

BREADTH

MULTIPLE TRAUMAS

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“**T**ry to avoid sticking yourself with the needle—she’s a prostitute,” a resident said to me as he handed me the needle and driver. The patient laid before me was a young black woman in her early twenties stabbed over 20 times in the face, neck, chest, arms, and legs. “Jane Doe” read her chart and she was writhing in pain. While she was given light doses of lorazepam and lidocaine, she still cried out with every saline wash, every stitch we placed. She begged for more pain medication. At one point, she refused further wound closure until her pain needs were addressed.

As her wounds were dressed in succession, Jane was subjected to a series of handovers. Details of her medical care were interlaced with commentary, “I have to warn you, this one’s difficult.” “I would have finished sooner if she hadn’t complained so much.” Inside her room, half-hearted coaxes of “a little stinging here” and “just a little more” offered her no respite. She asked us over and over again, “Why are you doing this to me? You keep telling me that you’re treating the pain but you’re still hurting me!”

I asked a resident why she was not considered for the operating room. “She’s already been through enough,” the resident shrugged, and continued to adjust the light for the next row of sutures. Despite his causal assuredness, what he meant remained unclear to me. If I were the patient, I would have gladly gone to the operating room for anesthesia. She had indicated her desire to go. Why wasn’t this option offered to her?

Implicit bias describes the attitudes or stereotypes that affect our decisions and actions in an unconscious way. No physician enters the medical profession with the intent of providing biased care; yet, studies show we are all complicit in its practice. It may start with a simple subconscious assumption about a patient’s background or education, and snowballs quickly into miscommunication, suspicion, distrust, and ultimately, mishandling of patient care.¹ I worry that Jane Doe’s case is such an

example. What may have been speculation about her background—a sex worker, maybe active drug use, likely of poor education—turned into beliefs about her ability to communicate her pain, her unspoken, assumed desire for opioids.

The role of implicit bias in treating pain is well documented. Scores of studies have shown that Caucasians presenting with bone fractures are more likely to receive pain medications than African Americans or Latinos, even when controlled for pain severity and insurance coverage. A study by Hoffman published in 2016 involving medical students and residents in Virginia found a strong correlation between the number of false racial beliefs and the likelihood of undertreating pain for black patients when compared to white patients.²

The roots can be traced back to our history of racial bias in medicine. Racial biology, a pseudoscientific belief that African Americans are biologically different, declined in popularity after World War II. But these beliefs still exist in some form today. Many subjects in Hoffman’s 2016 study falsely believed that blacks have less sensitive nerve endings than whites; Dr. Samuel Cartwright made similar claims in 1851. More than a third of subjects in the same study asserted that black skin was thicker than that of whites, while a physician published this statement over a hundred years ago.³

I met Jane Doe as a medical student. While I was introduced to the concept of implicit bias in medical school, I failed to identify it during the encounter. I thought about her for months afterward because the whole situation seemed so wrong. Brought to the emergency department before I arrived, she was still getting stitched up by the end of my twelve-hour shift. She continued to beg for pain medication, water, ice chips, and food through the night. After the trauma of the attack, she was subjected to the trauma of our care. But what could have I said to change her course of care, especially from my position in

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training? I was not prepared with the language to discuss the potential role of implicit bias with the resident.

I am now a resident. I regularly see cases where implicit bias may have played a role in a patient's care. Yet, I still hesitate to discuss it openly. I worry that my questions would be interpreted as an insinuation that someone may be racist, rather than as an opportunity for an open conversation. Unlike cognitive biases, we have yet to develop a language and framework for approaching implicit bias. We could improve patient care if we systematically challenged our implicit biases in the same way we do with cognitive bias.

Methods to address implicit bias in clinical practice are lacking. Scientists have found that trainings

around self-realization, such as the implicit association test (IAT) can help providers explore subconscious biases. While medicine has started to adopt practices in identifying implicit bias, there are few opportunities to continue the discussion in residency and beyond.⁴ There is little to no guidance offered around how to address these biases in real time.

Implicit bias continues to be a heated topic of national conversation. Physicians, nurses, residents, and trainees must have these conversations as well. We must not fall behind the natural speed of progress.

References

1. Chapman EN, 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. Hoffman KM, Trawalter S, Axt JR, et al. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci.* 2016;113(16):4296-4301.
3. Hoberman J. *Black and Blue: The Origins and Consequences of Medica.* University of California Press; 2012.
4. Byrne A, Tanesini A. Instilling new habits: Addressing implicit bias in healthcare professionals. *Adv Heal Sci Educ.* 2015;20:1255-1262.