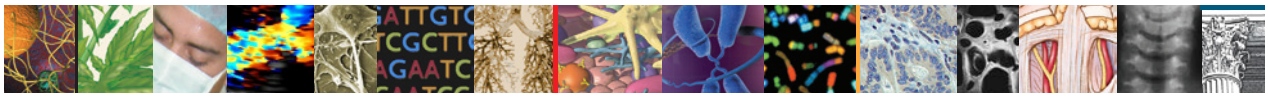

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Perspective

Bias, Black Lives, and Academic Medicine

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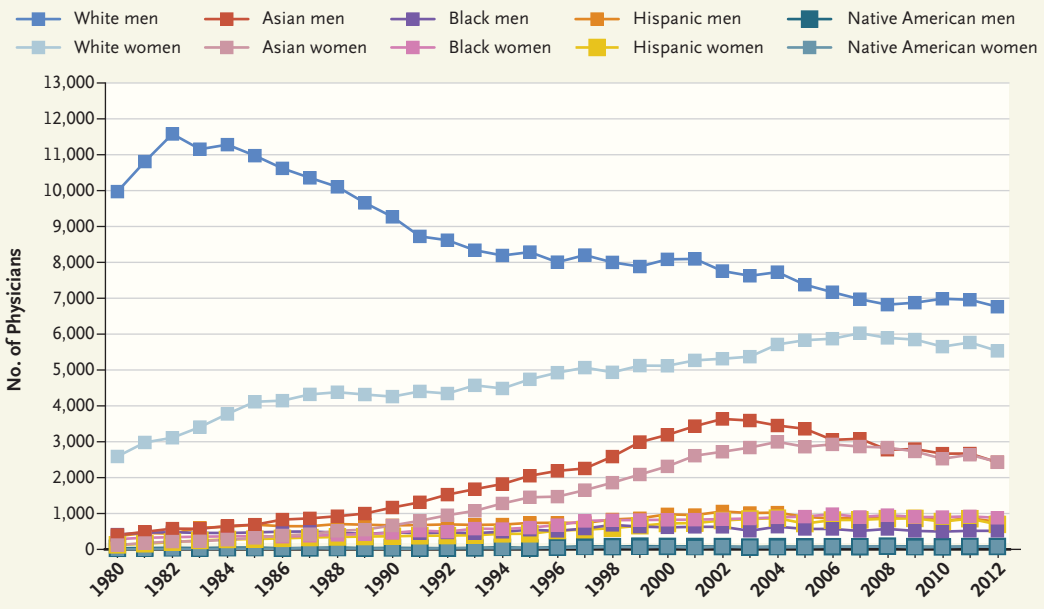
At noon Pacific Standard Time on December 10, 2014, thousands of students from 70 medical schools throughout the United States held silent "White Coats for Black Lives" die-ins. These demonstrations, the largest coordinated protests at U.S. medical schools since the Vietnam War era, were initiated by medical students in California and spread across the country in response to the following call to action posted online at thefreethoughtproject.com:

"We feel it is essential to begin a conversation about our role in addressing the explicit and implicit discrimination and racism in our communities and reflect on the systemic biases embedded in our medical education curricula, clinical learning environments, and administrative decision-making. We believe these discussions are needed at academic medical centers nationwide." Though the stimulus for the die-ins was the nationwide protests in response to the killing of unarmed black men by police officers, the students demanded an examination of racial bias within our country's academic medical centers.

What are the systemic biases within academic medical centers, and what do they have to do with black lives? Two observations about health care disparities may be relevant.

First, there is evidence that doctors hold stereotypes based on patients' race that can influence their clinical decisions.[1] Implicit bias refers to unconscious racial stereotypes that grow from our personal and cultural experiences. These implicit beliefs may also stem from a lack of day-to-day interracial and intercultural interactions. Although explicit race bias is rare among physicians, an unconscious preference for whites as compared with blacks is commonly revealed on tests of implicit bias.[1]

Second, despite physicians' and medical centers' best intentions of being equitable, black–white disparities persist in patient outcomes, medical education, and faculty recruitment. In the 2002 report *Unequal Treatment*, the Institute of Medicine (IOM) reviewed hundreds of studies of age, sex, and racial differences in medical diagnoses, treatments, and health care outcomes.[2] The IOM's conclusion was that for almost every disease studied, black Americans received less effective care than white Americans. These disparities persisted despite matching



White									
Men	9972	11,281	10,105	8617	8005	8084	7727	6821	6763
Women	2589	3,775	4,380	4344	4925	5117	5712	5895	5533
Asian									
Men	400	652	924	1526	2188	3191	3452	2777	2427
Women	120	270	516	951	1470	2313	2996	2838	2434
Black									
Men	411	456	468	471	516	614	632	569	517
Women	286	362	405	493	675	824	893	954	880
Hispanic or Latino									
Men	369	629	706	696	741	976	1024	912	766
Women	125	276	345	384	525	721	869	856	696
American Indian or Alaska Native									
Men	30	47	51	31	63	83	77	90	81
Women	3	19	21	30	48	73	57	85	72

Number of U.S. Physicians by Graduation Year, Race, Ethnic Group, and Sex, 1980–2012.

Data are from the Association of American Medical Colleges. An interactive graphic is available at NEJM.org.

for socioeconomic and insurance status. Minority patients received fewer recommended treatments for diseases ranging from AIDS to cancer to heart disease. And racial gaps in health care outcomes have persisted. For example, gaps in blood pressure, cholesterol, and glycated hemoglobin control between black and white members of Medicare health maintenance organizations were found throughout the period 2006 to 2011.[3]

The IOM found "strong but circumstantial evidence for the role of bias, stereotyping, and prejudice" in perpetuating racial health disparities.[2] The finding that physicians have implicit racial bias does not prove that it affects patient–doctor relationships or changes treatment decisions. But some research suggests that there's a direct relationship among physicians' implicit bias, mistrust on the part of black patients, and clinical outcomes.[1] Although the causes of health care disparities are certainly multifactorial, implicit bias plays some role.

Implicit bias may also influence administrative decisions at academic medical centers — decisions ranging from what services are provided, to whether to accept insurance plans that serve the most disadvantaged members of minority groups, to which neighborhoods to choose when establishing new physicians' offices. The likelihood of such influence does not mean that bias is the only explanation for unequal treatment or administrative decisions that favor one group over another. The point is simply that there is potential for making racially biased decisions, and it generally goes unexamined.

Implicit racial bias might contribute to the failure to achieve

greater inclusion of black students in medical education. Though there has been progress in the recruitment of some underrepresented minority groups to medical schools, the percentage of black men among all medical school graduates has declined over the past 20 years (see graph). The country's traditionally black medical colleges — Howard, Meharry, and Morehouse — continue to graduate a disproportionate number of black medical students. In 2012, there were just 517 black men among the more than 20,000 graduating students at U.S. medical schools (see graph). Black medical students are more than twice as likely as white students to express a desire to care for underserved communities of color. Our inability to recruit black men into medicine is alarming, given the urgency of racial health care disparities in the United States.

Recruitment and retention of black faculty members have also long challenged academic medicine. Only 2.9% of all faculty members at U.S. medical schools are black.[4] A 2010 study showed that among faculty members who had been hired in 2000, blacks were less likely to have been retained than any other demographic group. Black faculty members are less likely than their white counterparts to be promoted, to hold senior faculty or administrative positions, and to receive research awards from the National Institutes of Health.[5] Thirty-one percent of the 84,195 white faculty members at U.S. medical schools were full professors in 2011, as compared with just 11% of the 3952 black faculty members. The paucity of black faculty members contributes to a climate in which black medical students may lack accessible black role models. The IOM has defined the climate for diversity as "the perceptions, attitudes, and expectations that define the institution, particularly as seen from the perspectives of individuals of different racial or ethnic backgrounds." Though there may be various drivers of poor recruitment, retention, and promotion of black faculty members, the role of institutional bias and the climate for black faculty at academic medical centers deserve scrutiny. By any measure, academic medicine's persistent difficulty in developing black faculty members is a serious concern.

For the sake of not only black lives but all lives, we should heed our students' call to examine the implicit biases in our academic medical centers. We can begin by assessing how bias contributes to the persistence of black–white disparities in health care, medical school recruitment, and faculty retention in our own institutions. We can audit the care we deliver to ensure that the right treatments are provided and the best outcomes are achieved regardless of patients' race, class, or sex. We can assess the climate within our centers and strive to ensure that our recruitment processes, classrooms, clinics, administrations, and boardrooms are inclusive to all. But most important, we should talk about bias, with our students, our faculties, our staff, our administrations, and our patients. Maybe then we'll have a chance to finally eliminate the racial health care disparities that persist in the United States.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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