WHAT DO WE DO NOW? BIAS, RACE, AND TOLERANCE AT WORK, SCHOOL, & IN SOCIETY

By Bruce L. Adelson, Esq.

What Do We Do Now?

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Bruce is the testifying expert in federal and state lawsuits alleging violations of federal civil rights laws.

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Bruce is an award-winning author and the Montgomery County (MD) PTA President of the Year (2018-19)

What Do We Do Now?

Law enforcement reported 7,175 hate crimes to FBI in 2017….. up from 6,121 in 2016.

According to the report, the most common bias categories in single-bias incidents were race/ethnicity/ancestry (59.6) percent, religion (20.6 percent), and sexual orientation (15.8 percent). In addition to the 7,106 single-bias incidents reported last year, there were also 69 multiple-bias hate crimes reported.

FBI

Which are our biases?

Gender

Race

Disability

Skin Tone

Appearance

Height

Religion

Accent

Age

Weight

Name

Sexual Orientation

What Do We Do Now?

Thought/Stereotype Suppression

("Color blind"- race or gender)

Wegner et al. Paradoxical Effects of Thought Suppression, JPSP, (1987)

Trying not to think about stereotypes often backfires
"Suppression rebound"

Macrae et al. (1994)

Monteith et al. (1998)

It's not whether you have biases. It's about which one is your bias

Uhlman & Cohen (2007)

What Do We Do Now?

Sex and racial biases, in particular unconscious ones, often manifest in the form of microaggressions

Addressing the Elephant in the Room:
Microaggressions in Medicine
Annals of Emergency Medicine, 10/20
Melanie F. Molina, MD;* Adaira I. Landry, MD, MEd; Anita N. Chary, MD, PhD; Sherri-Ann M. Burnett-Bowie, MD, MPH

What Do We Do Now?

Microaggressions …. [are] subtle, stunning, often automatic, and non-verbal exchanges, which are ‘put downs…. ‘

“Micro” refers not to insignificance of these exchanges, but rather to their being “commonplace, daily exchanges.”

Although a comment may not be intended to offend or cause harm, this does not change its effect on the receiving party.

What Do We Do Now?

Although microaggressions occur on individual and interpersonal levels, macroaggressions occur on institutional or systemic levels and manifest as biased or discriminatory policies, governance, and other practices….

Setting the Stage

Unconscious or implicit bias refers to attitudes or stereotypes about certain groups (eg, women, racial minorities, LGBTQ people) that affect understanding, actions, and decisions unconsciously.

These unconscious assessments or attitudes can be either favorable or unfavorable and are automatically activated. Unconscious bias may produce behaviors that are opposite to consciously stated values

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Setting the Stage

From residency lore to mainstream press, there are mentions of female physicians being called “sweetie” or “honey”; in response, many become well versed at reminding patients and colleagues of their qualifications as physicians.

Addressing the Elephant in the Room:

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Annals of Emergency Medicine, 10/20

What Do We Do Now?

NY Times, August 2020

For Doctors of Color, Microaggressions Are All Too Familiar, “They ask you if you’re coming in to take the trash out — stuff they wouldn’t ask a physician who was a white male, ” microaggressive behavior, bias, and discrimination remain significant issues in health care and medical education.

What Do We Do Now?

What Do We Do Now?

St. Louis Cardinals
@Cardinals

You love baseball, she loves jewelry. On May 17th, it's a win-win. atmlb.com/2pdT73K

What Do You Do?

- At #WaltWhitman HS report of 2 students who posted a pic of themselves in blackface with the “n-word”. The principal says it was on a private social media account - but as these things do - quickly spread to others. Washington Post

- Looking at Montgomery County Public Schools data, reported hate incidents have gone up significantly since 2014-2015. Does this mean they are happening more? Or that students are more aware & empowered to say something? Fox 5 DC

What Do We Do Now?

Md. high school students distribute 'passes' granting permission to use racial slur

- Students at a suburban Maryland high school distributed "N-word passes" that were intended to grant students who received the pieces of paper "permission" to use the racial slur. The passes were issued by students at Winston Churchill High School during lunch Friday.

- It wasn't the only such incident at Churchill this school year. In November, a swastika was found on a desk. The symbol was again discovered at the school in more recent weeks, MCPS said.

Washington Post, 2019

What Do We Do Now?

- “A school district spokesperson said the passes were distributed to about 15 students during Friday’s lunch period and one student alerted administrators.

- Three students involved in creating and distributing the passes will be punished according to the Student Code of Conduct.

Bethesda Magazine

What Do We Do Now?

"You are too nice a girl for engineering school. Let's look at something else.

"These schools are not right for you. We'll look at other schools instead"

"You're supposed to be good in math."

"Asians are not a real minority."

What Do We Do Now?

Virginia Students Told to Be Slaves for Black History Month Gym Activity:

The school principal apologized to parents and said the “lesson was culturally insensitive“

What Do We Do Now?

"You speak English so well. Where did you learn to speak English?"

"You look illegal"

What Do We Do Now?

The Complaint alleges that the RCHSD staff discriminated against Kyler (age 14) by continuously referring to him with female pronouns, despite knowing that he was a transgender boy and that it would cause him severe distress. RCHSD's staff allegedly refused to treat Kyler as a boy precisely because of his gender non-conformance.

In fact, the Complaint alleges that one RCHSD employee told him, "Honey, I would call you 'he,' but you're such a pretty girl."

PRESCOTT v. RADY CHILDREN'S HOSPITAL SAN DIEGO
(S.D., Calif, 2017)

What Do We Do Now?


I set the rules, and you follow
them blindly, okay?
And if you have a problem with that,
then you can talk to our complaint department

What Do We Do Now?

Leadership & Organizational Culture

Increased awareness and understanding that such behaviors and comments are inappropriate, disturbing, and may well be illegal under our civil rights laws.

Indeed, microaggressive behavior invariably is part of a macro organizational pattern and practice that enables hostile work and learning environments to exist and maintain themselves.

What Do We Do Now?

Every time Ms. Prescott observed staff calling Kyler "she," she reiterated that “it was essential to exclusively refer to Kyler with male gender pronouns, and that misgendering caused him serious harm.“ The Complaint alleges that in response, RCHSD blocked her number, leaving her unable to call the CAPS unit.

As a result of RCHSD staff's conduct, Kyler suffered severe emotional distress and harm, and Ms. Prescott was and continues to be traumatized by the experience.

Prescott v. Rady Children's Hosp.-San Diego,
265 F.Supp.3d 1090 (S.D. Cal. 2017)

What Do We Do Now?

Despite concerns over Kyler's continuing depression and suicidal thoughts, Kyler's medical providers concluded that he should be discharged early because of the staff's conduct.

Prescott v. Rady Children's Hosp.-San Diego,
265 F.Supp.3d 1090 (S.D. Cal. 2017)

What Do We Do Now?

Kyler was discharged on April 8.

On May 18, Kyler died by suicide.

What Do We Do Now?

"….a supervisor's use of certain unambiguous racial epithets is likely to alter the conditions of employment and create a hostile working environment, weighing heavily in the severity factor…."

What Do We Do Now?

Plainfield's practice of honoring the racial preferences of residents was accompanied by racially-tinged comments and epithets from co-workers.

For instance, in the presence of a resident, a white nurse aide named Audria called Chaney a "black b….." Another time, a white coworker looked directly at Chaney and asked why Plainfield "... keep[s] on hiring all of these black……."

Chaney v. Plainfield Healthcare Ctr., 612 F.3d 908 (7th Cir. 2010)

What Do We Do Now?

Chaney alleges that more subtle racial slights and comments continued even after management was notified of the problem.

Most importantly, Plainfield acted to foster and engender a racially-charged environment through its assignment sheet that unambiguously, and daily, reminded Chaney and her co-workers that certain residents preferred no black CNAs. Unlike white aides, Chaney was restricted in the rooms she could enter, the care that she could provide, and the patients she could assist....

Chaney v. Plainfield Healthcare Ctr., 612 F.3d 908 (7th Cir. 2010)

What Do We Do Now?

Muhammad, who is of Pakistani descent, works for Motors, a large automobile dealership. His coworkers regularly call him “camel jockey,” “the local terrorist,” and “the ayatollah,” and intentionally embarrass him in front of customers by claiming that he is incompetent.

The EEOC finds reasonable cause to believe that the constant ridicule has made it difficult for Muhammad to do his job and has created a hostile work environment in violation of Title VII.

What Do We Do Now?

- Unconscious bias is measurable, widespread, disassociated from conscious bias, and is now cognitively and quantitatively validated. It is reflected in attitudes or stereotypes that affect one's understanding, decision-making, and behavior, without consciously realizing it in many instances.

- The first step in solving any problem is to recognize its existence. Understanding the science related to identifying and conceptualizing bias helps us to recognize and acknowledge bias and its possible effects. The following discussion reviews many of the scientific factors revealing bias.

Psychology Today

What Do We Do Now?

The amygdala is the “emotional” center of the brain that reacts to fear and threat and other senses.

Scientists have found a measurable correlation between amygdala activity and implicit racial bias. The point again is that research shows a visual brain response, even though an individual may not be conscious of it.

Psychology Today

What Do We Do Now?

The amygdala isn't the only part of the brain involved in unconscious bias. The frontal cortex is also identified as important in forming impressions of others and in measuring empathy.

Memories, such as dates and facts, also subconsciously steer people toward choosing one option over another.

Psychology Today

What Do We Do Now?

Medical research has revealed that implicit bias is found throughout the brain. There are useful aspects of implicit bias that pertain to instinctual behaviors of environmental adaptation and survival, such as being able to quickly assess and respond to dangerous stimuli.

However, automatic responses to facial stimuli, combined with social conditioning, can result in bias against individuals, often based on race. Acknowledging that we all have biases is the first step toward reducing our reliance on generalizations or stereotypes.

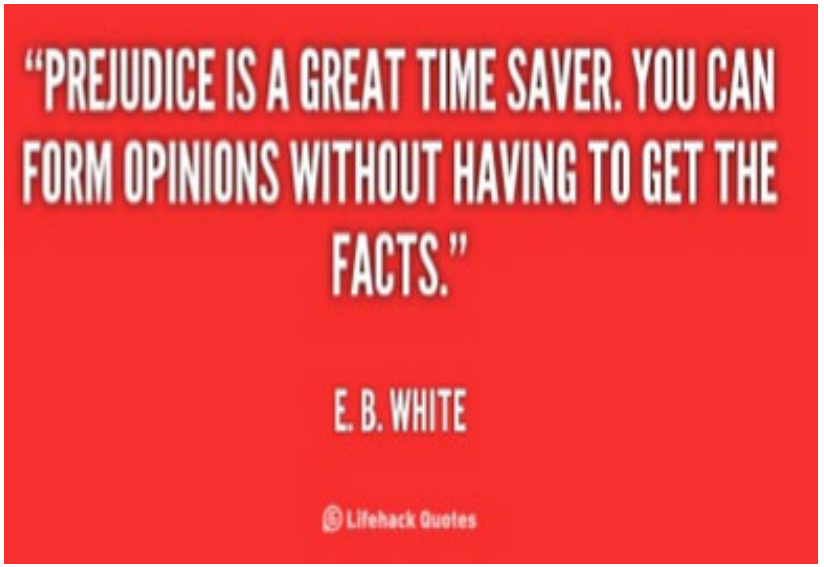
Georgetown University School of Medicine

Increased by…

- ✓ stress
- ✓ time pressure
- ✓ multi-tasking
- ✓ lack of clear criteria for decision-making
- ✓ ambiguous or incomplete information
- ✓ lack of familiarity with people from the group

Not decreased by…

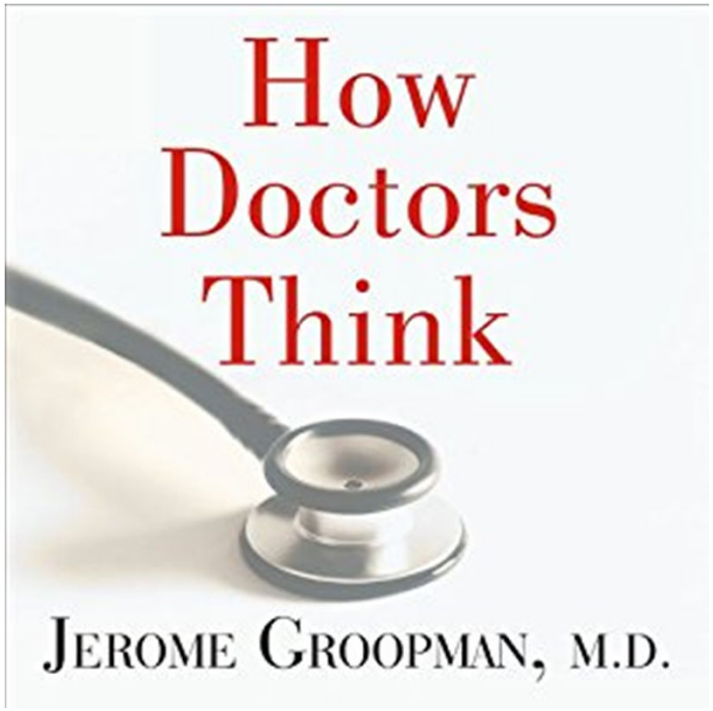
- X good intentions
- X someone else telling you to reduce your bias
- X suppressing bias
- X avoiding people from other groups
- X thinking you don't have bias



How People Think

Pattern Recognition

- Triage, time sensitive details being sorted out quickly
- Clinical conditions are sorted with overall "picture" stored in doctor's memory.
- Drawing on stereotypes to make decisions, can miss some relevant information and fail to identify the right patterns.



Source: J. Groopman, MD. How Doctors Think

What Do We Do Now?

"[Discriminatory intent] is… the cumulative evidence of action and inaction which objectively manifests discriminatory intent."

Dowdell v. City of Apopka, Florida, 698 F. 2d 1181 (11th Cir. 1983)

Plaintiffs claimed that Apopka intentionally maintained a racially and geographically segregated system of municipal services.

The Court agreed.

What Do We Do Now?

Are Your Encounters Different Because of the Patients' Race, Color, Language, Age, Sex, Religion, Sexual Orientation, Sexual Identity, or National Origin?

"[Discriminatory intent] is, rather, the cumulative evidence of action and inaction which objectively manifests discriminatory intent."

What Do We Do Now?

"Although none of these factors is necessarily independently conclusive, "the totality of the relevant facts," … amply supports the finding that the City of Apopka has engaged in a systematic pattern of cognitive acts and omissions, selecting and reaffirming a particular course of municipal services expenditures that inescapably evidences discriminatory intent."

What Do We Do Now?

- “Chinasa, an experienced retail professional who works for National Retailer, speaks English with a Nigerian accent. National Retailer selects Chinasa for a Regional Loss Prevention Manager position.
- An executive who will oversee Chinasa's work approaches her immediately after the promotion and comments, "I bet this is a great achievement considering where you came from. As an African, you must be the first to achieve this much success in your family given your accent."
- The executive tells Chinasa to "try to speak more like an American" and also to be careful about her demeanor because, in his opinion, "Africans are known to be brash and aggressive." The executive repeats these comments on several occasions during Chinasa's first several months on the job.

What Do We Do Now?

- There is no evidence, however, that staff members misinterpret or do not understand Chinasa's spoken English. In fact, the evidence shows that staff members respond promptly to Chinasa's directions without seeking clarification and provide information that is responsive to her requests. Nonetheless, after nine months, the executive terminates Chinasa's employment, telling her that she is a "poor fit" and laments that she did not speak "more like an American."
- Based on these facts, the EEOC finds reasonable cause to believe that National Retailer discriminated against Chinasa because of her national origin." *Albert-Aluya v. Burlington Coat Factory Warehouse Corp*., 470 F. App'x 847 (11th Cir. 2012)

What Do We Do Now?

What Do We Do Now?

1) "examining and understanding attitudes, such as mistrust, subconscious bias, and stereotyping, which practitioners and patients may bring to clinical encounters;

2) gaining knowledge of the existence and magnitude of disparities, including the multifactorial causes of health disparities and the many solutions required to diminish or eliminate them; and

3) acquiring the skills to effectively communicate and negotiate across cultures, languages, and literacy levels, including the use of key tools to improve communication. "

Recommendations for Teaching about Racial and Ethnic Disparities in Health and Health Care - Annals of Internal Medicine, 2007

What Do We Do Now?

- "Most managers accept that employers benefit from a diverse workforce, but the notion can be hard to prove or quantify, especially when it comes to measuring how diversity affects a firm's ability to innovate.
- But new research provides compelling evidence that diversity unlocks innovation and drives market growth—a finding that should intensify efforts to ensure that executive ranks both embody and embrace the power of differences."

- Harvard Business Review

What Do We Do Now?

- "The report found higher financial performance for companies with higher representation of women board directors in three important measures:
  - Return on Equity: On average, companies with the highest percentages of women board directors outperformed those with the least by 53 percent.
  - Return on Sales: On average, companies with the highest percentages of women board directors outperformed those with the least by 42 percent.
  - Return on Invested Capital: On average, companies with the highest percentages of women board directors outperformed those with the least by 66 percent."

Catalyst & The Chubb Corporation

What Do We Do Now?

"The correlation between gender diversity on boards and corporate performance can also be found across most industries—from consumer discretionary to information technology."

Catalyst & The Chubb Corporation

What Do We Do Now?

"We seek to help solve the puzzle of why top-level leaders are disproportionately White men.

We suggest that this race- and sex-based status and power gap persists, in part, because ethnic minority and female leaders are discouraged from engaging in diversity-valuing behavior. "

Does Diversity-Valuing Behavior Result in Diminished Performance Ratings for Non-White and Female Leaders? 2017

What Do We Do Now?

"We hypothesize, and test in both field and laboratory samples, that ethnic minority or female leaders who engage in diversity-valuing behavior are penalized with worse performance ratings, whereas White or male leaders who engage in diversity-valuing behavior are not penalized for doing so.

We find that this divergent effect results from traditional negative race and sex stereotypes (i.e., lower competence judgments) placed upon diversity-valuing ethnic minority and female leaders."

Does Diversity-Valuing Behavior Result in Diminished Performance Ratings for Non-White and Female Leaders? 2017

What Do We Do Now?

Addressing Gender and Racial Bias Among Clinicians

Harvard Business Review 9/13/18

It's an all-too-familiar problem:

Throughout the work world, women are often perceived as lower status or somehow less capable than their male counterparts. That's no less true in health care than in other fields.

Every female doctor has experienced some version of the **story** Loren Rabinowitz recently recounted in the *New England Journal of Medicine*. The senior resident in an ICU, she had just finished a difficult discussion with a patient's family. As she sat down to document the conversation, the unit's telephone rang. It was the patient's wife, with whom she'd just spoken, asking to "talk with his doctor"—Dr. Rabinowitz's male intern.

What Do We Do Now?

We had both sat through medical school lectures on implicit biases as they relate to patients and health disparities. Until that day in the ICU, it hadn't occurred to either of us to apply the lessons we learned from bias training to our peers and other hospital personnel, or that it might be our obligation to educate patients about their unconscious biases regarding their health care providers.

That moment of mutual acknowledgment that we all have blind spots and wrestle with how we perceive and are perceived by others will remain among the most important of my residency training. As physicians, we strive to treat all our patients equally. It is imperative that we do the same for our colleagues.

What Do We Do Now?

The first step in addressing implicit biases and microaggressions is to recognize that they exist.

The second step in addressing unconscious or conscious bias is to identify strategies to counteract it. One such strategy involves developing frameworks to respond to microaggressions directly in a productive and respectful way.

Lastly, ongoing efforts are needed to diversify the workforce, strengthen multidisciplinary teamwork, and identify strategies to promote a healthy work environment.

Addressing the Elephant in the Room: Microaggressions in Medicine

Conditions That Can Produce Biased Behavior

Bias is more likely to affect behavior in certain situations:

- Heavy workload
- Fatigue
- Tight deadlines
- Stressful situations

How Can We Solve This Problem?

1. **Understand**
   - Bias is *normal* and reducing implicit bias is like *breaking a habit*

2. **Be aware of your biases**
   - **Assess what makes you make *snap judgements***

3. **Realize the impact of your biases**
   - A person's *merit and character* should be above all else
   -

4. **Replace those biases**
   - Think more broadly
   - Counter stereotypical examples
   - Perspective taking

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. L. (2012). Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. Journal of Experimental Social Psychology, 48, 1267-1278

What Do We Do Now?

Are Your Encounters Different Because of the Patients' Race, Color, Language, Sex, Age, Religion, Sexual Orientation, Sexual Identity, or National Origin?

"Discriminatory intent is the cumulative evidence of action and inaction that objectively manifests discriminat[ion]."

What Do We Do Now?

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