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Summary

Medical students are often taught to associate race with disease as a method to diagnose and prescribe appropriate medical treatment. Unfortunately, this often leads to inaccurate and misleading assumptions related to race being used in medical decision-making. The role of provider bias and stereotyping in the clinical decision-making process have been extensively studied and suggested as possible contributors to racial health disparities experienced by Black men. Evidence also suggests that current cultural competency programs in medical school are non-inclusive and ineffective. In this brief, I outline a three-tiered approach to address provider bias and ensure that all students are exposed to racial bias training. Intentional efforts to address bias at the institutional level can influence the culture of medical education. Efforts by the Association of American Medical Colleges (AAMC) can serve as the model to better serve all communities.

Author Biography

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Understanding the Role of Provider Racial Bias in Medical Training and Clinical Decision Making

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While matriculating, medical students are often taught to associate race with disease as a method to diagnose and prescribe appropriate medical treatment. Unfortunately, this often leads to inaccurate and misleading assumptions related to race being used in medical decision-making. For example, research has shown that Black men are less likely to be diagnosed accurately, less likely to receive quality cardiovascular care, kidney transplants, or be prescribed pain medication (Smedley, Stith, and Nelson 2003). Provider bias, rather than sound medical decision-making, contributes to these and other health inequities, increasing rates of morbidity and mortality.

Provider Bias in Medical Decision-Making

Implicit bias is defined as an unconscious evaluation of one group and its members relative to another (Blair, Steiner, and Havranek 2011). The role of provider bias in the clinical decision-making process has been extensively studied and suggested as a possible contributor to racial health disparities (Sabin et al. 2008; Burgess et al. 2007). In 2003, the Institute of Medicine issued a report that provided key details regarding health disparities experienced by Black individuals living in the United States. The report suggested and encouraged the scientific exploration of provider bias and mistrust of medical institutions. Since then, several academic studies have investigated the role of implicit bias in clinical settings.

Evidence from this research suggests that early developmental experiences with race play a significant role in how individuals interact with one another. Thus, racial bias can manifest both explicitly (i.e. overt or intentional) and implicitly (i.e. unconscious or unintended), representing two related but independent pathways for bias to manifest in clinical interactions. There is substantial evidence to suggest that well-meaning Whites who do not perceive themselves as overtly "racist," demonstrate unconscious racial attitudes and make decisions based upon negative stereotypes (Dovidio et al. 1996). Research also finds that medical doctors demonstrate a strong preference for White patients over Black patients (Green et al. 2007). Considering how race and racism influence the patient-provider relationship, it is critical to improve our understanding of epistemological approaches used in medical school.

Cultural Competency Training in Medical School

A deeper understanding of the power dynamics within the patient-provider relationship is necessary to examine patient satisfaction, treatment adherence, malpractice, and medical errors. The National Academy of Medicine has extensively researched provider bias, described its impact, and have provided suggestions to increase cultural competency among medical professionals. In 2000, the Association of American Medical Colleges (AAMC)'s Liaison Committee on Medical Education (LCME) acknowledged the body of research on provider bias and introduced a cultural competence curriculum for use in medical schools. Since then, the LCME has periodically updated the *Tools for Assessment of Cultural Competency Training* (TAACT) in response to new research. However, because the Cultural Competence

Source

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Further Reading

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Green, Alexander R., Dana R. Carney, Daniel J. Pallin, Long H. Ngo, Kristal L. Raymond, Lisa I. Iezzoni, and Mahzarin R. Banaji.2007. "Implicit Bias Among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients." *Journal of general internal medicine* 22(9): 1231–1238.

Sabin, Janice A., Frederick P. Rivara, and Anthony G. Greenwald. 2008. "Physician Implicit Attitudes and Stereotypes About Race and Quality of Medical Care." *Medical Care* 46(7):678–685.

Smedley, Brian D, Adrienne Y Stith, and Alan R Nelson. 2003. *Unequal Treatment*. Washington, D.C.: National Academy Press.

Burgess, D., Van Ryn, M., Dovidio, J., & Saha, S. (2007). "Reducing Racial Bias Among Health Care Providers: Lessons from Social-cognitive Psychology." *Journal of General Internal Medicine* 22(6):882–887.

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Curriculum is not required by all medical schools it has been insufficient in addressing the problem of provider bias.

Research by Plaisime et al. (2017) and others have documented the ineffectiveness of current cultural competency programs in medical schools. Instead of current programs, I recommend a three-tiered approach to address provider bias in medical education. Intentional training and curriculum redesign are critical tools needed to address racial health disparities.

1. **Formally Train Medical Students and Faculty in Anti-Bias**

   The AAMC should add additional training on microaggressions and provider bias for both medical school students and faculty. Currently, the AAMC has several resources on assorted topics related to diversity and inclusion. The AAMC should also encourage faculty to include lessons deliberately associated with racial and ethnic disparities in their syllabi.

2. **Require All Medical Schools to Use Tools for Assessment of Cultural Competency Training (TAACT)**

   The AAMC is committed to reducing health disparities and has endorsed the use of a need assessment: Tools for Assessment of Cultural Competency Training (TAACT). The tool consists of five domains and additional steps should be taken to examine Domain III: Understanding the Impact of Stereotyping on Medical Decision-Making.

3. **Require Courses on Understanding the Impact of Bias**

   Medical students perceive current cultural competency programs as inefficient or ineffective. A specific course on racial and ethnic disparities should be required for all medical students. The course should use the results from the TAACT and explore: (a) the history of stereotyping and how it has restricted access to healthcare; (b) bias, stereotyping, discrimination, and racism; and (c) the effects of racial and ethnic stereotyping on medical decision-making. As a part of the course, students would be required to take the Implicit Association Test to provide context for self-reflection and classroom activities.

Policy Implications & Recommendations

Eliminating racial and ethnic disparities in healthcare is important; but unfortunately, the clinical setting creates the perfect atmosphere for error, explicit and implicit bias, and stereotyping to occur. Therefore, this three-tiered approach to teaching medical students about provider bias ensures that all students are exposed to racial bias training. Intentional efforts to address bias at the institutional level can influence the culture of medical education. The AAMC can serve as the model to better serve all communities.

Policy recommendations

This brief presents a feasible three-tiered approach to address provider bias in medical education:

- Phase I: Formally train medical students and faculty in anti-bias
- Phase II: Require all medical schools to use *Tools for Assessment of Cultural Competency Training* (TAACT)
- Phase III: Develop and require courses on understanding the impact of racial bias and stereotyping