Racism and Racial Bias in Medicine

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Racism and Racial Bias in Medicine

• Evidence for Racism and Racial Bias in Medicine

• Impact on Patient Care

• Impact on Diversity of the Medical Profession

• Counteracting and Preventing Racism and Bias in Medicine
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A Role for Implicit Bias?
Physicians’ Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender
Sabin, Nosek, Greenwald, Rivara

- “. . . Implicit preference for White Americans was strong among all MD groups except for African American MDs”
- “White MDs showed the strongest implicit preference for Whites”
- “African American MDs, on average, did not show an implicit preference for either White Americans or Black Americans”

Physician Implicit Racial Bias is One Thing …

But What About Physician Explicit Racial Bias (Racism)?

Black-White Race IAT also asks for self-reported explicit racial biases

White, Asian, and Hispanic physicians have self-reported having mild levels of explicit anti-black bias, or racism1,2.

Medical students self-report explicit negative attitudes toward Blacks3

1Sabin. J of Healthcare for Poor Underserved. 2009
2Capers. Academic Medicine. 2017
3Harrison. Proc Baylor U Med Ctr. 2019
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The Effects of Oncologist Implicit Racial Bias in Racially Discordant Oncology Interactions

- 18 Oncologists (non-Black) took the Black-White IAT
- Treatment of 112 Black pts several weeks later
- Office visits were recorded and “graded” by neutral observers
- Oncologists higher in implicit racial bias had shorter interactions
- Patients and observers rated these oncologists’ communication as less patient-centered

Penner. Journal of Clinical Oncology 34, no. 24 (August 2016)
Disparities in Cardiovascular Care: Physician Bias?


- 220 IM and EM residents from 4 programs in Boston and Atlanta completed web-based study

- Participants took “Implicit Association Test”: computer-based, psychological test to measure unconscious bias

- Participants were unaware of purpose of study

Disparities in Cardiovascular Care: Physician Bias?

- Clinical Vignette:
  - Mr. T is a 50 year old male smoker with HTN who presents to the ED having a heart attack.
  - Residents were less likely to treat the Black man with thrombolytic therapy (heart attack drug)

- Biggest predictor of the decision to not treat the Black man: implicit negative bias about Blacks and implicit association of Black Man = “less cooperative”
I. AICD therapy in pts at risk for SCD

AICD Therapy in Patients at Risk for Cardiac Arrest

**Circ 2003 Jul 22; 108 (3):286-291**

6,000 Medicare patients after cardiac arrest
OR for Blacks (vs Whites) to receive AICD: 0.5

**Circ 2016 Aug 16;134(7):517-26**

21,000 pts with severely weakened heart muscle

Blacks and Hispanics less likely than Whites to get counseled re: ICD
II. Restoring Blood Flow to Blocked Leg Arteries

Treating Poor Circulation

- Arch Surg 1995 Apr; 130 (4): 381-6
  19,236 Medicare pts with LE ischemia
  African Americans compared to Whites:
  More likely to undergo amputation
  Less likely to undergo revascularization

- J Racial Ethn Health Disparities. 2017
  African Americans 200% and Hispanics 50% more likely to have amputation than Whites
III. Rapid Treatment of Blocked Heart Arteries in Heart Attack Victims

Before stent, artery closed, no blood flow to heart

After stent, artery open, blood flow to heart restored

Cardiac Catheterization and Stent Placement: A Life-Saving Therapy for Heart Attack
The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization

“Men and whites were significantly more likely to be referred than women and blacks.”

Kevin Schulman, MD, et. al, NEJM, February, 1999

Temporal trends and predictors of time to coronary angiography following non-ST-elevation acute coronary syndrome in the USA

Muhammad Rashid, David L. Fischman, Sara C. Martinez, Quinn Capers, Michael Savage, Azfar Zaman, Nick Curzen, Joie Ensr, Jessica Potts, Mohamed O. Mohamed, Chun Shing Kwok, Tim Kinnaird, Rodrigo Bagur, and Mamas Mamas

• National US Inpatient Sample, 4.3 million NSTEMI/USA pts, 2004-2014
• 57% of pts received coronary angiography
• Endpoint: Early (within 24 hrs) vs Late (> 3d after admission) coronary angiography

Coronary Artery Disease 2019
Temporal trends and predictors of time to coronary angiography following non-ST-elevation acute coronary syndrome in the USA

Findings:
Independent predictors of LATE vs EARLY coronary angiography:

- Female gender
- African American race
- Weekend admission
- Lack of Private Insurance

Coronary Artery Disease 2019

Racial Disparities in Cardiovascular Care: A Review of Culprits and Potential Solutions

Quinn Capers IV - Zarina Sharalaya

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Matriculants
From Emory University, Aug 5, 1959

“Dear Mr. ___________

I am sorry I must write you that we are not authorized to consider for Admission a member of the Negro Race.”

Implicit Racial Bias in Medical School Admissions
Quinn Capers IV, MD, Daniel Clinchot, MD, Leon McDougle, MD, and Anthony G. Greenwald, PhD

Abstract

Problem
Implicit white race preference has been associated with discrimination in the education, criminal justice, and health care systems and could impede the entry of African Americans into the medical profession, where they and other minorities remain underrepresented. Little is known about implicit racial bias in medical school admissions committees.

Approach
To measure implicit racial bias, all 140 members of the Ohio State University College of Medicine (OSUCOM) admissions committee took the black-white implicit association test (IAT) prior to the 2012–2013 cycle. Results were collated by gender and student versus faculty status. To record their impressions of the impact of the IAT on the admissions process, members took a survey at the end of the cycle, which 100 (71%) completed.

Outcomes
All groups (men, women, students, faculty) displayed significant levels of implicit white preference; men (d = 0.697) and faculty (d = 0.820) had the largest bias measures (P < .001). Most survey respondents (67%) thought the IAT might be helpful in reducing bias, 48% were conscious of their individual results when interviewing candidates in the next cycle, and 21% reported knowledge of their IAT results impacted their admissions decisions in the subsequent cycle. The class that matriculated following the IAT exercise was the most diverse in OSUCOM's history at that time.

Next Steps
Future directions include proceeding and following the IAT with more robust reflection and education on unconscious bias. The authors join others in calling for an examination of bias at all levels of academic medicine.

Academic Medicine. March 2017
Implicit Bias Testing: White Preference
OSU COM Admissions Committee 2012

"White Preference" displayed on Implicit Bias Testing

Implicit Bias in Medical School Admissions
“An Exploration of Myths, Barriers, and Strategies for Improving Diversity Among STS Members”

- STS Task Force on Diversity and Inclusion surveyed 5,158 members with a response rate of 9.3% (n = 481 respondents). Questions:
  - What are some of the barriers to diversity and/or inclusion within cardiothoracic surgery?
  - If there is a barrier not included in the list above, please explain.
  - How can STS improve diversity and/or inclusion in cardiothoracic surgery and/or the Society?


“An Exploration of Myths, Barriers, and Strategies for Improving Diversity Among STS Members”

- “White males are currently being discriminated against in admission to college, med school and residency programs! CT [cardiothoracic] surgery should be a meritocracy.”

- “I do not believe barriers exist. This myth of the necessity of diversity and inclusiveness is political correctness on steroids. We need to worry about turning out well trained residents....”

- “[The STS] doesn’t need to [address diversity] and this should not even be on the radar of things to be done.” (15% of respondents)

- “There are no barriers. None of the above are important!”

110 respondents (57% of US Cardiology Fellowship Programs represented)

55% Adult General Cardiology

45% Adult Subspecialty Cardiology

Q3 “Diversity is a driver of excellence in healthcare delivery,” in other words, the more diversity represented amongst your health care providers, the better the care delivered to patients. Do you believe this statement is true?

Answered: 110  Skipped: 0

Crowley. JAHA. 2020
Q4 Can you quote 1-2 references that support this statement?

Answered: 110  Skipped: 0

Yes

No

Q8 Which statement most accurately describes your position with respect to increasing diversity in your program?

1) 21%: We want to Increase Diversity in Our Program, But Don’t Know How to Do it

2) 18%: We want to Increase Diversity in Our Program, and Have a Plan to Do it

3) 61%: Our Program is Diverse Already So Diversity Does not Need to be Increased
Top 3 Considerations When Making Your Rank List?

“Cigar smoke-filled backroom”

Crowley. JAHA. 2020
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2020: Racism/Racial Bias is a “Second Pandemic”

• Blacks, Hispanics:
  • Overrepresented in Patients Hospitalized for COVID
  • Overrepresented in Patients Dying From COVID
  • Overrepresented in those Dying From Fatal Police Encounters (While Unarmed)
  • Underrepresented in the Medical Profession
Academic Medical Centers

Bold Anti-Racism Statements

The Most Powerful Anti-Racism Statement That Medicine Can Make is ...

- To Diversify Our Ranks!
Eliminate Bias and Racism

• Training. Rehearsing. Training Some More

• Direct Interventions

• Promote Anti-Racism Images/Role Models/Social Media

• Enhance Diversity in Medicine by Dismantling Bias/Racism in “Pipeline”
  • Deep Pipeline
  • Selection Strategies

Annual Implicit Bias/Holistic Review Training
OSU Faculty Screeners and Admissions Committee
How Clinicians and Educators Can Mitigate Implicit Bias in Patient Care and Candidate Selection in Medical Education

Quinn Capers IV

How to mitigate implicit bias

AIM

In an attempt to help mitigate implicit bias, our unconscious minds make certain group associations on the basis of our experiences. Physicians are not immune to these implicit associations or biases, which can lead physicians to unconsciously exercise certain stereotypic groups with negative connotations, like danger, incompetence, and lower competence. These biases can influence clinical decision making in ways that potentially harm patients and may unfairly influence the medical school, residency, and fellowship application processes for candidates to certain underrepresented groups. To minimize the potential negative impact of implicit biases on patient care and training in the medical field, we should be aware of our biases and be intentional in reducing them. This article discusses the potential impact of implicit bias in health care and medical training and educates readers on how to reduce implicit bias in interview interactions.

Keywords:
Implicit bias; race; black; white

As you fill out the X-rays, completed paper work, electrocardiogram, laboratory tests, and complete the history and physical, you have unconsciously applied an implicit bias. The unconscious mind is in a constant state of filtering and organizing information, and our implicit biases can influence our decision-making processes.

WHAT IS IMPLICIT BIAS?

Implicit bias is a set of biases and attitudes that we have learned over time, and we are not even aware of. This unconscious process is important in helping us make decisions about certain groups of people. A perfect example would be the association of a white person with an athlete and a black person with a scientist.

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ATS SCHOLAR

How clinicians and educators can mitigate implicit bias

1. Common identity formation. Ask interviewees questions about interests and activities that you share in common (Focus on a shared, common identity between YOU and the interviewee).

2. Perspective taking. Take the perspective of a member of the group against which you have the unconscious bias.

3. Consider the opposite. When data seem to point to one conclusion, look for data supporting the opposite conclusion before making a final decision.

4. Counter-stereotypical exemplars. Spend time with or focus on individuals admired from groups against which you have a bias.

Sources:
Eliminate Bias and Racism

• Training. Rehearsing. Training Some More

• Direct Interventions

• Promote Anti-Racism Images/Role Models/Social Media

• Enhance Diversity in Medicine by Dismantling Bias/Racism in “Pipeline”
  • Deep Pipeline
  • Selection Strategies

How I Do It
Bias and Racism Teaching Rounds at an Academic Medical Center
Quinn Capers IV MD, Uday S. Nori MD

New Idea:
Bias and Racism “M & M” Teaching Rounds
“Events” noted by attendings, housestaff, students, RNs
Collected and discussed in non-threatening way
Education and Prevention

Capers. CHEST. 2020
American College of Cardiology Program Directors Summit

ACC Heart House 2019

Eliminate Bias and Racism

• Training. Rehearsing. Training Some More

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Twitter Campaign to Inspire and Encourage

#BlackMenInMedicine

(L-R: PGY6 💜 fellow; Anesthesia PGY1; EM PGY1; M3 student; IM PGY1)

#DiversityDrivesExcellence in Cardiac care @OSUWexMed

Quinn Capers, IV @DrQuinnCapers4

With these CARDIOLOGISTS around, Heart Disease is in trouble.
So is RACISM 🪐

#DidntComeToPlay
The OSU African American Male Mentoring Roundtable

Eliminate Bias and Racism

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  • Selection Strategies
Ohio State University-Columbus City Schools K-12 Health Sciences Academy

“Growing Your Own Garden”
Make “Ability to Enhance Diversity/Cultural Competency of Program” A Top Priority When Ranking GME Candidates

Diversity Drives Excellence … In the Cath Lab!

For 8 years in a row, an underrepresented minority Interventional Cardiology Fellow
Summary

- Bias and Racism in Medicine Exacerbate Healthcare Disparities
- Bias and Racism Contribute to the Lack of Diversity in Medicine
- Lack of Diversity in Medicine & Healthcare Disparities Put Patients at Risk
- There is a Global Call to End Racism
- Academic Medicine Must (and Can) Heed this Call