Blank
Bias expert

Tēnā koutou. Welcome to these modules which are an introduction to understanding bias in health care.

Having biases related to particular groups or individuals can impact on their health. These modules encourage health professionals to examine their biases and how they affect the health care they provide and their interactions with consumers.

We can show implicit/unconscious or explicit/conscious biases, because of someone's ethnicity, age, gender, appearance, sexual orientation, disability, socio-economic status, religious beliefs, or for many other reasons.

Becoming conscious of these attitudes and biases is the first step towards change. This first module looks at what implicit bias is and how to identify and address it.

Dr Kyle Eggleton
General practitioner, Northland

I had started read some literature around how Māori were not treated the same as Pākehā and I thought, 'that surely wouldn't happen to me because I'm not a racist, so my treatment of people is going to be the same'.

So what I did was try to prove that that by auditing myself and I started looking at how I was prescribing a particular medication, called statin medications, to people who had ischaemic heart disease. Everyone who has ischaemic heart disease should be taking this medication called a statin to lower their cholesterol. And what I discovered that I wasn't prescribing at the same rates for Māori and non-Māori. As a matter of fact for Māori I was prescribing lower rates of statins than I was for Pākehā. It really made me think why on Earth was I doing this? What was happening? And it kind of gave me a bit of a fright and I guess that was my epiphany into realising that bias was operating inside myself.

So, every time I saw a person who should be on a statin, I started asking myself the question why didn't I prescribe a statin it to them and what I realised was that I was attributing characteristics or values to that particular person that weren't based on reality.

So I might see the person in front of me and because they were Māori I might assume that they weren't going to take their medication so I wouldn't offer the medication to them. Or, I might have thought that they wouldn't be consistent with taking their medication, so I wouldn't persist with trying to talk someone into taking their medication, even though I knew that it was the best thing to do.

So, that was my initial journey into understanding implicit bias really operated in myself.

Dr Inia Tomas
Emergency department consultant, Middlemore Hospital

Kia ora.
Ko Karirikura te moana.
Ko Whangatauatia rātou ko o Kokohuia ko Taumata-Māhoe ngā maunga e toru.
Ko Tinana te waka.
Ko Tūmoana te tangata.
Ko Te Rarawa te marae.
Ko te Rarawa te iwi hoki.
Ko Inia Tomas ahau.
He uri au nō Te Tai Tokerau.

So my name is Inia Tomas.

I am a consultant here at Middlemore Hospital where I have been working for the past two years, in that capacity. But I trained here over the past decade on and off.

I'm always scared of saying I'm aware of my own biases because, by definition, you're not aware of your own unconscious biases. But I think the first step is to accept that you possibly could have some unconscious biases, and I've done that.

For instance, growing up, I had an unconscious bias against Pākehā because I was raised in a large Māori family. I went to kōhanga I went to a bilingual school, and then when I went to high school, I was in class that had three Māori students out of 90 and the rest were Pākehā, for the most part.

Despite the fact that I'm half Pākehā, I always considered Pākehā to be different to me and had a vague feeling that I didn't fit in with them – actually an overt feeling that I didn't fit in with them – and I think that affected the way I interpreted my interactions with Pākehā. They were always, not 'the enemy', but 'other'; different to me, and I didn't feel comfortable.

So I think, then getting into med school and working with patients and realising that maybe I was a bit discriminatory against them helped me to improve my overall care actually. I think it was always OK for Pākehā, my care, because I was raised and educated in Western

medicine at a university in a Western country. But if I was able to have that sort of attitude towards Pākehā, who are the dominant cultural group in New Zealand, then I thought what sort of attitudes might I have to other ethnicities as well?

I had a breakthrough with Muslim female patients for instance when I decided to recognise that bias I had. And rather than just walk straight in and say 'I'm not going to see you. I will get the next available female doctor', actually sitting, talking with the patient and the family who were there and asking them were they comfortable to see a male doctor? And on two notable occasions they were entirely comfortable. So, because I had recognised my unconscious bias and enquired with the patient and asked them what they preferred, things went differently – better.

Dr Carla Houkamau
Associate professor, University of Auckland

The human mind has evolved to categorise other people instantaneously. We're really wired to form impressions of other people immediately. And the reason why we do that is because it serves a protective function. You need to be able to determine whether someone is warm and approachable, attractive, or someone you can trust, or someone who is going to be dominant. Our brain has evolved to instantaneously associate people with stereotypes. And that needs to happen because of the huge amount of information that we're bombarded with. We suffer from cognitive overload and what that means is we have to apply stereotypes in order to make sense of the social world. Unfortunately, however, we tend to just do that without really being conscious of it and the implication is that we can act in a discriminatory way without really meaning to do that.

There are lots of different ways to define implicit bias but, in this context, it's probably most easily understood as being some kind of distortion in perception that people have in relation to particular categories of people. That perception can result in behaviours which have a discriminatory impact, and then the discrimination itself becomes a problem. We talk about implicit bias as being a type of bias that people aren't fully conscious of, so it is coming from a level of awareness that might not be conscious to individuals.

I think it's useful, however, to understand the idea of what implicit associations are. Implicit association is a scientific term for the relationship that people make between a thing, a person, an object, a situation and a thought or feeling that they have in their minds. So that's actually physiologically in your brain. Our brain cells make associations between ideas and things. So they're called implicit associations and that's the term that scientists, social psychologists and cognitive psychologists tend to use in this area.

In social psychology we understand that people generally have a natural affinity with people who are like themselves, so people within, we say, their own 'in group'. That 'in group' will change depending on the situation, but usually it's related to ethnicity. It can also be related to age or gender.

So, how do societal stereotypes impact on the way that we see other people? For example, there's a lot of research that shows that stereotypes around the elderly affect the way that we perceive older people and what they're competent and able to do. As well as stereotypes

around gender that impact upon how people perceive leadership as being, perhaps, a masculine quality and nurturing, a female quality.

So all of these stereotypes exist in society and the idea of implicit bias is that we internalise these into our minds without really being consciously aware of them. That's really important for understanding discrimination. There has been research in New Zealand that has looked at the attitudes that medical students in New Zealand have towards Pākehā, European and Māori clients that was carried out at the University of Auckland. And what they found is that medical students actually have have pro-European and pro-Pākehā biases. By and large, these are implicit. However, they also have implicit biases towards Māori and those relate to the idea that Māori are less compliant.

If you are a doctor or a health care provider and you suspect that your client might not be as compliant if you give them instructions or you give them medication, or you're not very proactive with your health care, and you dont trust your client to actually engage in that fully, or they're less complaint, that can have quite negative implications for the patient and their outcomes, because it means that they are not getting the proactive care that they require.

Dr Kyle Eggleton
General practitioner, Northland
Most of my clients are Māori and what I do in my consultations is I spend a lot of time trying to build that initial relationship with a person. You do have to be a little bit brave, and I think have to also acknowledge that the feelings that you're feeling about feeling confonted or feeling a bit vulnerable or a little bit angry – they're probably normal feelings.

You have to ackowledge that but you have to move past it. No one is really going to criticise you if you start this journey. People are going to support you. You're going to have a lot of people who around you that are going to encourage you on your journey, and I think what you'll find is that it's a really uplifting experience.

Anton Blank
Bias expert

Strategies that show promise in countering implicit bias for individuals include:

- contrasting negative stereotypes with specific counter examples
- individuate. Take time to see the people as individuals rather than stereotypical members of their ethnic or social group
- try to see things from the perspective of the person who is being stereotyped
- make an effort to mix with members of other racial and ethnic groups
- expose yourself to media that aims to break down prejudice and discrimination
- and treat people as individuals but also as part of the family and whānau.

Our model proposes that there are two systems of thinking. Bias brain is triggered by our implicit biases. The thinking is automatic, fast, judgemental and unkind. When we are under pressure we are more likely to be operating in bias brain. Mindful brain helps workers detatch from their emotions which is where the biases are stored. They can then make more

considered, thoughtful and balanced decisions. This is especially important for professionals working under pressure, because research shows that this is when bias is most likely to drive decision making.

Now you have watched this module, we invite you make this just the start of your learning about bias in health care. To find out more, make sure you watch the other two modules in this series of three and see the Health Quality & Safety Commission's website.

Kia ora tātou.