**Policy, Advocacy and Activism: On Bioethicists’ Role in Combating Racism**

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Marion Danis et al., make a compelling case for the claim that bioethicists have an “obligation to promote health equity” by drawing attention to, and attempting to remedy, racial differences in health and healthcare that are “avoidable, unfair and unjust” (Danis et al., 2016). They argue that in addition to the structural factors that reinforce racism and social disadvantage “implicit biases subconsciously shape the perceptions and reactions of many individuals … when encountering black and brown bodies” (Danis et al., 2016). Further, they point out that physicians’ unconscious racial biases are associated with “negative emotional tone, more clinician dominance in medical encounters, less patient-centered care … and subsequent distrust among African-American patients” (Danis et al., 2016). Research on the social determinants of health further demonstrates that racism is one cause of injustice in the healthcare setting.

Danis et al. suggest several ways in which bioethicists might contribute to addressing racism and its effects. One such recommendation is that bioethicists intervene at the policy level within their institutions by focusing on how to reduce the effects of implicit biases perpetuated through the “manner in which clinicians make decisions for patients” (Danis et al, 2016). This will require proposing ways to alter unconsciously driven behaviors shaped by implicit racial biases. However, Danis et al., leave open “whether and to what extent bioethicists should play an advocacy or activist role” (Danis et al., 2016).

In this respect, their conclusions are much too tentative. As demonstrated by recent efforts in the discipline of philosophy (and elsewhere), there is a crucial need for both advocacy and activism if biases built-in to “business as usual” are to be attenuated. The clear injustices that result from implicit bias call for bioethicists to be assertive and persistent in promoting institutional reform. One significant obstacle to reducing the effects of implicit bias is the investment of decision-makers in the rationality of their own judgments. Like philosophers, health care practitioners (HCPs) are highly trained professionals charged with making complex, authoritative decisions on the basis of their considered judgments. Indeed, in the healthcare setting, patients’ lives depend on HCPs’ ability to confidently move forward on the basis of what they judge to be the right course of action. HCPs are therefore likely to find it difficult to let go of the belief that their judgments are fully rational and evidence-based. This reluctance will, in turn, negatively impact their ability and willingness to change behaviors and decisions that flow from unconscious racial (and other) biases.

In order to overcome this difficulty, bioethicists need to advocate for changes in the self-concepts of HCPs. In particular, they need to challenge the bedrock assumption that HCPs’ judgments are always rational. This will require providing evidence of both the presence and effects of implicit bias in the healthcare setting. Evidence that a given individual has unconscious biases is not too difficult to demonstrate. HCPs can simply be encouraged to take one of several reputable implicit association tests (IATs) available on the internet. These allow a person to see how often she associates negative concepts with particular social groups (Kang and Banaji 2006). Providing evidence that these biases are having deleterious effects on patient treatment is somewhat more difficult, but still possible. Such evidence cannot merely point out disparities in health outcomes and quality of treatment among social groups, because it is too easy to attribute these disparities to causes other than racism in the clinic or hospital where members of these groups are seen. Rather, in order for the research to be convincing to HCPs, it must show that implicit biases are determining decisions in an irrational way even when they are trying their best to make good decisions. For instance, Jerry Kang and Mahzarin Banaji describe a study in which,

Two hundred and ninety-one medical interns in the Boston and Atlanta metropolitan areas were randomly assigned to view, read symptom profiles, and make diagnoses and treatment recommendations for a hypothetical Black or White patient. Consistent with the prevalence of coronary artery disease (CAD) in Black and White Americans, Black patients were more likely to be diagnosed with CAD than white patients. However, treatment with state of the art Thrombolytic Therapy was given *equally* to Black and White patients … The most highly biased interns as measured by the IAT were also the most likely to treat White patients with Thrombolytic Therapy, despite their own diagnoses of Black Americans’ higher likelihood of CAD. … [Even though the interns] were subject to strong demand effects to demonstrate that they were colorblind, they still engaged in disparate treatment that correlated with their implicit biases (Kang and Banaji, 2006).

Bioethicists can use this type research to reinforce the notion that if HCPs wish to behave in a rational manner consistent with their conscious belief that all patients are equally valuable, then they must come to understand themselves as acting on implicit racial biases that they do not endorse. This change in self-concept will then open up the possibility for bioethicists to design and implement strategies to combat implicit bias in the institutions where they work. Changing entrenched policies and behaviors is always challenging, but will be much easier with the support of people who recognize that these measures are clearly necessary. However, even with the broad support of HCPs, bioethicists will probably need to adopt an activist role with respect to achieving and reinforcing concrete change at the institutional level, especially when new policies add time, effort and expense to existing procedures.

Bioethicists should push for changes modeled on existing best practices for “de-biasing” already in use in the hiring and evaluation of employees in academia and business as well as in law enforcement training. These “equality protocols” should adapt proven de-biasing strategies to specific healthcare settings. Bioethicists can be instrumental in outlining and justifying policies narrowly tailored to particular specialties such as emergency medicine, general practice, and cancer treatment. Following Kang and Banaji, these policies should take the form of “proactive structural interventions” modeled on a public health approach (Kang and Banaji, 2006). This is a preventive approach in which it is taken as given that problems produced by implicit bias cannot be corrected merely through the “conscious practice” of individuals (Kang and Banaji, 2006). Instead, interventions should start from the premise that implicit biases are harmful but difficult to detect on a case-by-case basis, and so can only be screened out by proactive measures that re-shape physician-patient interactions in fundamental ways. For example, they note that “where water safety cannot be guaranteed, we do not wait until citizens get infected, we inject a purifying agent prior to imbibing” (Kang and Banaji, 2006). By analogy, where non-discriminatory treatment cannot be guaranteed due to implicit bias, preventive measures must be implemented at the level of policy.

What might such policies look like in practice? Below, I briefly sketch a few interventions that are worth considering in more detail.

* Formation of implementation intentions combined with rehearsal and simulated decision-making: Research has shown that the formation and rehearsal of “implementation intentions” can give rise to nonbiased behaviors quite successfully (Stewart and Payne 2008; Kelly et al., 2010). Implementation intentions are if-then action plans that take the form of, for instance, “if I see a Black face, I will think ‘compliant patient’” designed to counter an undesirable behavioral, cognitive or emotional response (in this case, the common - biased - view that people of color are less compliant with recommended courses of treatment). It has been shown that provided implementation intentions are rehearsed a sufficient amount, the rehearsed response will be automatically generated in the relevant real-world conditions (Stewart and Payne 2008). Implementation intentions can be tested and further reinforced by combining them with simulated decision-making scenarios, which are an established element of law-enforcement de-biasing training (Feingold and Lorang 2012).
* Decreasing time pressure: Jennifer Saul and Sally Haslanger emphasize that implicit biases have their greatest effects when people are working quickly or rushing, and when they are not able to give their full attention to the task at hand (Saul 2012; Haslanger 2008). While measures to reduce time pressure are likely to seem unrealistic in a healthcare setting (and are likely to be unpopular with insurers), mere efficiency does not justify persisting in unjust practices. If HCPs are expected to diagnose and treat patients according to evidence-based criteria and not by relying on background assumptions and biases then they must have enough time to go through the necessary cognitive steps and the ability to focus their full attention on this task. Combined with other strategies, allowing more time per patient encounter could help guard against bias as well as ensure higher quality treatment for all.
* Accountability through continued monitoring: Individuals must be aware of the patterns their decisions exhibit in order to identify exactly when and where biases are at work. To this end, institutions should institute monitoring and review procedures aimed at uncovering over-, under- or non-standard treatment of certain types of patients on the basis of race. This strategy has been employed in law enforcement contexts, where supervisors are able to look for any irregularities or disproportionalities in the conduct of individual officers by periodically reviewing reports on their work with the reduction of bias in mind (Carmichael 2015).

**References**

Carmichael, Sarah Green. 2015. Training Police Departments to be Less Biased. *Harvard Business Review.* <https://hbr.org/2015/03/training-police-departments-to-be-less-biased>. Accessed: January 14, 2015.

Danis, Marion, Wilson, Yolanda and White, Amina. 2016. Bioethicists Can and Should Contribute to Addressing Racism. *American Journal of Bioethics.*

Feingold, Jonathan and Lorang, Karen. 2012. Defusing Implicit Bias. *UCLA Law Review Discourse* 59: 210-228.

Haslanger, Sally. 2008. Changing the Ideology and Culture of Philosophy Not by Reason (Alone). *Hypatia* 23: 210-223.

Kang, Jerry and Banaji, Mahzarin R. 2006. Fair Measures: A Behavioral Realist Revision of “Affirmative Action”. *California Law Review* 94: 1063-1117.

Kelly, Daniel, Faucher, Luc and Machery, Edouard. 2010. Getting Rid of Racism: Assessing Three Proposals in Light of the Evidence. *Journal of Social Philosophy* 41: 293-322.

Saul, Jennifer*. 2012. Ranking Exercises in Philosophy and Implicit Bias.* Journal of Social Philosophy. 43: 256-273.

Stewart, Brandon D., and Payne Keith B. Bringing Automatic Stereotyping Under Control: Implementation Intentions as Efficient Means of Thought Control. *Personality and Social Psychology Bulletin* 34: 1332-1345.