We must be aware of and fight unconscious bias in healthcare

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It comes in many forms and can even affect patient safety, write Narinder Kapur and Peter Jones

In 2013, Kayo Adebayo graduated with a masters' degree in nursing (name and details changed for anonymity, but based around a real case). Over the next four months, she submitted her CV to dozens of prospective employers, without a response.

In November that year, she attended a workshop on unconscious bias and a few days later sent her CV to two prospective employers. Ten days later Kayo began work after choosing from two job offers from her two applications. The only change Kayo had made was in her name; Kayo Adebayo had become Kayla Benjamen.

What Kayo learned was that UK employers unconsciously shift out job applications with Asian or African sounding names, and making her name less obviously of African origin might overcome this unconscious bias. It worked.

Bias can be benignly defined as a disposition to think, feel or act in a particular way and can be seen as cognitive short-cuts, saving the brain energy. They can arise from long-standing beliefs, ingrained habits, peer or organizational pressures, stress and anxiety, cognitive overload, and goals that need to be achieved.

Unconscious bias occurs when such dispositions or tendencies are outside our awareness and conscious control.

Affecting staff

Unconscious bias in such a large and diverse organization as the NHS has major potential to affect the treatment of staff in a variety of ways – recruitment, promotion, work allocation, allowances at work, awards, allocation of resources, support during ill-health or when under stress, treatment when the individual raises concerns ('whistleblowing'), performance management, application of disciplinary procedures, and reporting to a regulatory body.

Disparities in ethnic representation at senior levels in the NHS highlight the issue of conscious or unconscious racial bias in recruitment and / or promotion. Unconscious bias may be present at the level of organizations and in relationships between staff, especially in hierarchical settings.

NHS disciplinary hearings are quasi-judicial affairs, yet the NHS seems oblivious to the fact that there are a wide range of ways in which unconscious bias may operate in the various processes involved in judicial decision making.

In his 2015 report into whistleblowing in the NHS, Sir Robert Francis referred to the presence of kangaroo courts in the NHS, and leading lawyers have recently called for a major overhaul of the NHS disciplinary process in view of the numerous potentials for bias in the current system.

The NHS currently spends huge amounts on legal fees and other costs when there are disciplinary hearings, employment tribunal cases, High Court battles and compromise agreements that include financial settlements. No-one knows the exact amount, but it is likely that it runs into millions of pounds.

Unconscious bias tends to escalate staff and Trust dissatisfaction and disagreement, since a Trust may perceive certain staff such as whistleblowers as being troublemakers, rather than people who have genuine concerns.

Affecting patient care

Such bias in relation to certain ethnic groups, especially when combined with other factors, may result in a less serious diagnosis and a lower likelihood of referral of ethnic patients to a specialist.

Unconscious race bias in favour of white versus black people has also been found to affect whether pain relief is prescribed to black patients.

Unconscious bias has been found to play a role in diagnostic errors, which form a key contributory factor to many serious patients safety events, many of which end up in litigation. There is an indirect cost to the NHS that emanates from the presence of such bias.

Unconscious cognitive biases can operate in subtle ways. Let's take an example.

Dr Jones, a consultant in A&E, had experienced a busy week during which he had seen three cases of presumed hiatus hernia, all of which had turned out negative after further investigations.

There is an overload of beds occupancy in the Acute Admission Unit, and Dr Jones was given strict instructions by the chief executive to restrict the number of patients coming from A&E to the Acute Admissions Unit. It seems that the unit was very costly to run, and was contributing to the hospital's financial crisis.

A 30 year-old man, a long-term asthmatic, is brought to the A&E by ambulance. The patient admits to chest pain, and Dr Jones goes down the line of a cardiac condition.

He orders an ECG and then an echocardiogram, which is normal. He further orders a cardiac angiogram, which is also normal. Because of the bed costs issue, he chooses not to admit the patient. Subsequent investigations are found to reveal that the patient has a hiatus hernia.

The three unconscious biases operating here are – Availability Bias (having recently seen three possible cases of hernia, all of which turned out to be negative); Goal Attainment Bias (being influenced by the order regarding pressure on beds); and Confirmation Bias (repeatedly trying to get evidence to confirm an initial hunch, without considering other options).

Detection and prevention

The Implicit Association Test has been widely used across a range of settings, centred around the work of Professor Banaji at Harvard University in the form of Project Implicit.

Similar instruments have been developed in the UK. We have developed an unconscious bias test that is the first one to be designed to assess attitudes towards whistleblowers in healthcare settings.

This test might be of value in the selection and training of Freedom to Speak Up Guardians, who have been appointed in every NHS Trust as one of the recommendations of the 2015 Francis Report.

Biases are usually multifactorial in origin, often reflecting organisational, situational and individual factors, one or more of which may be long-standing and deeply entrenched.

It is worth noting that there have been advances in cognitive techniques to help reduce bias. Such techniques may include:

- **promoting knowledge and awareness of forms of unconscious bias**
- **avoiding triggers that may precipitate the occurrence of bias**
- **slowing down thinking at key times**

- **presentation of scenarios where such bias may occur and confronting individuals with examples that run counter to thinking habits which promote unconscious bias**
- **having contact with groups for whom individuals may have stereotype bias**
- **having role models who speak and act in ways that are counter to bias**
- **putting yourself in the shoes of others by perspective taking exercises**
- **having regular tests of unconscious bias in respect of particular domains**

In the case of unconscious racial bias, we have developed a virtual reality app that allows the individual to be 'put in the skin' of a black avatar, whose head movements mirror those of the game player.

Senior clinical and management staff in healthcare settings should undergo formal, systematic training in respect of unconscious bias, with annual refreshers, rather than the superficial one-off training that is currently in place in many parts of the NHS.

Staff involved in recruitment and disciplinary procedures should undergo an enhanced form of such training, with six monthly refreshers, and a refresher within two months of a recruitment or disciplinary hearing.

Such training should be documented in annual staff appraisals. The more senior the post, the more rigorous and more frequent should be the training in relation to unconscious bias.

It behoves the NHS to accept that conscious and unconscious bias exists and to take steps to prevent its occurrence and mitigate its adverse effects.

The problem with many current interventions in the NHS is that they are often off-the-shelf products that do not allow for the complexities of the NHS, they are seldom delivered by those with direct

experience of working in the NHS, and they rarely have an explicit or implicit assessment of learning that is ecologically valid.

Peter Jones is a bias psychologist at Shire Professional and Narinder Kapur is a visiting professor of neuropsychology at University College London