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Original Research

Bridging racial differences in the clinical encounter: How implicit bias and stereotype threat contribute to health care disparities in the dermatology clinic

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ABSTRACT

Background: Positive interactions that build good relationships between patients and providers demonstrate improved health outcomes for patients. Yet, racial minority patients may not be on an equal footing in having positive interactions. Stereotype threat and implicit bias in clinical medicine negatively affect the quality of care that racial minorities receive. Dermatology, one of the least racially diverse specialties in medicine, further falls short in providing patients with options for race-concordant visits, which are noted to afford improved experiences and outcomes.
Objective: This study aimed to analyze implicit bias and stereotype threat in a dermatology clinical scenario with the goal of identifying actions that providers, particularly those that are not racial minorities, can take to improve the quality of the clinical interactions between the minority patient and provider.
Methods: We illustrate a hypothetical patient visit and identify elements that are susceptible to both stereotype threat and implicit bias. We then develop an action plan that dermatologists can use to combat stereotype threat and implicit bias in the clinical setting.
Results: The details of an action plan to combat the effect of stereotype threat and implicit bias are as follows: 1) Invite practices that increase representation within all aspects of the patient visit (from wall art to mission statements to creating a culture that embraces difference and not just diversity); 2) employ communication techniques targeted to invite and understand the patient perspective; and 3) practice making empathic statements to normalize anxiety and foster connection during the visit.
Conclusion: Knowledge of stereotype threat and implicit bias and their sequelae, as well as an understanding of steps that can be taken preemptively to counteract these factors, create opportunities to improve clinical care and patient outcomes in racial minority patients.
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Introduction

The quality of the patient–doctor relationship directly influences the quality of care received. In fact, patient understanding of diagnostic and therapeutic options, information recall, treatment satisfaction, and adherence are all affected by the quality of the relationship (Aronson et al., 2013). A study by Kelley et al. (2014) highlights this, revealing that patients who had a good relationship with their primary care doctor had the same rate of myocardial infarction as patients taking a daily aspirin. Improved patient–doctor relationships result in better management of chronic diseases (e.g., high blood pressure, diabetes, and human immunodeficiency virus infection), improved pain control, and decreased hospital readmissions (Carter et al., 2020; Farin et al., 2013; Flickinger et al., 2016; Hojat et al., 2011; Schoenthaler et al., 2009; Stewart, 2005). Indeed, the quality of the patient–doctor relationship correlates with improved outcomes in many areas of medicine.

The evidence and reasoning for investing in the patient–doctor relationship is clear, but it is important to point out that not all patients are on an equal footing to have a positive experience or relationship with their doctor. The literature shows that Black patients in particular consistently experience poorer communication quality in doctor–patient interactions, and members of minority groups are more at risk of having negative interactions with

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their doctors (Cooper et al., 2006; Shen et al., 2018). Health care disparities are well documented in the literature, but it is important to realize that these disparities are multifactorial and involve both implicit bias and increased experience of stereotype threat (Aronson et al., 2013; Hasnain-Wynia et al., 2007; Institute of Medicine, 2002; Trivedi et al., 2014). Prior studies confirm that health care providers stereotype their patients and that patients sense this bias. As a result, patients feel more dissatisfied with the care they receive (Penner et al., 2010; van Ryn and Burke, 2000).

According to Aronson et al. (2013), "the experience of stereotype threat does not require any actual prejudice or bias—implicit or explicit—to be manifested; targets can feel devalued by their interaction partners merely as a function of interacting across racial, ethnic, or other social identity divides" (Major et al., 2002). Aronson et al. (2013) further explain that "the minority patient can feel a sense of threat without ever encountering unfair or unkind treatment." Research suggests that these feelings may be shared among minority patients (Burgess et al., 2010). The effect that stereotype threat has on physiological, psychological, and self-regulatory processes can contribute to ill health (Aronson et al., 2013). Laboratory studies show that stereotype threat elevates blood pressure and induces anxiety (Blascovich et al., 2001; Inzlicht and Kang, 2010; Phelan, 2010). Stereotype threat complicates the patient–physician interaction and may evoke avoidance, disengagement, and distrust that affects follow through with provider recommendations. Prior studies show that investment in patient–doctor relationships leads to better patient outcomes (Merriel et al., 2015; Ruberton et al., 2016).

Studies show that many Black patients find that race-discordant dermatology visits (provider of another race) often lack specific knowledge of Black patients' skin, hair, and hair care regimens and that these dermatologists fail to offer individualized treatments for their disorders, with >70% of Black patients preferring a Black dermatologist (Gorbatenko-Roth et al., 2019; Taylor, 2019). Black patients perceive dermatologists at Skin of Color Centers as more trustworthy, better trained to care for them, and more likely to exhibit greater respect toward them and afford them greater dignity (Gorbatenko-Roth et al., 2019). With Black and Hispanic dermatologists making up only 3% and 4%, respectively, of the total number of dermatologists in the United States, this race-concordant preference does not meet the demand of the ethnic minorities who make up 12.8% and 16.3%, respectively, of the population (Pandya et al., 2016). Addressing the unmet need for more Black and Latino dermatologists in our field is critical and will increase the diversity of perspectives in our field as well as Black, Indigenous, and Latino communities' access to dermatology. In the meantime, how can we as a specialty become more skilled and optimize care for racial minority patients, particularly Black, Indigenous, and Latino patients?

To address this issue, we must first explore the concepts of implicit bias in ourselves and stereotype threat in our practice. Unconscious bias(es), also known as implicit bias(es), is defined as beliefs individuals have about other identity groups (e.g., racial, social, sexual) that are not in their conscious awareness. These beliefs are created from exposures and past experiences and become the lens through which we see the world as we attempt to organize people in our social worlds by categorizing them. Negative experiences from unconscious biases are far more common than conscious bias or prejudice, which most individuals explicitly reject as incompatible with their values. When we activate our stress response, such as when we are multitasking and running behind schedule, we are more likely to default to our unconscious biases to make decisions rather than our conscious mind, which takes longer to access. Notably, implicit biases have been shown to override individuals' stated commitments to equality and fairness, thereby producing divergent behavior (Racial Equity Tools, 2020).

Implicit bias exists in both minority and nonminority individuals. In essence, it is an unconscious lens through which one views the world, others, and relationships. In contrast, stereotype threat is another burden that minority persons bear. Stereotype threat is defined as a disruptive psychological state that is experienced when one feels at risk of confirming a negative stereotype associated with one's identity (e.g., race, gender, ethnicity, social class, or sexual orientation; Aronson et al., 2013). The triggering and interplay of these two concepts in the clinic can lead to significant downstream consequences of poorer patient experiences, as well as increased morbidity and mortality, in particular for Black, Indigenous, and Latino patients (Abdou and Fingerhut, 2014). Stereotype threat has the potential to be triggered by a microaggression, defined as a subtle comment or action that often unconsciously or unintentionally expresses implicit bias toward a member of a marginalized group, such as Black, Indigenous, and Latino patients.

Let us consider how both unconscious bias, stereotype threat, and microaggression play a role in the following clinical scenario: Joanne is a Black corporate lawyer visiting the office of a White dermatologist, Dr. Rogers, for the first time in an affluent, White neighborhood. Upon arrival, Joanne notes the wall art of White faces and that she is the only person of color in the reception area. Upon check in, the White receptionist smiles and asks, "Do you have insurance?" Joanne later notices that the receptionist asks a White patient, "Can I have your insurance card?" Dr. Rogers is 25 minutes late, and when she finally enters the room, she does not introduce herself, calls Joanne by her first name, stands throughout the visit, and does not apologize for the delay. Joanne begins to wonder if she is simply an unskilled clinician and communicator or if she may be treating her differently because she is Black. Joanne's thoughts are informed by previous experiences she has had with physicians when she has felt that she was treated differently and often with less respect and dignity than White patients. Throughout the encounter, Joanne experiences an internal conflict. She wants to verbalize her dissatisfaction, but she fears that expressing her frustration may confirm stereotypes Dr. Rogers may have about Black patients and remains quiet and disengaged. She does not articulate her concerns because she fears she will not be heard and leaves the visit without developing a therapeutic alliance. The condition for which she initially came in for treatment remains unresolved.

What is the role of implicit bias?

Implicit bias on the part of the receptionist

The receptionist asked the White patient for her insurance card, whereas she asked the Black patient, Joanne, whether or not she had insurance. The subtle difference in how this question is posed could be a direct result of the receptionist's unconscious bias related to Black patients and a perception that Black patients are underinsured. The wording of her questions indicates the presence of this bias, of which the receptionist is unaware. Joanne, in turn, perceives this as a microaggression because the question reflects a negative judgement of Joanne based on assumptions.

Lived experience of the patient

The patient may come to the encounter with negative past health care experiences, which are reinforced in this office that lacks staff diversity and visual cues that racial minorities are welcome (in this case, only pictures of White people on the wall). In

any case, when a bias is applied to an individual as a result of group membership, that in itself creates a barrier in the individual relationship. The patient believing that the physician's office and behaviors are biased is an expected response to internalized oppression and past lived experiences. In the context of racial hierarchy and social dynamics, this phenomenon requires those who belong to racially privileged groups to proactively take actions that build trust.

Implicit bias on the part of the physician

The White physician, Dr. Rogers, may have had negative past experiences with Black patients. Prior studies show that health care providers hold conscious and unconscious negative stereotypes of non-White patients, often viewing them as less educated and less likely to be adherent than their White counterparts (Burgess et al., 2010). A study of social environments discovered that, among White Americans, 91% of people comprising their social networks are also White (Cox et al., 2016). Thus, it is possible that this White physician may not have many friends or family members who are Black. Her perception of Black people may be informed by negative stereotypes. Misperceptions of Black people and culture are ubiquitous in the media and entrenched in our policies, institutions, and medical system (Cox et al., 2016). Biases are shaped by individuals' lived experiences, perceptions of difference, family, and culture of origin and identities, which all together consciously and unconsciously affect attitudes and actions in the clinical encounter.

What is the role of stereotype threat?

Joanne's struggle to verbalize her dissatisfaction and ultimate decision not to speak up is an illustration of stereotype threat. Joanne was fearful that voicing her dissatisfaction with the physician's staff, office, and communication in the encounter could confirm the stereotype of an "angry Black woman." The psychological phenomenon of stereotype threat was first described by Blascovich et al. (2001) in the education realm while studying the gender gap in mathematics. Stereotype threat is believed to affect performance by inducing physiological stress and prompting attempts at both behavioral and emotional regulation, which each have the effect of consuming cognitive resources needed for intellectual functioning (Aronson et al., 2013). The downstream consequences, if encountered frequently, can be disengagement, discounting of feedback, and de-identification. In this scenario, the stereotype threat that Joanne experienced ultimately had a negative effect on Joanne's health. Because Joanne did not feel that she could engage and develop a therapeutic alliance with the provider, she

Table 1
Personal/implicit bias awareness toolkit.

Personal awareness and development actions you can take
Have a growth mindset: • Access selected readings, podcasts, and educational material on the topics of racism and implicit bias. • Sukhera and Watling (2018) recommend a six-point framework around implicit bias, including increasing knowledge about the science behind implicit bias, emphasizing how biases influence behaviors and patient outcomes, increasing self-awareness of existing implicit biases, improving conscious efforts to overcome implicit bias, and enhancing awareness of how implicit bias influences others.
Books and articles: • Sukhera J, Watling C. A framework for integrating implicit bias recognition into health professions education. Acad Med 2018;93(1):35–40. • Kendi IX. How to be an antiracist. London: One World; 2019. • DiAngelo R. White fragility: Why it's so hard for white people to talk about racism. Boston: Beacon Press; 2018. • Diaz T, Navarro JR, Chen EH. An institutional approach to fostering inclusion and addressing racial bias: Implications for diversity in academic medicine. Teach Learn Med 2019;1–7. • Kendi IX. Stamped from the beginning: The definitive history of racist ideas in America. New York: Random House; 2017.
Podcasts and videos: • Center for Primary Care, Harvard Medical School. RoS racism and inequity in healthcare with Utibe Essien [Internet]. 2020 [cited xxx]. Available from: https://primarycare.hms.harvard.edu/rospod/ros-racism-and-inequity-in-healthcare-with-utibe-essien/ • Public Broadcasting Service. Implicit bias: Peanut butter, jelly, and racism [Internet]. 2016 [cited xxx]. Available from: https://www.pbs.org/video/pov-implicit-bias-peanut-butter-jelly-and-racism/ • Roberts D. The problem with race-based medicine [Internet]. 2015 [cited xxx]. Available from: https://www.ted.com/talks/dorothy_roberts_the_problem_with_race_based_medicine • The Nocturnist. Black voices in healthcare [Internet]. 2020 [cited xxx]. Available from: http://thenocturnists.com/the-nocturnists-Black- voices-in-healthcare • Brown B. Interview with Ibram X. Kendi on how to be an antiracist [Internet]. 2020 [cited xxx]. Available from: https://brenebrown.com/podcast/brene-with-ibram-x-kendi-on-how-to-be-an-antiracist/
Take implicit association tests: • Understanding and having awareness around our own biases, particularly as they relate to race, is a critical step in working toward addressing those biases, questioning them when they arise, and delving deeper into the truth and reality of the cultural stereotypes that underlie them (Bosson et al., 2000; Greenwald et al., 1998; Teal et al., 2010). • Project Implicit. Take a test [Internet]. 2011 [cited xxx]. Available from: https://implicit.harvard.edu/implicit/takeatest.html
Reflect on one's own identities, relationships, privilege, power, and biases: Articles and books • Holm AL, Rowe Gorosh M, Brady M, White-Perkins D. Recognizing privilege and bias: An interactive exercise to expand health care providers' personal awareness. Acad Med 2017;92(3):360–4. • Irvin Painter N. The history of white people. New York: W. W. Norton & Company; 2010. • Tsai J. What role should race play in medicine? [Internet]. 2018 [cited xxx]. Available from: https://blogs.scientificamerican.com/voices/what-role-should-race-play-in-medicine/ • Institute of Medicine, Board on Health Sciences Policy, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press; 2002.
Podcasts: • Scene on Radio Podcast. Seeing white series. Durham: Center for Documentary Studies at Duke University; February-August 2017.
Participate in learning or discussion groups to further deepen your personal awareness: • Consider taking the 21-day racial-equity challenge, created by expert Eddie Moore Jr., that focuses on the intersections of race, power, privilege, supremacy, and oppression (https://www.americanbar.org/groups/antitrust_law/committees/committee-at-womenconnected/wc-21day-challenge/) • UN training provides insights and tools to end racism and oppression in the form of workshops (https://untraining.org/) • The White Noise Collective offers trainings and workshops aimed at addressing gender oppression and white privilege (https://www.conspireforchange.org/workshops-and-dialogues/)

Table 2
Clinical interventions to address implicit bias and stereotype threat in the clinical setting.

Increase visual cues of diversity to create a welcoming atmosphere within all aspects of the patient visit (Brach and Fraser, 2000; Burgess et al., 2010; Howe et al., 2019)

- This can be done with simple methods to provide clear and relevant visual cues that racial minorities are valued.
- Diversify the wall art and magazines in the reception area.
- Display mission statements or antiracism policies that include welcoming language for diverse identities.

Personalizing as opposed to generalizing in the clinical encounter (Howe et al., 2019**)**

- Consider each patient as an individual and avoid assumptions based on any given identity, such as race.
- Make social comments and learn something about the patient you cannot read in the chart.
- Approach the patient with unconditional positive regard, assume best intentions, and avoid judgement.
- Ask about both good and bad previous experiences with medical providers.
- Ask the patient directly about what has worked well and what has not worked well for them in their past experience with providers.
- Try using some of these helpful statements:
  - *"So that I can learn a little more about you, what is an average day like for you?"*
  - *"What is most important to you in this visit today?"*
- Avoid why statements
  - Instead of *"Why haven't you been taking your medications?"* which can sound judgmental, try *"Tell me more about what's working or not working with your medication?"*

Use positive affirmations (Aronson et al., 2013; Institute of Medicine, 2003**)**

- Celebrate patient successes and provide encouragement and respect for the symptom and the emotional and personal stories of the patient
- Try using some of these helpful statements:
  - *"I respect how much effort you have put into prioritizing your health."*
  - *"I appreciate that you have read so much about your condition."*
  - *"You've done so great with applying the creams I prescribed last time. It can be really hard to keep up with that, but it seems like we both think it's making a difference."*

Implement active communication skill building through practice, with feedback and reflection (Chou, 2017**)**

- Take the time to be present so the visit does not feel rushed and mechanical.
  - Refer to patients using their formal title
  - Apologize if there is a wait
  - Introduce yourself and your team, including names and roles
  - Sit down
- Make your introduction *intentional*:
  - A warm welcome: *"Hello, Mrs. Jones, how was your trip in today? I am so glad to see you."*
- Invite the patient's agenda before contributing your own:
  - *"Before we get into the details, could you tell me the list of the things that bring you in today?"*
- Invite the patient's perspective into the visit by asking explicitly about ideas, concerns and expectations regarding their agenda items for the visit (Matthys et al., 2009)
  - *"What ideas do you have about what's causing the rash?"*
  - *"What are you most concerned about?"*
  - *"What are you hoping we can do in this visit? What's most important to you?"*
- Avoid monologues and downloads when sharing information
  - Instead, share chunks of information and check in with the patient in between to be sure you are meeting them where they are and engaging in a dialogue rather than a monologue.
  - This technique also maximizes patient ability and likelihood to follow through because of the shared plan.
  - The technique of the ART loop (i.e., ask, respond, tell) when sharing information can be helpful (Kalet and Chou, 2014; White and Barnett, 2014).
  - Ask "*What have you heard about psoriasis before?*"
  - Patient response: "*My sister has psoriasis. I know she did something called light therapy and had lots of creams, but that's about all I know.*"
  - Respond: *"I'm sorry to hear your sister also has this problem. You are right, light therapy is one of the treatments we can use to manage psoriasis."*
  - Tell/teach: *"I would like to tell you about a few more options and we can talk about what is best for you."*
- Share information: "*Based on your symptoms and your exam today, I think you have psoriasis.*"
- Ask for feedback from colleagues and patients and listen to that feedback to understand the impact of actions and behaviors with a mindset to improve.

Reduce anxiety (Howe et al., 2019**)**

- Use empathic statements and pay attention to nonverbal (body language) communication to validate the patient's experience, preferences, and concerns.
- Acknowledge injustice and health care injustice and health care inequity when appropriate.
- Elicit emotion explicitly and name it when it comes into the room (Chou, 2017; Cooper et al., 2006)
- Use PEARLS to remember examples of empathic statements (Healthcare, 2014):
  - **P**artnership: "Let's work together to figure this out."
  - **E**mpathy/Emotion naming: "I can hear how worrisome it feels to have a skin lesion that's changing."
  - **A**pology: "I'm sorry that it took so long to get you an appointment. I'm glad you're here now."
  - **R**espect: "I respect that you took the time to come in today. I know it can be hard, and I am glad to see you today."
  - **L**egitimization: "Anyone would be worried about losing their hair."
  - **S**upport: "I'm here for you every step of the way to get you feeling better."

did not explain her concerns in detail, the provider did not understand her issue, appropriate therapy was not prescribed, and the health outcome for Joanne was unnecessarily poor.

In the health care setting, the downstream consequences of both implicit bias and stereotype threat can be profound and lead to increased morbidity and mortality. Black, Indigenous, and Latino patients who perceive discrimination and report higher levels of mistrust are the patients most likely to miss medical appointments and delay needed or preventive medical care, contributing to disparities in care (Aronson et al., 2013).

To counter these forces in the medical encounter, health care professionals have an obligation to practice culturally competent care by implementing both personal awareness practices as well as specific relationship-centered techniques. These techniques can and should be applied to all encounters, and they are essential in bridging differences in the clinical encounter, such as in racially discordant visits. We analyze implicit bias, stereotype threat, and microaggression in dermatologic clinical scenarios to identify skills and steps that providers can learn and prioritize to improve the quality of clinical interactions between patient and provider and

Table 3
Structural changes that welcome and value different identities.

Ensure and embrace diversity and inclusion in your staff
• Inclusion goes beyond having racially diverse employees. Create a multicultural culture that embraces difference rather than creating a multicultural look.
• Create a culture of diversity that embraces difference and values employees who bring their authentic selves to work each day.
• Consider inclusion and belonging separately from diversity. Invite conversations that demonstrate that the practice values employees above and beyond how they contribute to the bottom line.
Increase diverse representation in the provider group to reflect that of the population (Diaz et al., 2020; Pandya et al., 2016)
• Encourage medical school programs and residency programs to take meaningful and effective steps to increase the number of URM applicants: Give strong positive value to a wider range of accomplishments and talents, such as cultural competence and likelihood to care for the underserved.
• Dermatologists should serve as allies and mentors for URM students at their own institutions by leading and supporting programs that increase the number of URM applicants to the field.
Invest in workforce diversity, equity, inclusion, and belonging (Brach and Fraser, 2000; Howe et al., 2019; Pandya et al., 2016)
• Commit to the recruitment and retention of URM providers and staff and the advancement and promotion of URM providers.
• Leaders need to develop their own skills that demonstrate that staff are valued specifically for the background, culture, and language they bring to work.

URM, underrepresented minority.

ultimately affect better health outcomes for Black, Indigenous, and Latino patients. We acknowledge that these skills are applicable to all providers and particularly so to those providers who are part of racially privileged groups.

A number of techniques for combating implicit bias and stereotype threat are available. Herein, we describe a toolkit for relationship-centered care that actively mitigates both implicit bias and stereotype threat in the clinic setting (Tables 1–3). The details of a three-point action plan to combat the effect of stereotype threat and implicit bias are outlined as follows:

1. Personal awareness and implicit bias awareness
   a. We detail selected educational material on the topics of racism and implicit bias for providers.
   b. We provide information implicit bias association tests to develop awareness of unconscious bias in a clinical setting.
2. Clinical interventions to address implicit bias and stereotype threat in the clinical setting
   a. We provide strategies to increase visual cues of diversity in all aspects of the clinical encounter.
   b. We detail techniques to personalize the visit during the clinical encounter to develop rapport.
   c. We describe active communication skill building with feedback, reflection, empathy, and positive affirmation.
3. Structural changes that welcome and value different identities
   a. We review methods to ensure and embrace both diversity and inclusion regarding clinical staff.
   b. We discuss how to increase diverse representation in the provider group to reflect the population.
   c. We expand on ways to invest in workforce diversity, equity, inclusion, and belonging.

The combination of these behaviors creates the basis for trust, connection, and relationship building. Investment in communication training for staff and providers with observation and feedback can significantly improve individual communication skills. Many of the skills we discuss are references directly from the Academy of Communication in Healthcare, a professional organization that provides evidence-based tools and skills for improved communication. The application and impact of these skills to health care encounters with racial differences is specifically detailed by Dr. Denise Davis in Chapter 14 on culture and diversity. Although we cannot diversify the field of dermatology overnight, as providers we can take steps to ensure we are creating an atmosphere that welcomes all patients, in particular racial minorities, and minimize the effect of implicit bias and stereotype threat in the clinical encounter. This manuscript is the foundation of a future study of one author (B.W.) exploring the impact of implementing the guidelines featured in our toolbox on minority patients' dermatology experience. Positive patient–physician interactions and a strong therapeutic alliance result in better patient outcomes, particularly for our Black, Indigenous, and Latino patients (Garroutte et al., 2008; Simonds et al., 2011). In the words of Maya Angelou, "People will forget what you said, people will forget what you did, but people will never forget how you made them feel."

Conflicts of interest

None.

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Study approval

The author(s) confirm that any aspect of the work covered in this manuscript that has involved human patients has been conducted with the ethical approval of all relevant bodies.

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