

3 Ways to Make Less Biased Decisions

by Howard J. Ross

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Unconscious bias - judgments and behaviors toward others that we're not aware of - is everywhere in our lives. And while this type of bias may seem less dangerous in the workplace than it may be on the streets of Ferguson, Mo., or in a courtroom, it still leads to racial injustice.

In March 2013, a U.S. Equal Employment Opportunity Commission report identified “unconscious bias and perceptions about African Americans” as one of seven “major obstacles hindering equal opportunities for African Americans in the federal work force.”

In fact, simply having a name that sounds black can reduce the chance of you getting an interview, according to a study conducted by researchers at MIT and the University of Chicago. The research showed that this is true *even at companies that are actively looking for diversity in hiring*. Similar trends have been identified in virtually every aspect of the talent management system. For example, another study from the University of Warsaw, found that women described with feminine job titles (e.g. “chairwoman”) are perceived (by men) to be as significantly less warm and marginally less competent than women with masculine job titles. And men reported that they were less likely to hire these women.

In my 30 years of consulting and research, I have seen this unconscious bias play out again and again. It not only results in lack of equity in organizations, but in poor talent management practices. How can we hire, retain, and develop the best people – regardless of race – if we are not even aware of the forces that dominate the choices we make?

Unfortunately, it is unlikely that we can eliminate our biases. We are learning more and more that they are a natural part of human functioning. Psychologist Joseph LeDoux refers to bias as our human “danger detector,” as it provides a quick way to insure our safety. We make fast judgments about what is “normal” and what isn’t and often this works in our favor. For example, a good leader may sense that certain behaviors are consistently more dependable in meeting client needs and may develop a “bias” toward those approaches. Even if they are not correct 100% of the time, they may still make more sense as a rule than approaching each client situation as if it has never happened before. Of course, that doesn’t mean that one approach should be chiseled in stone.

The good news is that there are things that we can do to mitigate the negative impact of biases on our organizational decision-making.

3 Ways to Make Less Biased Decisions

First, by realizing and accepting that we all have bias, we can learn to watch for it in ourselves and help others who work with us to do the same. This process of building awareness is similar to what happens when we step on the clutch in a standard transmission automobile. The motor doesn’t stop running (bias doesn’t stop), but the car is no longer moving forward. When we are on the lookout for biases, they are less likely to blindly dictate our decisions.

Second, we have to develop tactics that help us make decisions more consciously. There are three types of approaches that can help: *priming*; *reorganized structures and systems*; and *new forms of accountability*.

Priming is a memory effect that gets created when one activity subtly, and often unconsciously, impacts subsequent behaviors. By consciously priming people to pay attention to potential areas of bias, extensive research as well as our experience with clients has shown that they can be encouraged to be more conscious of their decision-making processes. For example, before reviewing resumes, managers can be asked to respond to a series of questions like:

“Does this person’s resume remind you in any way about yourself?”

“Does it remind you of somebody you know? Is that positive or negative?”

“Are there things about the resume that particularly influence your impression? Are they really relevant to the job?”

“What assessments have you already made about the person? Are these grounded in solid information or are they simply your interpretations?”

Similar safeguards can be put in place around many aspects of talent management: recruiting, interviewing, hiring, promoting, and performance reviews. As Nobel Prize winner Daniel Kahneman said: “The odds of limiting the constraints of biases in a group setting rise when discussion of them is widespread.”

Reorganizing structures and systems can also help reduce the impact of bias. Structure creates behavior in organizations and by creating consistency in how certain processes get carried out, you can encourage less biased behavior. For example, structured interviewing processes, in which the questions are consistent across candidates, have been found to reduce bias relative to unstructured or free-form interviews. In fact, as a rule, structured processes can reduce the patterns of unconscious bias that take over when people are just “trusting their gut” in informal structures like mentoring, managing, coaching, and reviewing performance.

Finally, you can put **new forms of accountability** in place so that it becomes clear when bias is occurring. For example, if a manager gives 10 performance reviews, five to men and five to women, and four out of the highest five are women, it should at the very least call for an inquiry into whether there might be a pro-female bias in the process. It might be total coincidence, but it is worth checking. You might get input from some colleagues who also work with the people being rated and see if they make the same evaluation.

Another place to encourage accountability is in diversity metrics. If you look at metrics individually you might argue that you're reaching your company's diversity goals of representation at each point in the process. But if you look at the batch of metrics together – for example, the percentage of people who apply for jobs, the percentage who are offered jobs, the percentage who accept those jobs, and the percentage who are successful in their jobs after six months – you are far more likely to be able to pinpoint the places in the system where breakdowns are occurring.

Bias may be as natural as breathing and it may very well be impossible to drive it out of human consciousness. But by shifting your mindset and inviting constant inquiry into how you make decisions, you can create businesses in which the diversity of your workforce is truly the strength that you hoped it would be.



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VIEWPOINT

Reducing Bias in Academic Search Committees

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Faculty members are often called on to serve and participate on search committees for deans, department chairs, leaders of centers of excellence, and senior-level positions in medical schools, academic hospitals, and health systems. These search committees are generally charged not only to find qualified candidates but also to consider diversity and inclusion in the process.

The demographics of the US population are changing. Reports from census experts suggest that as many as 40 million immigrants have arrived in the United States since the origin of the Immigration Act of 1965.¹ Further, the non-US-born population is projected to reach nearly 19% of the total US population by 2060.² The Latino/Hispanic population is now 17.6% of the US population and together with the black/African American population accounts for nearly 31% of all US residents.³ Additionally, according to the Pew Research Center, Asian Americans are the fastest-growing and best-educated racial ethnic group entering the United States.⁴ These facts, coupled with continued challenges with health disparities and minority underrepresentation in key allied health positions, require specific actions and policies to ensure diversity, inclusion, and unbiased hiring practices.

In 2015, African Americans made up only 4.4% of faculty members of US medical schools who are listed as a single racial group.⁵ Concerns have also been raised that a proportion of those included in that number are not truly faculty members but practicing affiliated

implicit or unconscious bias. Major private corporations are aware of this issue and are installing bias training coursework for top executives and key committee members, an innovation that leads to greater diversity and contributes to both financial and human capital.⁸ The following 5 suggestions represent a rigorous attempt to formulate a new approach and address the concern of biased search committees.

1. **Pretraining:** After receiving the charge to join and serve on a search committee, invited members should participate in programmed pretraining. This step should include provision of reading materials with appropriate references and accompanying presentations regarding the nature and definition of implicit bias, as this will be a critical starting place for establishing a foundational knowledge base and self-awareness of the team. All members should take an implicit bias self-assessment, such as implicit association tests offered by Project Implicit.⁹ Open discussion of the findings of these assessments will be beneficial for transparency and team building.
2. **Outcome framework design:** Prior to beginning the active recruitment process, the search committees should construct a diagram or visual image of key characteristics that the ideal candidate might encompass, with notation of suitable substitutes or allowable similarities. For example, if a candidate with a research background is sought, the type, quality, and quantity of research articles, collaborations, capabilities, and any acceptable substitutions enter the framework for the outcome design. In this manner, the committee becomes insulated against renegeing on qualifications based on individual or group bias.
3. **Table placement and seating design:** Committees to select high-stakes individuals are often composed of accomplished and sometimes politically powerful and influential faculty members. This possibility may be in some ways addressed by alternating seating arrangements to hinder the formation of unconscious power alliances, which can in turn influence the proceedings and the decision-making dynamic of the search committee.
4. **Scribe usage:** A common but unavoidable human trait is for a group of individuals to hear the same words but to have multiple interpretations of what was actually stated. Words and phrases are easily and variably interpreted based on preexisting bias and possible lapses in attention. The use of an impartial scribe or professional note taker could assist in having a reliable record to clarify any statements or issues that arise during the latter stage of deliberations of the search committee.

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physicians.⁶ Specifically, there were 62 260 white associate or assistant professors and 27 866 white full professors at US medical schools.⁵ At the same time, there were 7157 black and Latino assistant, associate, and full professors combined, excluding multiple race categories. Similarly, women account for 36.4% of faculty members at US medical schools at those ranks, including 7758 full professors and 43 041 associate or assistant professors, but have lower compensation than male faculty.⁷

To create a more diverse, "level playing field" of leadership representation, one area of concentration should be the formation, conduct, and management of search committees for top-ranking academic positions and health system executives. Although many leaders understand and comply with the call for diversity among the members who serve on these search committees, there is a need for a more rigorous and detailed process to reduce the human factors of

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5. Quantity of minority and underrepresented candidates: Having ample representation both on the search committee and among the invited candidates of minority representatives is crucial. For example, merely having symbolic African Americans, Latinos, or women either as candidates or as members of the committee does not guarantee lack of bias. The committee should agree in advance to have a preferred target goal for the number of minority applicants to review. It may be determined that a specific number of candidates need to be considered to guarantee a fair process. If that target cannot be reached, the group must be in agreement that sufficient efforts were expended.

There are no data that these recommendations will reduce bias on search committees or indeed improve diversity at

the highest levels of US medicine, which is the most important outcome. Yet to accommodate necessary changes as the United States strives to promote an equitable and socially just society, these steps should be considered vital and taken as a whole, not in fragments. A larger and more encompassing framework for these committees hopefully will help encourage greater opportunity for success. The less-biased search committee may not reach perfection, but without efforts to improve the process, the outcomes will never lead to equity and diversity in leadership. The unbiased search committee represents a necessary and desirable step forward that can help to ensure the future success of medical education and of academic medical centers in the United States.

ARTICLE INFORMATION

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REFERENCES

- Center for Immigration Studies (CIS). Three decades of mass immigration: the legacy of the 1965 immigration act. CIS website. <http://cis.org/1965ImmigrationAct-MassImmigration>. September 1995. Accessed September 27, 2016.
- New Census Bureau report analyzes U.S. population projections. PR Newswire. <http://www.prnewswire.com/news-releases/new-census-bureau-report-analyzes-us-population-projections-300044527.html>. 2015. Accessed July 3, 2016.
- US Census Bureau. QuickFacts: United States. US Census Bureau website. <https://www.census.gov/quickfacts/table/PST045215/00>. Accessed October 22, 2016.
- Pew Research Center. Asian Americans. Pew Research Center website. <http://www.pewsocialtrends.org/asianamericans-graphics/>. 2012. Accessed October 3, 2016.
- Association of American Medical Colleges (AAMC). Table 11: distribution of US medical school faculty by sex, race/ethnicity, and rank. AAMC website. <https://www.aamc.org/download/453396/data/15table11.pdf>. December 31, 2015. Accessed September 27, 2016.
- A JBHE check-up on blacks in US medical schools. *The Journal of Blacks in Higher Education* website. http://www.jbhe.com/features/47_medicalschoools.html. Accessed October 22, 2016.
- Jena AB, Olenski AR, Blumenthal DM. Sex differences in physician salary in US public medical schools. *JAMA Intern Med*. 2016;176(9):1294-1304.
- Hunt V, Layton D, Prince S. Why diversity matters. McKinsey & Co website. <http://www.mckinsey.com/business-functions/organization/our-insights/why-diversity-matters?xtlnkusaolp00000619>. February 2015. Accessed September 22, 2016.
- Project Implicit website. <https://implicit.harvard.edu/implicit>. Accessed October 23, 2016.

The Opinion Pages

A Fix for Gender Bias in Health Care? Check

Jessica Nordell

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When Dr. Elliott Haut and his team at Johns Hopkins Hospital in Baltimore designed their blood clot prevention protocol back in 2006, they didn't expect to discover systemic gender bias. But the data were clear and the implications were alarming: Women who were trauma patients at Johns Hopkins Hospital were in considerably greater danger of dying of preventable blood clots than men.

Why? Because doctors were less likely to provide them with the appropriate blood clot prevention treatment. At Hopkins, as at many hospitals, both men and women were receiving treatment at less than perfect rates, but while 31 percent of male trauma patients were failing to get proper clot prevention, for women, the rate was 45 percent. That means women were nearly 50 percent more likely to miss out on blood clot prevention.

Blood clots, gelatinous tangles that can travel through the body and block blood flow, kill more people every year than breast cancer, AIDS and car crashes combined. But many of these clots can be avoided — if doctors prescribe the right preventive measures.

Haut is a trauma surgeon, not a bias expert, so gender disparities were the last thing on his mind when he and his team put together a computerized checklist that requires doctors to review blood clot prevention for every patient. “Our goal was not to improve care for men or women or whoever, it was to improve the care of everybody,” he said. But what they found was that after the introduction of the checklist, appropriate treatment for everyone spiked. And the gender disparity disappeared.

In trying to end preventable blood clots, the Hopkins team may have quietly stumbled upon a way to eliminate at least one form of gender bias.

Gender bias has received significant attention in recent years, and has been scrutinized as a factor in the dearth of female chief executives, the treatment of presidential candidates and the lower pay of Hollywood actresses.

In health care, gender disparities are especially pernicious. If you are a woman, studies have shown, you are not only less likely to receive blood clot prophylaxis, but you may also receive less intensive treatment for a heart attack. If you are a woman older than 50 who is critically ill, you are at particular risk of failing to receive lifesaving interventions. If you have knee pain, you are less likely to be referred for a knee replacement than a man, and if you have heart failure, it may take longer to get EKGs.

It's not clear what causes these differences. While situational factors and variations among patients may explain some of them, broad gender differences in treatment protocols that play out across large numbers of patients suggest a systemic bias. What's especially difficult in ending such discrimination is that providers may not even realize they're behaving in biased ways.

Such implicit bias, as researchers now understand, happens when we unintentionally use stereotypes or associations to make judgments. “Perhaps we take women's symptoms less seriously, or we interpret them as having an emotional cause as opposed to a physical cause,” said Dr. Christine Kolehmainen, the associate director for women's health at the Middleton Memorial Veterans Hospital in Madison, Wis. Studies bear this out: in one study of patients with irritable bowel syndrome, doctors were more likely to suggest that male patients receive X-rays and more likely to offer female patients tranquilizers and lifestyle advice.

In the case of blood clot prevention, doctors' assumptions about women's risk factors could lead to disparities in treatment. “There might be stereotypes about women's biology or environment or occupation that could all play into

medical decision-making,” Kolehmainen said.

Whether unintentional, unconscious or simply based on erroneous assumptions, treatment differentials clearly exist. Interventions like the Hopkins checklist can help correct them.

The Hopkins checklist is considered a “decision support tool,” and it works like this: Whenever a provider is admitting a patient to the hospital, a computerized checklist pops up onscreen. It asks if the patient has specific risk factors for blood clots, or for bleeding from blood thinning medication. Then the system offers a recommended treatment.

Like any checklist, this one serves as a reminder of proper protocol. Championed most notably by Dr. Atul Gawande in “The Checklist Manifesto,” checklists have been used for decades to improve flight safety, and have in recent years been applied in a wide range of medical settings. In one trial, a checklist reminding health care workers to do things like wash their hands led to a **66 percent drop** in infections within 18 months. Results from a study of surgery patients at eight hospitals showed that post-checklist, complications dropped by 35 percent, and death rates **dropped by 47 percent**. Checklists plug memory holes and put a safety net under human errors. As Gawande wrote, they “remind us of the minimum necessary steps.”

But implicit gender bias isn’t about forgetting, it’s about making assumptions. And this is where the Hopkins checklist makes a difference. In spelling out the specific criteria for determining a treatment plan and then recommending one, the checklist interrupts bias in two important ways.

First, it disentangles the thinking that goes into a medical decision. Typically, clinicians aggregate relevant patient information and use their judgment to arrive at the best course of action. The Hopkins checklist disaggregates that decision into its constituent parts. In a sense, the Hopkins checklist puts the decision about blood clot prevention through a prism, separating out and clarifying the sub-decisions the way a prism separates white light into its rainbow colors. In illuminating each step, the checklist interrupts habitual biases, preventing them from corrupting the decision-making process.

Second, the checklist reduces reliance on human judgment. “The decision support tool makes it very cut and dry — the decision isn’t, ‘Hey, what do you think you should do?’ The decision is — click, click, click, here’s what the computer says to do,” Haut said.

There are, of course, limitations to the uses of checklists. One of the biggest is that doctors may resist using them because it can feel like they are being asked to defer to the wisdom of a machine **instead of relying on their long training**. Of course, checklists cannot replace doctors’ judgment. But they can, in many situations, improve it.

It all hinges on how such checklists are put in place. While studies of the practice have pointed to remarkable outcomes, real-world results haven’t always measured up. Why? In many cases, the checklists haven’t been used as designed. In a review of **7,000 surgical procedures**, researchers at Imperial College London found that while checklists were used 97 percent of the time, they were completed only 62 percent of the time. (An incomplete checklist defeats the purpose.)

Interviews with more than 100 staff members at 10 British National Health Service hospitals revealed that some providers opt out because they’re not convinced of the checklist’s utility. Others feel they haven’t been adequately consulted, and the checklist is just another irritating dictum from on high. Yet others felt the checklist wasn’t correctly tailored for a specific scenario.

But, crucially, these checklists were all optional. The Hopkins checklist was mandatory. Clinicians can override its recommendation, but they can’t opt out of participating. “These passive approaches don’t seem to work,” Haut said. “Handing out laminated cards, education, reminding people — it doesn’t work as well.”

If done correctly, however, the checklist approach could reduce biased treatment for myriad patient backgrounds and conditions. (Studies have shown that **African-American and Hispanic patients** also receive lower quality health care compared with white patients.)

The checklist principle could be used in other fields as well. Indeed, structuring decision-making in order to root out bias is already gaining traction in business — companies like Google and Slack have begun to use structured interviews to avoid discrimination in hiring. Instead of allowing interviews to be free-form, guided by the interviewer’s own judgments, these companies use the same interview techniques and questions for each candidate.

Just as every Hopkins patient is assessed for the same blood clot risk factors, every job candidate is assessed the same way. This ensures fairer interviews.

The Hopkins blood clot prevention checklist has been enormously successful — after the intervention, the incidents of potentially preventable blood clots in medical patients **dropped to zero**. The checklist is now the standard of care throughout Johns Hopkins Hospital. Any patient who enters the hospital — for a birth, **brain surgery**, **pneumonia**, even psychiatric treatment — is assessed for blood clot prevention. That means 50,000 patients a year are receiving treatment that isn't biased by their gender (or race, or any other factor). Hundreds of thousands of patients have benefited since the checklist was put into place in 2008.

Given the chances of clot-related deaths, that's dozens more women's lives saved, and dozens of families who didn't lose a mother, sister, grandmother or daughter. And that's just one hospital. Rolled out across the country, this relatively straightforward intervention could save thousands of lives — of both women and men — each year.

Jessica Nordell (@jessnordell), a journalist based in Minneapolis, is at work on a book about implicit bias.

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