Veteran's Health Equity Podcast Transcript
Implicit bias and its effects on health in Veterans

I want to welcome everyone and thank you all for joining. My name is Lauren Korshak, and I lead translation activities for the VA's Office of Health Equity. The Office of Health Equity was established in 2012 and champions the advancement of Health Equity and reducing health disparities among veterans. My job means that I get to tell stories about the data.

What we have about veterans and their health today on the Health Equity and veteran podcast series will be discussing implicit bias and how it can negatively affect veterans. But first, I'm excited to introduce today's speakers.

Dr. Ursaline Bankhead is a native of Buffalo, New York, and a graduate of Buffalo Public Schools, Penn State University, East Carolina University, and the University of Buffalo. She is a New York State licensed psychologist who has worked in federal service for 15 years focusing on geriatrics, health disparities, and equity. Dr. Bankhead is a health psychologist who has trained on various topics, including communication, implicit bias, diversity and inclusion, grief and loss, cognitive impairment, and gender issues. Participants have included the legal community, health care organizations, religious communities, and nonprofit organizations. This year, she completes her second term on the Attorney Grievance Committee for the New York State 8th Judicial District. She is also a co-founder of Women-to-Women WNY.

Lauren Russell is the Access Co-lead in the Chief Medical Officer for the VA New England health care system and is a former presidential management fellow.

So, I'd like to first ask Dr. Bankhead what biases are there? This funny thing? Right. Our brains want to categorize and sort items into what we like and what we don't like. So really, bias ease, you know, our preferences. And there can be a subtle, as you know. I have a tendency for strawberry ice cream over butterscotch, or I have a choice for things such as one type of person over another, or even attraction. You know I'm more attracted to somebody tall or short, so a bias is I prefer or against, and we all have them, so I think that that's something fundamental to bring out that we all have biases that we grow up with that are just personal preferences.

So, biases in and of themselves aren't necessarily nasty or negative. Right. OK. Then what is the difference between a bias and implicit bias? Or could can you give us more information about an implicit bias? So here's kind of my example, right? Is that for a bias? I prefer American culture because it's familiar. Still, the implicit part of that is that all those subtle messages are that I have a bias that I'm not even aware of. Right. So, I know that I like chocolate ice cream over strawberry ice cream. But biases feel implicit biases are where it's so subtle and so insidious, where we recognize things as being better or worse. Even, you know, let me go back to height. So taller men tend to be viewed as more intelligent, robust, or attractive than shorter men. But we don't consciously think about it, right. So, it's those subtle cognitive processes. One of the examples I like to use when I'm talking about implicit bias. And this is really kind of a low-level thing: expectations around holidays and even the colors, sights, and smells. So, if you celebrate Christmas, you expect to see red, white, jingle bells, and all of that. And if instead, if I said, hey, we're going to celebrate Christmas, and you're coming to my house. And I said, hey, you know what, come over for Christmas, and you know, we're going to have a great meal and everything. It's

going to be black and purple and orange, and instead of Turkey and macaroni and cheese and so on, what we're going to have been I'm going to have hot dogs and hamburgers, right? Our implicit biases are so deep to tell us what's wrong. Right. And so, do you know what I mean? Like, it's like, here's our expectation about how the world works. And it's so normalized that we don't think about it consciously. And we act either pro or con. So, our implicit biases go. This is what's expected. Or what's abnormal. And then we respond in such a way, or we feel uncomfortable. You know, one way or another. So, if I said, hey, you want to come on the 4th of July? And I said we're going to have haggis. Would you say, well, that's a great 4th of July, right? I mean, I'm just saying I've never had haggis. Maybe it's delicious. But my bias tells me I don't want it right, especially for the 4th of July. It doesn't fit our expectations. Right. Hot dogs and hamburgers are great for the 4th of July, but. Not necessarily for Thanksgiving, suitable?

But it even goes beyond expectations. It even goes into things such as discussed feelings of safety. It goes even deeper into who we think belongs. So even when we think about African American woman's hair, what's considered professional, you know, is it locks or does it have to be straightened more European and appearance, even the way people speak, if we hear an accent out of Appalachia, do we make assumptions about what that means?

Without thinking overtly about, Oh my gosh, here's my stereotype versus. Oh, let me draw a conclusion based on how someone speaks or someone's name. So again, it's subtle, insidious. And you based on expectations, but more so based in messages about when we're talking about people based in statements about the other and even working with veterans, implicit bias, ease about even groups of people who served. Stereotypes are based on implicit biases. Even let's say around Vietnam Veterans versus World War II veterans, so we can read those messages far without even knowing it. And so, how can implicit bias impact health and or the provision of care. So, a couple of ways. So, I'll tell you, if you don't mind, like a true story recently, this is not, you know, veteran related. But my husband is African American male, and he recently had surgery, you know, significant. One of the things that I worried about was the research on health care disparities.

How are people going to treat my husband based on race? And there's a lot of data out there saying that African Americans are undertreated for things such as pain in many ways. When we look at maternal rates of death and fetal death, we find that black and brown women are dying at two to four times. More likely than our white counterparts, even when we've controlled for things such as income and insurance provider. But what staves that off is sometimes having a black doctor where everything equalizes, so it's not so when we talk about bias. It's that people are getting dismissed. In healthcare, people are not being believed. People are not being listened to. So that's on the one end, and on the other end are those biases towards health care providers by certain groups.

And you know, so. Can I trust this doctor? You know, so with my husband myself, can I really trust you? Will you really give me good care? Maybe I'm going to hold off on getting care because I don't know that you're really going to listen to me. I don't want to have the headache of explaining to you 37 times that my symptoms are real. So, it really is a two-fold thing, and we see this right now in the early stages of COVID vaccination. There's a lack of belief or attending to specific groups. On the one hand, there's a lack of trust in the other bias, and implicit bias creates this maladaptive feedback loop. When we look at health care, including mental health care. So, we're not communicating well because we don't trust each other enough to be honest or care enough. And so that's something that we must continuously fight

against in healthcare: how to listen well and how to gain trust. Yeah. And I think just in terms of how this relates to, you know, promoting HealthEquity or addressing health disparities. Within the VA is that you know these biases.

If there, you know, left sort of unacknowledged or unaddressed. Can Azar's line be saying, you know, really negatively influence patient-provider interactions or discourage people from seeking health care services and could also, you know, really influence how a provider decides what sort of health treatment options are best for particular patients. So, I think, in terms of addressing them, it's critical that health care providers and patients in our veterans also take the time to. Acknowledge and address these unconscious bias ease, and it really, you know, I know in terms of thinking through veterans, it's essential to recognize that they're coming from, you know, the communities around us and that there are neighbors and that it's critical to identify what's going on, maybe in their world and how that might be shaping their perspective when they're coming into our healthcare systems. And the same with recognizing that that's potentially shaping provider's perspectives as well.

And so, for us to really help veterans attain their highest level of health, it's. Imperative for us to be more thoughtful about, you know, how these biases you shaped the provision of care into, I think to try to reduce sort of the stigma around talking about implicit or unconscious bias. Ease and have increased training and awareness about them within the healthcare setting. And I would agree with that. Right.

It's having the conversations, and I think that one of the struggles I know certainly talking with some providers is that there's an assumption that if I have the conversation, it's an indictment that I'm not. That I don't care, or that I'm not a good provider, and it's like we've got to move away from that message to no, no. You can be a great provider, but we're talking about how to listen better or listen differently because our patients do talk. They'll say, oh my gosh, this provider is so good, and they tell each other, you know, they've really listened to me.

So, I mean, bias can be contagious. Implicit and overt can be really. I don't feel that I want to say contagious. Still, it can undoubtedly be contagious in both positive and negative ways. But yeah, we do have to address it. We must be open about what happens in healthcare, and if we are honest about it, we can deal with it. Sure, I know you all during some things within the Medical Center, the VA medical centers you all work with. Can you share some of the efforts you're working on addressing implicit bias in clinical care? Yeah. So much of the work we've been doing in the VA, New England health care system, you know, has really focused on screening. For health-related social needs like food insecurity or housing instability, transportation, or legal requirements, among others, and training for helping providers feel more comfortable asking about these needs and understanding resources to address them. Questions and conversations around sort of unconscious biases have also come up. And so as part of that, you know, our team built and a review guide and you know also worked with Earth line to develop that and make sure that we're, you know.

Trying to provide information to staff, whether there are clinical or administrative, about what our unconscious bias ease. What are examples, and how could they impact clinical care? So even using an example in there of you know how maybe a patient was treated differently based on these biases and talking through you know and providing strategies for reducing unconscious biases. So, you know through, this guide offers suggestions such as trying to take on a new perspective and reality. Put yourself in someone else's shoes. Many parents and adults probably told many of us growing up, you know, to try to really channel that and understand where the other person is coming from. And I think

that goes to my earlier comment about trying to see where our staff and our veterans are coming from in terms of the communities in which they reside or work or live.

And so, trying to take that perspective on trying to, you know, better see a person and not their stereotype, which I'm sure it could be easier to say than to do, but really trying to look at the individuality of. People, instead of looking necessarily at like the group they come from or these external factors that you can see just from looking at them, really try to get to know them as a person and ask thoughtful questions to better understand who they are and also to try to build partnerships and work with veterans as patients and then try to be aware that you know, there could be one that these unconscious biases could be impacting how we are providing care, but then also sometimes there can be these you know power balances or a lack of power balance between.

Sort of providers and patients, but to try to see a provider-patient ship as a more collaborative relationship or partnership. The two parties are equals as opposed to 1 being powerful than another. And so through this, I think you know, we're really hoping to just one break the ice in terms of talking about implicit or unconscious bias ease and then try and provide some potential means for acknowledging them and addressing them so that we can enhance the quality of care. We're providing to our veterans. Yeah, I would say in Worcester, New York, we're doing a little differently.

I'm certainly not in research, but I do know that across the board, certainly in the facility, you know, we've had HealthEquity conferences here. We have a grand rounds series that got a little derailed by COVID. Still, it's starting back up next month, where we are looking at disparities and inequities. So we have a series coming up that we're formalizing the calendar, but also. We're working with our fellows are medical fellows, were working with interns, you know, and mental health and in social work to really address these issues were having diversity discussions to say, how do you deal with a biased client-patient as well as how do you kind of figure out your own signs for bias?

So, we're also being very deliberate about saying, how do you one as an individual, but then also as part of our greater VA community, how do we want to tackle this? And what's neat? Indeed, I think for Western New York is that you must consider the geography of where you are. And we're in one of the top 5 most segregated midsize cities in the United States. So, I think also understanding again. You know what you're saying, which is looking at people beyond their demographics, right?

So, the individual is more than their demographic than what you know sitting in front of you. And so, we're having those candid conversations. What we also are having is, and I love this is some of our palliative fellows have gotten really excited about this issue of addressing health care disparities. And so, I make myself and others make themselves available to say, listen, consult with you, and be supportive. Our leadership has been great about that. So, they're also leading from the top down, which is critical to address. We're also looking at. Formulating a system to kind of trek disparities, do we see differences in outcomes? Do we see differences in complaints even?

And so, we're really in the talks right now about how to do that best without being punitive towards staff. So doing it compassionately, understanding that none of us are perfect. So, we're really exploring a lot of options as well. So, we're doing stuff, but we're also looking at how to grill. So, our HealthEquity committee is active, and that's pretty. You know, amazing to see people who care so much.

Yeah. I think that all sounds very impressive. I'm excited to see how that works in Western New York and the potential to expand it to other VA medical centers. Since I feel like this is kind of a lingering question for many different, you know, both folks within the operation side with clinical staff and then also on the research side of how we can better identify disparities and address them. But as you said, without any punitive action, but just to figure out how we can educate our providers. And inform them about what may or may not be happening within the clinics.

I don't know if you've had to, but I've had to do that HR role training. You know, the high reliability, organization training, and I'm a facilitator for that, which is cool. And so, I think that's kind of what we're talking about disparities and addressing them.

It's like keeping that idea in mind, which is looking to beat anybody up. How do we as a community and as individuals continue to grow to give optimal care from top to bottom? How do we provide the best care, and can our implicit biases and overt biases really get in the way of this? Doing that. So, let's do better, ideally better, but better. I just want to thank you all for having this essential conversation today. I want to thank everybody who listened for joining us, and I hope you all will join us on our next episode. Take care.