COMMENTARY

Discovering and Reflecting on Bias: A Discussion about Challenges and Benefits of Culturally Centered Patient Care with Women Physicians of the East Bay

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ABSTRACT

Implicit or unconscious bias is a lens through which we see our world based on our past experiences and learned stereotypes. Within health care, this lens of bias has typically had a negative impact on patient care, particularly for marginalized populations. We sat down with 3 physicians within Kaiser Permanente East Bay to learn about their personal experiences of bias in patient care. We also discuss the importance of acknowledging bias and practicing cultural humility in order to best ally with our patients. We are hopeful our conversation with these physicians will inspire more of the same, leading to improved health care for those that have suffered from bias in the past.

INTRODUCTION

Physicians, although often proud of their foundation in evidence-based, objective, and scientific care, cannot remove the unique vantage point that is created by our experiences, environments, and learned stereotypes. We each view our world from a unique vantage point that is created by our experiences, environments, and learned stereotypes. These perspectives or implicit biases live in our subconscious and inform our everyday actions. They create a lens through which we see our world and ultimately affect our choices, often resulting in unintended consequences.[1] We spoke to 3 physicians from the Kaiser Permanente (KP)-East Bay service area about how these lenses affect their patient interactions and how acknowledging our own implicit biases can improve the care we provide individually and as a health care system.

Nailah Thompson, DO; Patricia Castañeda-Davis, MD; and Amanda Williams, MD, are physicians who are leaders in local conversations about recognition of implicit bias and cultural humility in the health care system. However, to lead these conversations about steps to move forward through these challenges, we must have an understanding and an appreciation of the history of bias in health care.

HISTORY OF BIAS IN HEALTH CARE

Dr Thompson, who leads a blood pressure clinic for African American patients, highlights how history plays an integral role in her daily care: "*I started the African American blood pressure clinic to bridge the gap between the great job Kaiser [Permanente] was doing with blood pressure control across the nation and the discrepancy of suboptimal blood pressure control in African Americans.… I think patients are concerned about things like experimentation, which are real concerns … [because] for some of my patients, Tuskegee happened in their lifetime.*"

The Tuskegee experiment, conducted from 1932 to 1972, studied the effects of untreated syphilis in African American men. The prospective study was formally titled "Tuskegee Study of Untreated Syphilis in the Negro Male." However, the participants of the study had agreed to examination and treatment. They were not informed that the intent was to observe untreated disease and ultimately included withholding effective treatment once penicillin was determined to be curative treatment and the standard of care in 1946.[2] This overtly biased study ended more than 50 years ago. However, we still see disparity imparted by a more implicit bias against African Americans and Latinx (Latino/Latina) communities resulting in poorer outcomes for those with diabetes, hypertension, and other chronic conditions.[3] Results of multiple studies, such as those evaluated in a meta-analysis by Meghani et al,[4] also show that black patients were consistently less likely to receive any pain medications compared with white patients in a similar situation.

Maternal and child health care has seen some of the bleakest outcomes of implicit bias in medicine. Dr Williams knows these numbers well. "*There are huge disparities that have been revealed in maternal health.… [T]he risk of death and major disability, (or near-misses, is 2 times higher in African American women compared to white women, and the risk of death is 3 to 4 times the rate.*" A recent article in the *Journal of Clinical Obstetrics and Gynecology* discusses these statistics along with noting that these disparities have existed for centuries and have increased in the past 100 years.[5] Specifically, black women experienced the fastest growing rate of maternal mortality between 2007 and 2014.[5] Ethnic minorities such as African American women are also less likely to receive minimally invasive hysterectomies compared with open abdominal hysterectomies for benign indications.[6,7]

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CULTURAL HUMILITY

Understanding the history of bias and racism in medicine and its subsequent effects on community health is part of a crucial foundation in developing methods to mitigate health disparities. However, the topics of racial and social inequities and the problems they create in health care can be overwhelming, and although many institutions are working to incorporate these conversations, finding the most effective way can be challenging. Dr Castañeda-Davis reflected on her experience when she first started leading these discussions 13 years ago. She said, "*[T]hey asked me to work on cultural humility and essentially 'address all health disparities'.… I think they only gave me 1 hour a week to identify and address everything. I think it's well intended, but oftentimes people are unaware of how to tackle this big problem.*"

The conversation acknowledging the ill effects of implicit bias is growing in hospitals and medical institutions. Previously, organizations tried to address implicit bias through concepts such as cultural competency. However, there is now a shift from "competency" to "humility." Cultural humility focuses on the individual needs and stories of patients and their communities to start reducing the larger problem of implicit bias. Most importantly, cultural humility is acknowledging the impossibility of being fully competent in *all* cultures and knowing this does not diminish respect for the patient and his/her perspective. The focus of this humility is ultimately asking the physician to acknowledge that the patient is alone the expert of his/her personal cultural identity. This relinquishing of power from the physician requires acknowledgment of personal implicit biases and having the tools to overcome how they can create disparate care.[8]

ACKNOWLEDGING PERSONAL IMPLICIT BIAS

Dr Castañeda-Davis shared the following: "*I have my own personal bias specifically related to [maternal-child health]. I realized I subconsciously thought African American women were more likely not to breastfeed, but I assumed a Latina mom would be breastfeeding and therefore biased my counseling towards that. So I saw my individual bias is what was leading to an individual health disparity.*" She then reflected how she continues to perform the difficult task of internal reflection regarding her own biases. "*Part of cultural humility is checking in with yourself on things that you're doing when you're in an uncomfortable situation. Cultural humility poses questions that walk you through your own biases, like 'How often am I having to change my automatic response? What is my bias? Why do I have this bias and what can I do about it? Have I ever been surprised? What kind of detrimental things is the bias leading to?'*"

Through our conversation with Dr Thompson, she emphasized that although acknowledging our bias can be awkward, ignoring it often creates a much more uncomfortable patient interaction. She said, "*If you are not comfortable as a provider with the conversation, it has been picked up and sensed by the patient.*" She notes that just as patients can sense discomfort, they also easily sense respect and when a physician sees them without judgment. She continued, "*If you don't understand what's going on in their life, you make an effort and try to.… It's about rebuilding that trust and making sure patients know why, and what our motivation is, that we're trying to prevent heart attack and stroke and really get their blood pressure under control and help them live their healthiest life.*"

ALLYSHIP

This effort to understand and humble yourself to the patient's perspective is the first step in becoming an ally to your patient and providing equitable health care. *Allyship* is defined as a lifelong process of building relationships based on trust, consistency, and accountability with marginalized individuals and/or groups of people.[9] Dr Williams explained how effective allyship exists only with recognition of implicit bias.

> *I think one of the best ways to fight implicit bias is to intentionally make yourself uncomfortable.… You cannot be a good ally until you confront your own implicit bias… People have to deal with the bias and the privilege first and then they are more equipped to be a good ally. Your positive intent does not negate your painful impact that you might have. And we're responsible for both and we have to figure out when we do offend or we do hurt someone, how do we remedy that and make it better and commit ourselves to doing something differently.*

Dr Williams underscores that ultimately allyship is not self-defined and that our efforts must be recognized by those with whom we ally. All 3 physicians shared some of their experiences of advocacy and allyship and reflected how this adds passion and fulfillment to their careers.

Dr Castañeda-Davis told us about her time working in California Congresswoman Barbara Lee's office as a staffer specializing in health care issues.

> *My proudest moment in any of my careers was working as her staffer. An African American teenager came into her office. He had been at the wrong place at the wrong time and had been injured in the stomach by a bullet. Before his injury, he was a straight A student and was on his way to college. Due to his injury, he couldn't digest food and lived mostly on TPN [total parenteral nutrition]. His insurance company wanted to do a cadaver transplant but a facility in Chicago approached him about doing a living donor transplant. His brother was a perfect match but the insurance company wouldn't allow it because the Chicago facility was out of network. He fought them for a year and couldn't get it done and he came into our office, told us his story, and gave us the information.*

Nailah Thompson, DO, is an African American internal medicine physician at Kaiser Permanente Oakland Medical Center with expertise in preventive medicine. Dr Thompson played basketball throughout her academic studies and started her college education as an electrical engineering major. She transitioned to the medical field when she saw her sister and others struggle with diabetes. After completing her internal medicine residency at Highland General Hospital, Oakland, California, she went on to study preventive medicine and obtain her master's in public health degree at Columbia University, New York, New York. Since returning to the Bay Area, she continues to work fervently serving the underserved population in East Bay communities with a goal of addressing their health before chronic conditions can manifest.

Patricia Castañeda-Davis, MD, was born to a Mexican mother and Jamaican father, and with this background, started acknowledging bias and racism at a young age. She followed in her father's footsteps to become a physician, and with a passion for children, it was an easy choice for her to pursue pediatrics. She completed a pediatric residency at Children's Hospital of Oakland, Oakland, California, where she was able to care for a diverse patient population. She has

an interest in Latino and African American children and the stereotypes and health disparities they face. Her career has also been enriched by working as a congressional staffer in California Congresswoman Barbara Lee's office, where she focused, among other things, on health care issues in her district.

Amanda Williams, MD, is an African American obstetrician and gynecologist and is currently the chief of the OB/GYN Department at Kaiser Permanente Oakland Medical Center. She was born and raised in Washington, DC, and received her undergraduate degree from Harvard University in Cambridge, Massachusetts. She subsequently moved to Atlanta, Georgia, where she received both her medical degree and master's in public health degree from Emory University. Finally, she made her way to California for her internship and residency in obstetrics and gynecology at the University of California, San Francisco Medical Center, San Francisco, California. Since she joined Kaiser Permanente Oakland Medical Center, she has been involved in addressing racial health disparities in the realm of OB/GYN through her individual practice as well as through outreach via social media.

She reflects on the impact of simply being a physician in the political arena. "*I called the insurance company and I introduced myself as Dr Castañeda-Davis from Congresswoman Barbara Lee's office.… [A]t first the woman at the insurance [company] wanted to try to explain the procedure to me, and I was able to tell her that 'I'm a practicing medical doctor, I know the medicine. I don't understand why you won't pay for this.' And then, within 3 months, he had the surgery; they had flown him into Chicago, [had] done the surgery. The insurance approved it and paid for everything.*"

Dr Williams is also known for going beyond the role of physician by using her voice in social media. "*It's a different way of approaching people and trying to connect with them around their health. [Using social media is] a piece of the puzzle for me and I love it.… When you sit in your academic circle, you go over all of the details of the paper/study, but to use social media lets you think about how something applies to peoples' lives.… I think it's an avenue for me to express and connect with like-minded colleagues and patients, women, and people of differing opinions.*"

She views both her passion for social media and women's health as being avenues of connecting more deeply with patients.

> *As a physician, I'm not scared to engage. I think when you prioritize meeting the patient where they are; you can't be afraid to deal with some of the cultural issues, because those issues are there and influencing what's happening to your patient, no matter what you do. Prescribing a 4-times-daily medication for a new mother is going to be hard for her to manage. You have to think about the totality of peoples' circumstances. When you engross yourself in this type of work, around bias, around justice, around looking at people as their full selves, it really allows you to be a better clinician.*

Dr Thompson extends her role of physician outside the clinic walls and advocates for patients by meeting them in their own communities.

> *We can definitely make differences with our patients one on one, but a lot things we do need to have an effect on entire communities, like making sure there is access to healthy food and that [it] is safe to go for a walk for your exercise and people have clean water.… We recognize that everyone is not comfortable within our walls, so we go out into the places where our patients are and do education and screenings there, like blood pressure checks and glucometer testing.… We can also tie [our health events] to celebrating the culture such as Black History Month. We have a Chinatown street fair too; we do different care-beyond-our walls events at different places of worship around town in African-American, Spanish-speaking, and Filipino communities, so that's another great way that we can again address those health disparities by building trust by being present in the community.*

LOOKING TO THE FUTURE

This trust building is an integral part of creating an equitable health care system. Dr Castañeda-Davis acknowledges that simply starting to have these conversations about bias is a major step forward.

> *While these discussions focus on some of the big challenges that we are currently dealing with as individuals, as an organization, and as a country, the fact that we are even exploring these issues is something that wasn't happening years ago. There is more and more legislation regarding some of these issues around inclusion and diversity, which also is incredibly hopeful. The fact that we have an Equity, Inclusion, and Diversity Committee here at Kaiser [Permanente] that is working to educate individuals and identify gaps is noteworthy. We have much work to do, and at the same time, we are moving forward and we always have hope.*

These discussions are essential as we continue to engage in research that shows we are making strides to combat these internalized stereotypes. Already, Dr Williams has been encouraged by the work she has seen in the integrated health care system of KP Northern California, described in a recent study by Zaritsky et al[10] in December 2019, who found that there were no longer racial-ethnic disparities among the patients who receive minimally invasive hysterectomies.

Dr Thompson's African American blood pressure clinic is an exemplary model of how conversations about bias, humility, and allyship can turn into a different model of patient care. When speaking about her culturally concordant African American blood pressure clinic, she regards these visits as "*a time to slow down and help the patient[s] really understand their disease, their medications, and help them see how they can be most engaged.*"

Patient-centered care and conversations result in patients feeling more cared for and more confident in the quality of their health care. A study by Traylor et al[11] demonstrated higher rates of cardiac medication adherence in culturally concordant provider-patient relationships. This finding is promising in that these practices of acknowledging bias and cultural humility could provide an opportunity for marginalized populations to feel more comfortable seeking health care, and they could be healthier for it.

It is exciting to hear how these women physicians paved new pathways and started novel conversations in their careers about implicit bias and cultural humility. It is our hope that these conversations continue to not only reduce and eliminate bias in health care but also provide physicians the fuel and model of how to continue leading and paving new paths for a better health care system. ❖

Disclosure Statement

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Authors' Contributions

Chelsea Gong, MD, participated in the collection of background research and the drafting, critical review, and submission of the final manuscript. Carroll-Anne Heins, DO, participated in the collection of background research and the drafting and critical review of the final manuscript. Both authors have given final approval to the manuscript.

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