Perspective / Opinion

Leadership and Health Disparity

By Enrique Avila and Lauren Sikora

As healthcare providers and future physicians, our role is to treat all patients with respect, fairness, and equity. However, a dive into the literature reveals disparities in healthcare for underrepresented groups and populations in our country. This is quite the contrary to the equality in treatment we strive for as a community. Examples from the literature show that physicians are two- to three-times less likely to order bone mineral density tests or osteoporosis prescription treatment for Black women as compared to White women. Another example is that Black and Hispanic men are more likely to receive advanced cancer stage diagnoses and are less likely to receive definitive therapy compared to white men (Hoffman 2016). Statistics and findings such as these lead one to wonder why these inequities exist and pertain to why our group is a part of the leadership curriculum.

Discovering why healthcare disparities across different racial groups impact patient care is imperative to improving the healthcare experience overall. Scientists believe that implicit bias plays a role in these disparities. Implicit biases refer to attitudes or stereotypes, both favorable and unfavorable, that can unconsciously affect our understanding, actions, and decisions. Such biases can manifest unintentionally and unknowingly during patient-physician interactions.

While most healthcare workers enter the workforce with altruistic motives and a desire to improve their communities, they are still human and have internal biases. Several studies regarding perspectives of biological differences between Black and white patients had quite concerning outcomes, given that the individuals queried were medical students and other medical professionals. A statistically significant number of medical students and residents believe Black patients had thicker skin than white patients. Additionally, the data showed that medical professionals thought Black patients had higher pain tolerances than white patients (Hoffman 2016). Biases such as these can, and will, lead to racial disparities in treatment, and subsequently mistrust in the healthcare system. Only through systematic attack of our own beliefs through self-introspection with uncomfortable honesty and vulnerability, can bias be changed for the betterment of our patients.

Addressing implicit bias among MCW students

Recently, a survey conducted by the MCW Student Assembly Diversity Committee found that "41% of respondents felt that the MCW curriculum **DOES NOT** adequately teach about the impacts of racism and bias in patient care." This survey combined with the studies mentioned prior, sparked interest for our group of medical students to search for a solution and improve the current medical education by providing proper implicit bias education and training.

Thanks to a 2021 Transformational Ideas Initiative (TI2) of the Kern Institute, our group conducted a study created to introduce medical students to implicit bias and foster self-reflection. We challenged students to critically think about how individual bias shapes interactions, and how that bias could affect patient-provider relationships. The study utilized small group discussions, guest speakers, and role-playing based around a clinical vignette. This format, along with pre- and post-reflective surveys, was designed to provoke thought on their own personal biases and common biases plaguing the medical system. Data obtained from the surveys revealed that medical students believe unconscious bias plays a significant role in numerous levels of healthcare and that implicit bias training is important for medical education. Yet, the surveys also revealed that participants believe MCW does not prepare them well enough to treat patients of different backgrounds.

A significant finding from our study was that students were believed that these sessions were valuable and, therefore, should be formally integrated into medical school curriculum. This feedback was exciting, especially when asked to incorporate our work on implicit bias into the leadership curriculum led by Jeff Fritz, PhD, and Kelli Cole. We are thrilled to be working on a project with other students motivated by revolutionizing education through work that will educate medical students and impact our medical community for the better.

For further reading:

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, *113*(16), 4296–4301. https://doi.org/10.1073/pnas.1516047113

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