Three Levels of Bias Interruption By David Anderson Hooker

While challenging to do, acting on implicit bias can be interrupted at three levels: (1) the action; (2) the belief; or (3) the source of the belief.

Level 1: Interrupt bias-sourced actions
Arin N. Reeves, PhD has identified several strategies to bring bias-sourced actions into conscious awareness and to create new habits of responding in her book *The Next IQ*. Among the “Bias Breakers” Reeves suggests is “notice surprise;” when something is other than what is expected (i.e. your natural leaning) there will be surprise, which can be either a pleasant or an unpleasant experience. Just noticing the surprise and understanding what the biases or natural inclinations and expectations are creates an opportunity to adjust actions. With persistent attention and intention, harmful actions based on implicit bias can be changed.

Level 2: Change unsupported beliefs
An even more profound change will occur if the beliefs that are the source of those actions change. Medical professionals are especially challenged in the operation of implicit biases in their work because, in order to process massive amounts of information rapidly, health care professionals learn to process information in schema. Beliefs inform the schema. Many (probably most) beliefs or biases that cast others in a negative light were given to us and not based on personal perceptions or experiences. For instance, from an early age some of us were told that certain types of people do not trust authority, especially medical professionals, or that they are not capable of understanding complex (i.e. medical) concepts. Even before we have direct experience to develop our own understanding, we are required to develop (usually mimic) practices of others operating in that belief. Likewise, to be successful during training programs the medical professional may be required to demonstrate the ability to mimic the performance of others, which is often based on an implicit bias. The challenge with beliefs that are given to us is that we rarely examine them, we simply act on them. Information that does not conform to our beliefs is unconsciously rejected, and sometimes consciously rejected if it is jarring in its difference. Thomas Kuhn says, pre-paradigm shift science always rejects non-conforming data, which is to say that it is easier to dismiss information that doesn’t align with our implicit biases than to slow down to examine the non-alignments. This is especially true in fast paced and multiple transaction environments like most health care delivery settings.

One enduring example of the rejection of sound knowledge because it contradicts strongly held beliefs was developed in the medical community in what has come to be known as the Semmelweis reflex. The Semmelweis reflex is a reflex-like rejection of new knowledge because it contradicts entrenched norms, beliefs, or paradigms. In the original case, a physician and hospital
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administrator, Ignaz Semmelweis, conducted research and demonstrated that the mortality rate for mothers giving birth at a hospital could be significantly reduced if the physicians would wash their hands in a chlorine solution between treating patients and also after conducting autopsies. While this is “common sense” today, at the time of the discovery, this contradicted scientific belief and also was interpreted as a critique of physicians’ practices. The hand washing solution was summarily rejected by the medical community; Semmelweis’ career was ruined and many more women died before someone was willing to reconsider the practice. Semmelweis’ discovery was developed based on a “surprising” insight that caused him to reconsider a widely held belief. Each of us may have available to us similar insights, but their discovery will occur when health care providers are willing to pay attention to experiences that do not conform to widely held beliefs and overcome the reflex.

In order to test belief systems ask three questions:

a. What do I believe about this person, type of person or group of people?
b. Why do I believe it? (i.e., what is the source of my belief? personal experience (in education and training or other parts of life)? tradition passed down through research and instruction?)
c. Why do I need to believe it? What other aspects of action/practice will be impacted if this belief is not founded or accurate?

Simply entering into this inquiry will prime the practitioner to act more on present information rather than unconscious and implicitly biased information.

Level 3: Change the source of unsupported beliefs
Challenging the “source of beliefs” as a cause of implicit bias is a different and much more involved task than simply changing the beliefs discussed above. The “source of beliefs” is grounded in broad historical discourse about people in general, certain people groups and the nature of human beings. In the practice of medicine and the delivery of health care, one first step in recognizing the potentially limiting effects of bias-based actions is to acknowledge that considerable early medical research was framed by belief systems about certain groups of people that were saturated with prejudices and myths about certain people groups that have since been discredited, and conducted in ways to confirm the truth of those beliefs. Mental illnesses such as “drapetomania” “dysesthesia Ethiopia” - the refusal to remain enslaved as symptomatized by running away - are clear cases of the use of scientific methods to promote racial superiority or scientific racism1. In the 21st Century it seems relatively easy to recognize the fallacy of science based on size of skulls or the width of hips as being in some way reflective of meaningful variations among people groups, but other examples of medical research conducted to confirm bias-laden beliefs are more subtle. As a result, many of those biases were built into the nature of practice.

1 Scientific racism denotes the contemporary and historical theories that employ anthropology (notably physical anthropology), anthropometry, craniometry, and other disciplines, in fabricating anthropologic typologies supporting the classification of human populations into physically discrete human races that are claimed to be superior or inferior. (http://en.wikipedia.org/wiki/Scientific_racism).
While changing beliefs is challenging enough, changing the source of beliefs is a longer term, more involved and ultimately the most substantial change. Changing the sources of beliefs entails changing the discourse in those areas in which implicit bias has had its greatest impact in the delivery of healthcare. Many scientists have abandoned race, ethnicity and, in many instances, gender as viable categories from which to identify biologically significant variations. This suggests that those categories, which are socially constructed and yet often determinative or predictive of health care outcomes, represent clusters of implicit biases which are deeply sourced. By attending to the first two levels of implicit bias interruption – action and beliefs – the foundation is being laid to deconstruct the entire cluster of biases that form the narrative and inform the discourse on race gender and many other categories. While this might seem beyond the appropriate scope of attention for health practitioners, we have to acknowledge that without addressing the deepest discourse, ‘knowledge’ based in implicit bias will continue to develop and limit the practitioner’s capacity to give the best possible care.

These levels of interruption are listed in the order of difficulty for making the change, but also in reverse order for making the most profound and lasting changes. Similarly, biases are mostly unconscious, the impacts unintentional and the judgments made in a split second, but the interruption of these biases will occur in just the opposite manner -- consciously, intentionally and over an extended period.

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