

The Role of Implicit Bias in Medicine and Medical Education Institutional Climate, Culture, and Policies

Institutional climate, culture, and policies, 1:

The authors discuss the educational impact of one's institutional learning environment—the institution's ethos, teachers, modeling, policies, and processes—on the multicultural education of physician trainees. A usable conceptual model is offered with which educators can identify those dimensions of one's institutional curriculum that may enhance or obstruct trainees' optimal learning and behavior change regarding issues of multiculturalism in medicine. Comparisons are drawn to the recent medical literature concerning professionalism education and the hidden curriculum. Distinctions are drawn between overlapping areas of planned, received, intended and unintended learning and values, as communicated from faculty, attendings, and residents to students. Ways of maximizing ideal learning and minimizing unintended consequences are discussed.

Murray-Garcia JL; Garcia, JA (2008) The institutional context of multicultural education: What is your institutional curriculum? Academic Medicine 2008 July 83 (7) 646-652.

Institutional climate, culture, and policies, 2:

Explicit cross-cultural learning experiences in medical education are provided within the context of implicit experiences provided by a greater hidden curriculum. The authors conducted a content analysis of 983 cases presented in the 1996-1998 year one and year two curriculum at the University of Minnesota Medical School to determine in what ways they might embody elements of the hidden curriculum, i.e., how they either supported or undermined explicit messages about diverse patient populations. The findings revealed that cases featuring males out-numbered those featuring females; this ratio differed across courses, and appeared to differ from the actual epidemiology of the conditions. Sexual orientation was specified infrequently. When sexual orientation and behavior were specified, these appeared in the context of a risk assessment for particular diseases (e.g., HIV infection). Most cases did not provide racial or ethnic descriptions. For many of the ethnic descriptors, links to genetic, cultural, or socioeconomic factors were apparent; no such link was apparent when the racial terms white or Caucasian were used. Analysis of the 983 cases shows that the pattern of demographics and associations of particular groups with diseases or risk factors in cases conveys messages, as does the lack of mention of sexual orientation and race or ethnicity.

Turbes, S; Krebs, E; Axtell, S (2002) The hidden curriculum in multicultural medical education: The role of case examples. Academic Medicine: 2002 Mar 77(3) 209-216.

Institutional climate, culture, and policies, 3:

Eleven textbooks were screened, included four on internal medicine/cardiology, four on pharmacology and three on psychiatry. Results show that gender-specific information is scarce or absent and hardly accessible via index or layout. The scarce gender-specific information mainly applies to epidemiological data and reproductive items. Current medical textbooks are still gender-biased. They lack somatic and psychosocial information relevant to good medical practice. As a consequence, future doctors will be unaware of relevant differences between men and women in the presentation, diagnosis and treatment of illnesses.

Dijkstra, AF, Verdonk P, Largo-Jansen AL, (2008) Gender bias in medical textbooks: examples from coronary heart disease, depression, alcohol abuse and pharmacology. Medical Education 2008 Oct 42(10) 1021-1028.

Institutional climate, culture and policies, 4:

The authors focus on white physician trainees, the largest racial group of U.S. physicians and medical students. They first explain what they mean by the terms white and nonwhite. Racial identity theory is then applied, with true case examples, to explore such issues as where the self-proclaimed "color-blind" trainee fits into this theoretical schema, and how medical educators can best serve trainees who are

resistant or indifferent to discussion of racism in medicine and equity in health care delivery. Ultimately, the author's goal is to demonstrate that engendering genuine self-reflection can substantively improve the delivery of health care to the nation's diverse population. To help achieve that goal, they emphasize what to anticipate in effecting optimal trainee education and how to create an institutional climate supportive of individual change.

Murray-Garcia JL, Harrell S, Garcia JA, Gizzi E, Simms-Mackay P. (2005) Self-reflection in multicultural training: be careful what you ask for. Academic Medicine. 2005 Jul 80 (7) 694-701.

Institutional climate, culture, and policies, 5:

This article argues for the vulnerability of managerial work to unintended forms of racial and other bias. Recent insights into "implicit social cognition" are summarized, highlighting the prevalence of those mental processes that are relatively unconscious and automatic, and employed in understanding the self and others. Evidence from a response time measure of implicit bias, the Implicit Association Test, (IAT); (Greenwald McGhee, and Schwartz, 1998) illustrates this phenomenon. Recent work on the predictive validity of the IAT demonstrates that social cognitive pitfalls threaten a) managers' explicit commitments to egalitarianism and meritocracy and b) managers' performance in their three primary roles of processing information, interacting with others, and making decisions (Mintzberg, 1973). Implicit bias influences managerial behavior in unexpected ways, and this influence is heightened in the messy, pressured, and distracting environments in which managers operate.

Chugh, D (2004). Societal and managerial implications of implicit social cognition: Why milliseconds matter. Social Justice Research, 17, 203-222.

Institutional climate, culture, and policies, 6:

Systematic review of experimental evidence for interventions mitigating gender bias in employment. Unconscious endorsement of gender stereotypes can undermine academic medicine's commitment to gender equity. The authors performed electronic and hand searches for randomized controlled studies since 1973 of interventions that affect gender differences in evaluation of job applicants. Twenty-seven studies met all inclusion criteria.

Isaac, C; Lee, B., et.al. (2009) Interventions that affect gender bias in hiring: A systematic review. Academic Medicine 84 (10) 1440—1446.

Institutional climate, culture, and policies, 7:

Women in academic medicine are approaching parity without power. Although the number of women choosing careers in medicine has grown substantially over the last 35 years, there has not been a commensurate increase in the percentage of women in senior leadership positions. To redress this situation at the University of Illinois College of Medicine (UICM), the Faculty Academic Advancement Committee (FAAC) was established in January 2003. This case study outlines the history, conceptual approach, structure, initiatives, and initial outcomes of FAAC's efforts.

Morrissey, CS; Schmidt, ML Fixing the system, not the women: An innovative approach to faculty advancement. Journal of Women's Health, 2008 Oct 17 (8) 1399-1408.

Institutional climate, culture, and policies, 8:

Women are not advancing to leadership positions in academic medicine at rates predicted by their representation in medical school over the past 20 years. The prejudice persists, often as an unconscious mental model, that leaders should be men. We examined whether the presence of the word "leader" in written tenure criteria may have a differential impact on promotion of men and women in elite medical schools.

Marchant, A.; Bhattacharya, A., et.al. (2007). Can the language of tenure criteria influence women's academic advancement? Journal of Women's Health 16(7): 998-1003.

Institutional climate, culture, and policies, 9:

Given the considerable demographic changes occurring in the in the United States coupled with the urgent need for the field of medicine to continue to adapt to and better align with societal needs and expectations, a growing number of leaders in academic medicine have called for academic health centers to redouble their efforts to increase the diversity of students, faculty, and staff. Although it is laudable to call for increased attention and efforts to diversify, it is of paramount importance to review and distill what we have learned from past efforts so that future energy can be spent intelligently to ensure greater impact going forward. This article reviews the literature on both the barriers and facilitators for racial and ethnic minorities in academic medical careers and offers guidance for increasing the diversity of the nation's medical school faculty members and leadership.

Nivet, M.A. Minorities in academic medicine: Review of literature. Journal of Vascular Surgery (2010) April 51 (4 suppl) 53S-58S.

Institutional climate, culture, and policies 10:

Today, most agree that the health care system in the United States is in need of reform and that existing health disparities have huge implications for both that system and society as a whole. As a result, academic medicine has come to play a central role in addressing health disparities in a pluralistic society. Today, diversity is no longer a projection; it is a reality. Yet, most diversity efforts continue to run parallel to core institutional processes, rather than as part of the mission of the institution. Researchers agree that, to promote a healthy and vital society, leaders in academic medicine must create institutions that can serve diverse populations. To do so, they must first increase their institutional capacity for diversity. This article outlines the next generation of work on diversity and inclusion, drawing on a broad body of research and practice to identify some of the key elements for building the kind of institutional capacity necessary for sustained change in academic medicine, including a deeper engagement of mission, one that considers diversity as core to excellence; an inclusive and differentiated understanding of diversity institutionally; alignment and intentionality with respect to key institutional elements; key metrics associated with success and a serious process to monitor progress; and the identification of diverse talent for leadership at all levels.

Smith, DG. Building institutional capacity for diversity and inclusion in academic medicine. Academic Medicine 2012 Nov 87 (11) 1511-1515.