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The impact of implicit bias and emotional intelligence on physician attitudes and behaviors

Abstract

Implicit (subconscious) bias is defined as the tendency to process information based on unconscious associations and feelings, even when they are contrary to one's conscious or declared beliefs. They can have a profound effect on shaping values, perceptions, and attitudes that impact judgment, decision making behaviors, relationship interactions, and event outcomes. This is particularly important in the health care sector where physicians are the driving force behind the care management process and discriminatory behaviors can impact decisions that affect patient relationships and clinical outcomes of care. In an effort to enhance care relationships we need to gain a better understanding of the cause and effect of implicit behaviors, raise levels of awareness, enhance individual and organizational awareness and sensitivity, accountability, and responsiveness, address resistance, and provide appropriate education, training, and behavioral interventions to assure access and equity in delivering high quality patient care.

Keywords: behaviors, emotional intelligence, physician, stressed

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Introduction

It takes years of training and dedication to achieve the skill sets needed to become a proficient health care provider. The profession attracts highly motivated individuals with strong egos who have the necessary intellect, dedication, and fortitude to survive the highly intense competitive environment. The major focus of the training process is to develop the appropriate clinical and technical skills necessary to succeed in medical practice. Self- study, practice, and sacrifice are the tools for success with little attention paid to the importance of enhancing social and communication skills. Doctors are trained to take command and give orders and give little thought to the non- clinical factors that influence their thoughts and behaviors and the impact it has on others. In today's high pressure, multifaceted, complex medical world, this may lead to less optimal outcomes of care.

There are a number of different factors influencing an individual's thoughts, perceptions, values, biases, and behaviors (Table 1). Internal factors include feelings, perceptions, and values influenced by reactions related to age and generation (Baby Boomers, Generation X, Millenniums, etc.), gender and sexual identity, religion, spirituality, ethnicity and cultural beliefs, socioeconomic factors (education, finance, language, community support), and early life experiences that affect life perspectives. External forces include the influence of training and education, dynamics of the work environment, the impact of ongoing stress and burnout, and impressions fostered by social media, false information, and other life experiences that affect mood and disposition. All these factors influence preferences and (hidden) biases that shape one's personality and behavioral tendencies which can affect care relationships.[1] Many of these factors can be addressed through appropriate training and education programs which may include such topics as diversity management, cultural competency, DEI (Diversity/ Equity/ Inclusion), harassment, stress management, conflict management, personalysis, communication and team collaboration skills, and emotional intelligence.[2,3] The intent is there but there may be significant problems that impede implementation and success (Table 2).

Table 1 Factors affecting attitudes and behaviors

Internal	External
Age/ Generation	Education/ training
Gender/ Sexual identity	Work environment
Culture/ Ethnicity	Stress/ Burnout
Socio-economic factors	Social media/ False information
Early life experiences	Late life experiences
Biases/ Personality	Mood/ disposition

Table 2 Barriers to engagement

Barriers
Pride
Awareness
Need
Time
Resistance

The first problem is physician engagement. While physicians pride themselves on their intellect and clinical expertise, they are often unaware of the impact of their personal beliefs and values and how it may affect their approach to patient care. The second barrier is lack of appreciation of any need for these services, particularly when overwhelmed with their current medical duties with no time left for participation in any non- clinical training programs. A newly emerging barrier surfacing around mandating DEI (Diversity/Equity/ Inclusion) initiatives, is more organizational and individual resistance and push back fostering concerns about raising personal anxieties and questioning the value of these programs.[4,5] These barriers can only be overcome by raising awareness as to the negative downstream consequences that biases can have on access, equity, care relationships, satisfaction, quality, and patient safety.[6] The majority consensus is that these programs do work when backed by strong organizational leadership and care team support with mutual incentives aligned around delivery of best practice care.[7–11]

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Clinical implications

There is a great deal of evidence linking implicit bias to a number of different discriminatory behaviors that can compromise patient outcomes of care in Table 3.[12] One of the major discriminatory practices is related to race and ethnicity. A recent publication from The Commonwealth Fund reported that 50% of all health care workers say that they have witnessed discrimination against patients and feel that patients can receive disparate care based on race, ethnicity, or language.[13] A recent study published by The Kaiser Foundation found a significant degree of "unfair disrespectful treatment" related to Black, Hispanic, and Asian patients. One third of the patients reported at least one negative experience with a health care provider based on time spent, misassumptions, and lack of respect, limited discussion, or denying treatment.[14] There are a number of other studies on the specifics of race discrimination in regard to Black, Asian, Hispanic, and other non- white populations, and the negative impact it can have on patient care.[15,16] It's not just the patients who suffer from discriminatory actions.[17] A recent survey conducted by the Robert Wood Johnson Foundation reported that more than 80% of the nurses experienced racist/ discriminatory behaviors from patients and 60% reported racist/ discriminatory behaviors from colleagues.[18] Race and gender bias have also played a role in perpetuating health care inequities by influencing research protocols and artificial intelligence supported algorithms designed to support best practice care.[19,20] In addition to race and ethnicity, other discriminatory behaviors related to gender, sexual identity, socioeconomic factors (language, education, literacy, finances), age, habits (smoking/ substance abuse), physical appearance (weight, dress, tattoos, piercing, hygiene, disability), nationality and place of birthperson is from all influence subconscious biases, perceptions, and subsequent actions.[21]

Table 3 Discriminatory behaviors

Discriminatory behaviors
Race/ ethnicity
Gender/ sexual identity
Socioeconomic (SDOH- Social Determinants of Health)
Age
Substance abuse/ smoking
Physical appearance/ disability
Nationality/ place of birth

Clinical impact

Implicit bias and discrimination can compromise care in a number of different ways in Table 4. First encounters are often influenced by subconscious stereotypic classifications reinforced by the factors contributing to discriminatory behaviors listed in Table III. These initial reactions and subconscious predetermined conclusions may alter beliefs, expectations, comfort, trust and respect, which may limit access and prejudice discussions about diagnosis, treatment, fault, and expectations. Effective communication, collaboration, and relationship building is a key component of the care delivery process. Today's practice environment is extremely complex involving multiple types of health care providers, staff, and support teams with responsibilities that extend over the entire spectrum of care. Difficulties in communication and staff relationships have led to poor quality outcomes, patient safety issues including the occurrence of preventable adverse events, poor staff and patient satisfaction, and diminished morale.[22,23] Derogatory remarks in the patient's medical record and discriminatory biased care algorithms have also hampered care.[24–26]

Table 4 Compromises in care

First impressions/stereotypes
Trust, respect, beliefs
Communication/ collaboration/ care relationships
Stress and Burnout
Derogatory remarks / biased algorithms

Stress and burnout play a pivotal role in aggravating emotions that interfere with care.[27] Many of these issues start in the training environment and are further aggravated by the high pressure practice environment. Causes of high stress and burnout are related to multiple factors including overwork, more time spent on non- clinical tasks, impaired work- life balance, loss of autonomy and purpose, lack of respect, and physical and emotional exhaustion.[28] Discriminatory feelings toward others further aggravate the problem. As a result, many medical centers are now offering educational courses and workshops to help break the bias habit.[29,30] Training and education is a multi-step process. At the forefront there needs to be a strong organizational commitment to provide the necessary resources to enhance work relationships and improve the overall morale and well- being of staff members, employees, patients, and their families. The process starts by raising levels of awareness as to the nature and significance of implicit biases and discriminatory behaviors and how it may affect organizational dynamics. Individuals need to be open to suggestions on how they could improve personal interactions and be motivated by its contribution to improving care. Many of the underlying issues can be uncovered through gossip, individual experiences, or formal incident reports. A more efficient approach is to conduct a confidential internal cultural assessment to help focus on the key issues specific to the organization. One tool specifically designed to assess the impact of Implicit Bias is the Implicit Association Test (IAT) available through Harvard education.[31]

Depending on organizational need, training in diversity management, cultural competency, Diversity/ Equity/ Inclusion (DEI), sexual harassment, generational preferences, personality profiling, customer service, stress, anger, or conflict management can all provide valuable tools to enhance personal interactions.[32–34] Enhancing communication and collaborations skills are a crucial piece of the puzzle. Teaching skill sets that emphasize the importance of empathy, trust, engagement, attentiveness, reflective listening, and mutual discussion help set expectations and clarity for successful patient outcomes.[35] Raising levels of awareness and sensitivity to the contributions of Social Determinants of Care (SDOH) can help address non- clinical elements that affect care. One of the most important factors that can help individuals recognize the contributions of hidden biases, values, and preferences that influence thoughts and behaviors is Emotional Intelligence. Emotional Intelligence is a four-part process. The first part focuses on self-awareness to help individuals learn how to better recognize their own biases and trigger points that influence their actions. The second part is social awareness which teaches individuals how to become more aware of the needs, values, priorities, and sensitivities of the person they are dealing with. The third part is self- management with recommended strategies on how to more effectively control and manage initial impulses. The fourth part is relationship management where you put it all together to maximize the effectiveness of the interaction.[36] Whereas most of the training programs discussed previously focus on recognizing the wants, values, and needs of others, Emotional Intelligence training focuses on the individual becoming more aware of who they are, what biases they may have, potential trigger points, and how to better manage oneself in an effort to improve the relationship outcomes.

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In some cases there are more deep seated behavioral issues which may require individualized coaching, counselling, therapy, or more formal corrective action (Table 5).

Table 5 Training and education

Organizational commitment
Raise awareness/ need/ motivation
Internal Assessment
Diversity/ Cultural competency/ DEI (Diversity, Equity, Inclusion)
Gender/ Sexual Identity/ Harassment
Generation gaps
Personalysis
Customer service
Stress/ Anger/ Conflict management
Communication and team collaboration skills
Physical/ Social/ Economic/ Intellectual stereotyping (SDOH)
Emotional Intelligence
Coaching
Behavioral intervention/ Reporting/ Staff well- being

Discussion

Implicit biases exist in the brain to help people make quick judgements, assessments, and decisions about the situations and environments they are in. The brain builds automatic predictive models and mental shortcuts to process new data promptly and make swift decisions, but these can often contain inaccurate or misleading information. Physicians are often under conditions that require their brains to make especially quick and efficient judgements and decisions, particularly when stressed, overwhelmed, or under other time and capacity constraints, which can increase the brain's reliance on implicit biases. While these mental shortcuts can be useful in some areas of clinical work, they are detrimental to the treatment of patients, staff, and other personnel.[37] Implicit bias has a significant impact on thoughts, values, and perceptions that influence individual beliefs and subsequent behaviors. These issues are particularly prominent in the health care system for a number of different reasons.[38]

First is the physicians. Physicians play a dominant role in directing health care evaluation and treatment. They are trained in scientific principles with clinical and technical skills gained through years of intensive training and self- sacrifice. They have very strong egocentric personalities, and their goal is to take charge and give orders. As a consequence they are often unaware or insensitive to the needs of others and as a result they don't develop strong communication or relationships skills which may reflect low levels of empathy. They work in a high-pressure system, pushed beyond reasonable capacity which leads to high levels of stress and burnout that affect both their physical and emotional well- being. They don't have the time or interest in focusing on non- clinical activities unless you can show them how it affects patient care. Next is the organization. Pressured to maintain financial viability, cutting corners and overworking staff are common strategies designed to reduce expenses. What they don't readily see is the negative effect this can have on staff commitment, productivity, efficiency, the increased likelihood of medical errors and quality concerns, overall poor staff morale, dissatisfaction and impaired well- being, all of which hinder job performance. In the previous section we discussed the importance of addressing all these issues.

Table 5 provides a list of recommended strategies. The first step is raise levels of awareness of factors that can influence implicit bias and how these subconscious feelings can lead to inequities in care. Physicians, staff, and patients need to better understand the implications of discriminatory thoughts and how this can alter their approach and receptiveness to medical care. Performing an internal cultural assessment such as the Harvard Implicit Association Test (IAT) will help identify key areas of concern. Motivate acceptance by focusing on the benefits of improving outcomes of care. Address concerns about time availability and perceived need by offering services in a convenient meaningful manner.

The education and training programs discussed previously provide the necessary resources and tools for improvement. Role play scenarios help emphasize the importance of recognizing underlying biases, perceptions and reactions. Enhancing communication and collaboration skills will help improve care relationships and outcomes. Training in Emotional Intelligence will help individuals better understand themselves and provide tools to help them better manage the situation by understanding their own impulses as well as gaining better recognition of the importance of the other person's perspectives. Be sensitive to the high levels of stress and burnout in health care staff and provide resources to help them better cope with the pressures of medical practice and improve their well- being.[39] Some individuals may require individualized coaching or therapy. More deep-seated issues may require counselling or more formalized interventions especially if there are signs of disruptive behavior.[40] Individuals should be encouraged to report discriminatory behaviors to those in charge. Efforts to reduce factors that propagate a toxic workplace environment will reduce stress and burnout, improve satisfaction and morale, improve care efficiency, and lower the risk of staff exodus.

Several states have introduced mandates that require Implicit Bias training[41] as discussed previously there has been state pushback to implementation of these programs. (4) In July of 2023 the Joint Commission offered an Equity Certification for hospitals committed to making health care equity a strategic priority.[42] To date, eight hospitals have achieved this certification (Table 5).[43]

Conclusion

Best practice medical care evolves from applying the best possible clinical and technical skills under an umbrella that supports non-discriminatory behaviors to assure equitable access, understanding, empathy, and clear discussions about treatment and management options, expectations, and responsibilities. We are all affected by underlying hidden, subconscious, and implicit biases gained through our upbringing, training, and life experiences, but many of us are unaware of their impact on attitudes and treatment decisions when subconscious implicit behaviors adversely influence thoughts and decisions there may be compromises in patient care. Recognizing the role and impact of these forces will help individuals recognize what they need to do to improve care relationships. There are many reasons to say no but the key motivating factor is the improvement in health care outcomes which benefits all parties involved. Services need to be offered in a convenient meaningful format that enhance positive patient focused results.

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Conflicts of interest

The authors declare that there is no conflict of interest.

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References

1. Chapman E, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med*. 2013;28(11):1504–1510
2. Eramo L. Providing culturally competent care. *Medical Economics.* 2023.
3. Baum N, Dresher K. Advancing DEI in healthcare. *Physicians Practice.* 2023.
4. Cohen R. CA Suit targets anti-bias training in healthcare. *Medscape Internal Medicine.* 2024.
5. Maybank A. The plight of DEI leaders- heavy expectations and limited protection. *N Engl J Med.* 2024;390(14):1258–1260.
6. Implicit bias: recognizing the unconscious barriers to quality care and diversity in medicine. *American College of Cardiology*. 2020.
7. Cooper L, Saha S, Van Ryn M. Mandated implicit bias training for health care professionals- a step toward equity in health care. *JAMA Health Forum*. 2022;3(8):e223250.
8. Huben- Kearney A, Fischer-Sanchez D, Wertheimer M, et al. Recognizing and managing bias in the inpatient health care setting. *The American Society for Health Care Risk Management*. 2023.
9. Jindal M, Hagiwara N. Strides in racial bias training- a step closer to health equity. *JAMA Netwok Open.* 2024;7(3):e242164.
10. Elkins C, Frel F, Morriss A. Critics of D.E.I. forget that it works. *The NY Times***.** 2024.
11. Rosenstein A. Implicit training for doctors improves care. SF Chronicle Letter to the Editor. 2023.
12. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *Am J Public Health*. 2015;105(12):e60–e76.
13. Fernandez H, Ayo-Vaughn M, Zephyrin L, et al. Revealing disparities: health care workers observations of discrimination against patients. *The Commonwealth Fund*. 2024.
14. Artiga S, Hamel L, Gonzalez-Barrera A, et al. Survey on racism, discrimination, and health: experiences and impacts across racial and ethnic groups. *KFF*. 2023.
15. Brown C, Marshall A, Cueva K, et al. Physician perspectives on addressing anti-black racism. *JAMA Open Network.* 2024;7(2):e2352818.
16. Wang J, Vela M, Chin M. Addressing bias and racism against asian american, native hawaiian, and pacific islander individuals. *JAMA Network Open.* 2023;6(7):e2325872.
17. Altaf S, Taleghani S, Dillard A, et al. Original research: nurses' experience with racial, ethnic, cultural, and religious discrimination in the workplace: A qualitative study. *Am J Nurs.* 2023;123(5):24–34.
18. RWJF AND NORC Survey on Racism in the Nursing Industry. 2023.
19. Manchanda E, Aikens B, De Mio F, et al. Efforts in organized medicine to eliminate harmful race- based clinical algorithms. *JAMA Netw Open.* 2024;7(3):e241124.
20. Chin M, Afsar-Manesh N, Bierman A, et al. Guiding principles to address the impact of algorithm bias on racial and ethnic disparities in health and health care. *JAMA Network Open*. 2023;6(12):e2345050.
21. Daniel-Ulloa J, Haghighi A. Biases in health care: an overview. *Medical News Today.* 2023.
22. Bendix J. Hidden costs: how bias harms patient care- and how doctors should respond. *Medical Economics*. 2019.
23. Rosenstein A, Daniel M. A survey of the impact of disruptive behaviors and communication defects on patient safety. *Jt Comm J Qual Patient Saf.* 2008;34(8):464–471.
24. Brooks K, Raffel K, Chia D. Stigmatizing language, patient demographics, and errors in the diagnostic process. *JAMA Intern Med*. 2024;184(6):704–706.
25. Wilson P. Difficult patient: stigmatizing words and medical error. *Medscape Internal Medicine.* 2024.
26. Rosenstein A. understanding and managing stress and burnout: roadmap for success**.** *Advances in Health and Disease*. 2022;50:115–130.
27. Rosenstein A. growing physician dissatisfaction, stress, and burnout, and its negative impact on physician and staff behaviors that impact patient care. Distracted Doctoring II: returning to patient-centered care in the digital age. Springer Science & Business Media Morris Plains, New Jersey; 2024.
28. Rosenstein A. Physician stress, burnout, disenchantment, and undesirable behaviors: what can we do?. *Psychology and Psychotherapy Research*. 2023;6(3).
29. Carnes M, Sheridan J, Fine E, et al. Effect of a workshop to break the bias habit for internal medicine faculty. *Aca Med.* 2023;98(10):1211–1219.
30. Boatwright D, London M, Sorlano A, et al. Strategies and best practices to improve diversity, equity, and inclusion among us graduate medical education programs. *JAMA Open Netw.* 2023;6(2):e2255110.
31. Implicit Association Test.
32. Sabin J. Tackling implicit bias in health care. *N Eng J Med*. 2022;387(2):105–107.
33. Fricke J, Siddique S, Aysola J, et al. Healthcare Worker Implicit Bias Training and Education. *National Library of Medicine AHRQ*. 2023.
34. Aga R, Noor S, Kvalheim C, et al. Racism, equity, and inclusion: can clinical simulation train health care workers to build an anti- racism culture? *NEJM Catalyst.* 2024;5(3).
35. Gonzalez C, Ark T, Fisher M, et al. Racial implicit bias and communication among physicians in a simulated environment. *JAMA Netw Open.* 2024;7(3):e242181.
36. Rosenstein A, Stark D. Emotional Intelligence: A critical tool to understand and improve behaviors that impact patient care. *Journal of Psychology and Clinical Psychiatry.* 2015;2(1):1–4.
37. Byyny R. Cognitive bias: recognizing and managing our unconscious bias. The Pharos Winter. 2017.
38. Fitzgerald C, Hurst S. Implicit bias in healthcare professionals: a systemic review. *BMC Med Ethics*. 2017;18(1):19.
39. Rosenstein A. The link between physician stress, burnout, and disruptive behaviors. *Journal of Medical Practice Management.* 2023;38(4):163–166.
40. Rosenstein A, Karwaki T, Smith K. Legal process and outcome success in addressing disruptive behaviors: getting it right. *Physician Leadership Journal*. 2016;3(3):46–51.
41. Coopeer L, Somnath S, Van Ryn M. Mandated implicit bias training for health professionals- a step toward equity in health care. *JAMA Health Forum.* 2022;3(8):e223250.
42. Joint commission equity certification.
43. Hollowell A. The first eight hospitals to attain joint commission's equity certification. *Beckers Clinical Leadership*. 2024.