

August 2017 Editor-in-Chief Pick of the Month

A Systematic Review and Meta-Analyses (Other Than Evidence-Based Diagnostics)

Psycho-metrics

Let's just skip right over parking, nightshift staffing, and bonuses. In June, we already took care of the gender identity problem. So, this month let's take on race. No problem-o.

It has been said that all humans have racist beliefs, and what matters is not our thoughts, but what we do. Others argue that our actions usually reflect our thoughts. [Dehon and her colleagues](#) from the University of Mississippi present a somewhat surprising systematic review, suggesting that just because a doctor shows racial preference does not necessarily mean he or she will order more or less diagnostic tests or treatments based on race.

To better understand this data, may I suggest taking the [Implicit Association Test](#) (IAT) used in this paper. The website houses a portfolio of different tests aimed at helping you learn whether you prefer people who are fat or skinny, gay or straight, or young or old. (Coming soon: mayonnaise versus mustard).

So I took the Race IAT. And yes, I admit it. I tried to game my answers to make me look all academic and neutral-minded. After all, I do own a jacket with patches on the elbows, and I like Steve Harvey. A lot. So, anyone can see that I have no racial bias. Despite my attempt to cheat, this is what I got:

Debriefing

The sorting test you just took is called the Implicit Association Test (IAT). You categorized good and bad with images of Black people and White people.

Here is your result:

Your data suggests a moderate automatic preference for White people over Black People.

Your result is described as an "Automatic preference for Black people over White people" if you were faster responding when *Black people* and *Good* are assigned to the same response key than when *White people* and *Good* were classified with the same key. Your score is defined as an "Automatic preference for White people over Black people" if the opposite occurred.

Your automatic preference may be described as "slight," "moderate," "strong," or "no preference." This indicates the *strength* of your automatic preference.

The IAT requires a certain number of correct responses in order to get results. If you made too many errors while completing the test you will get the feedback that there were too many errors to determine a result.

Note that your IAT result is based only on the categorization task and not on the questions that you answered.

Crap. Neither the test nor my results were what I expected. Unlike other psychometric tests, the IAT does not ask you to make absurd "would you rather be a hammer or a nail"-type choices. In fact, the Race IAT just measures how fast the test taker associates positive and negative words with black and white people. Whether the kinetics of word association indicates racial bias remains debatable, and I have no idea what the gold standard would be.

Back to Dehon et al. Of nine studies noted, eight found the doctors tended to have a preference for white people, but only three studies found treatment preferences for whites in case vignettes, and these preferences were weak. These were pretend cases on paper, as opposed to measurements made in room 6. Thus, one implication of this review is the need to study emergency physicians on a busy shift to understand if implicit bias really affects their decision-making.

Best Wishes,
Jeffrey A. Kline
Editor-in-Chief, Academic Emergency Medicine

Narrative Summary

Zachary F. Meisel, MD, Associate Professor of Emergency Medicine at the Perelman School of Medicine at the University of Pennsylvania, places the EIC Pick into perspective in the emergency setting:

Have you ever tried to buy something interesting online but were told that it was out of stock? Well, **it probably hadn't even been made yet. Why? Paraphrasing a mentor** (who came from the world of business and marketing, but now works in healthcare delivery science): **"What people say and what people do are almost never the same thing."** He goes on to describe how—among savvy marketers—focus groups, interviews, and surveys are widely rejected when it comes to figuring out who will pay for different products and services. To understand how people behave, you have to observe them in action (or deceive them into believing they are doing something real, like buying a product **online that hasn't been manufactured**). Dehon and colleagues take on an immensely important task: summarizing the literature that correlates implicit bias with disparities in acute medical care for minorities. While the correlations between bias and disparate care in this review were relatively weak, most of the studies summarized here used simulated vignettes. Without **conducting ethnography (observing providers in their real work environments)** we can't know how their implicit biases translate into differential care for patients. This is an important topic and is an important primer for a lot of future work.