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ORIGINAL PAPER

Patrolling Your Blind Spots: Introspection and Public Catharsis in a Medical School Faculty Development Course to Reduce Unconscious Bias in Medicine

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Abstract Cultural competence education has been criticized for excessively focusing on the culture of patients while ignoring how the culture of medical institutions and individual providers contribute to health disparities. Many educators are now focusing on the role of bias in medical encounters and searching for strategies to reduce its negative impact on patients. These bias-reduction efforts have often been met with resistance from those who are offended by the notion that "they" are part of the problem. This article examines a faculty development course offered to medical school faculty that seeks to reduce bias in a way that avoids this problem. Informed by recent social–psychological research on bias, the course focuses on forms of bias that operate below the level of conscious awareness. With a pedagogical strategy promoting self-awareness and introspection, instructors encourage participants to discover their own unconscious biases in the hopes that they will become less biased in the future. By focusing on hidden forms of bias that everyone shares, they hope to create a "safe-space" where individuals can discuss shameful past experiences without fear of blame or criticism. Drawing on participant-observation in all course sessions and eight in-depth interviews, this article examines the experiences and reactions of instructors and participants to this type of approach. We "lift the hood" and closely examine the philosophy and strategy of course founders, the motivations of the participants, and the experience of and

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reaction to the specific pedagogical techniques employed. We find that their safe-space strategy was moderately successful, largely due to the voluntary structure of the course, which ensured ample interest among participants, and their carefully designed interactive exercises featuring intimate small group discussions. However, this success comes at the expense of considering the multidimensional sources of bias. The specific focus on introspection implies that prior ignorance, not active malice, is responsible for biased actions. In this way, the individual perpetrators of bias escape blame for their actions while the underlying causes of their behavior go unexplored or unaccounted for.

Keywords Cultural competence · Physician training · Health disparities · Minority health

Introduction

This article examines a one-semester Continuing Medical Education (CME) course offered to medical school faculty entitled "Teaching Medical Students How to Reduce Unconscious Bias in Medicine." The course was part of a broader effort to integrate social and cultural issues into the medical curriculum and to reduce racial and ethnic disparities in health care at a prominent Northeastern medical school. As detailed in the companion essay (Llerena-Quinn, this volume), this faculty course grew out of a course originally offered to medical students. The faculty course described in this paper was in its third iteration and was taught by three instructors[1] who were, themselves, from diverse racial and ethnic backgrounds.

Unlike many cultural competence courses that focus on the culture and behavior of patients, this course focused on the culture of health care providers and, specifically, sought to bring to conscious awareness providers' own biases. The syllabus stated the course rationale as follows:

> The course was developed in response to a growing body of literature that indicates that the culture of the provider is as important as the culture of the patient in the delivery of medical care. Evidence indicates that provider bias, prejudices, stereotyping, especially in a context of clinical uncertainty may contribute to error and health disparities. Conscious and unconscious attitudes relevant to race, nationality, gender, sexual orientation, and social class among others, are present even among the most well-intentioned.

These provider biases interact with "typical and expectable patient behaviors, including mistrust, further contributing to faulty interactions, misdiagnoses, and errors of commission or omission." Furthermore, these problems are often not documented such that "the most dangerous mistakes often go unnoticed."

The course rationale is grounded in contemporary social science research on racism and bias suggesting that the nature of racism has shifted in the post-civil rights era away from overt, biologically based racism and stereotypes toward more

[1] One of the instructors is the author of the companion essay.

subtle, hidden forms of bias (Bobo et al. 1997). Given strong contemporary norms of egalitarianism, discrimination and prejudice may not be the product of overt negative attitudes but instead the result of implicit attitudes and unconscious bias (Dovidio and Gaertner 2004; Gaertner and Dovidio 2005). Research from the field of cognitive psychology has shown that many forms of stereotyping occur below the level of conscious awareness (Greenwald et al. 2002; Burgess et al. 2007; Dovidio et al. 2008). As the course rationale states, "a biased attitude may manifest itself as simply as whose stories are assumed proper or the norm… through omission or emphasis, physicians are vulnerable to making errors that can have life and death consequences."

This focus on bias was a change from previous iterations of the course, which had emphasized self-awareness. This change in the official framing of the course had come in response to institutional interest in a more "skills based" approach to the teaching of cultural diversity (see Llerena-Quinn, this volume). Likewise, a stated goal of the faculty course was to help faculty integrate awareness of bias into their clinical teaching of medical students—that is, to render these issues "teachable."[2] That said, we found the on-the-ground experience of the course to be quite different from its official framing. First, the course was strongly focused on the *self*; individuals were encouraged to examine their own values, preferences, biases and blind spots. The course was designed to put the self in context; personal experiences and cultural socializations were seen as simultaneously interacting with gender, race, sexual orientation, social class, ethnicity, and religion. With this in mind, the course was composed as a series of paired sessions involving discussion of a series of readings on a form of bias (culture, race, class, gender, sexuality) and interactive exercises designed to facilitate introspection and, by extension, promote perspective taking and empathy. In general, there was much greater emphasis placed on the interactive exercises rather than assigned readings. Second, while providing "teaching tips" was a stated goal of the course, this was not borne out in practice. According to the syllabus, the interactive exercises were intended to be translated into clinical teaching (i.e., the clinical faculty would do the same exercises with their medical students). However, this point did not come across in the class and there was no discussion of how faculty might implement such exercises in their teaching—a perennial problem facing any content perceived to be "soft" or peripheral to the biomedical curriculum (cf. Good 1995).

Data and Methods

In the fall of 2007, we attended and fully participated in twelve course meetings, each lasting two hours. According to the syllabus, the sessions were paired to focus on a form of bias (e.g., gender, race, class) in one session with a focus on its

[2] This course, and our ethnography of it, is part of the large contemporary research literature on pedagogical strategies for bias reduction that involve notions of self-awareness and the development of cultural competence in medicine. See the recent special issue of Transcultural Psychiatry (Kirmayer 2012) and the recent work of Shapiro et al. (2006) and Yan (2005) who explicitly connect cultural competence education with notions of self-awareness.

Table 1 Course topics by session

Session	Topic
1	Course Rationale: Basic Concepts
2	Cultural Meanings and Assumptions of Culture
3	Teaching Medical Students to Explore Personal Perspectives and Cultural Socializations
4	Application: Integrating these concepts into one's teaching
5	Gender and Sexual Identity as a Factor in Medicine
6	Application: How to integrate gender and sexual orientation variables into our teaching
7	Understanding Race and Its Impact on Medicine
8	Application: How to integrate race into our teaching and clinical practice to enhance outcomes
9	Understanding Social Class and Its Impact on Medicine
10	Application: How to integrate social class into our teaching and clinical practice to enhance outcomes
11	Immigration and Health
12	Application: What and how should we teach to prepare physicians to work with immigrant populations?

application to clinical teaching in another session[3] (see Table 1). A total of 16 people attended course meetings, including three instructors and the co-authors. The participants included clinical scientists, psychologists, psychiatrists, and various other medical doctors currently in clinical practice or retired. They all engage in some form of teaching at the medical school. Participants were evenly split between men and women, their ages ranged from 50 to 70, and participants were from diverse backgrounds (Table 2). In addition to classroom observations, we regularly held informal conversations with participants after class and conducted formal interviews with three instructors/founders and five other participants after the course was completed. We used an interview guide developed for the project; interviews lasted between one and two hours, and were digitally recorded and transcribed.[4] Data were managed using the qualitative analytic software program, Atlas.ti (Scientific Software, 2012). Analysis of interview transcripts and observational fieldnotes proceeded inductively, involving immersion in the full dataset as a means to extract core themes. The authors engaged in ongoing dialog to reach consensus on the main findings presented herein.

[3] The official structure of the course, as reflected in the syllabus, did not map directly onto the way the course ran in practice. The topics outlined in the syllabus were covered, however, there was little focus on application to teaching.

[4] The course took place at a prominent medical school in the Northeastern United States. The data collected for this article were part of a larger project, under the direction of Professor Mary-Jo DelVecchio Good, and were funded by the Russell Sage Foundation, Grant Number 87-05-03. The project had full IRB approval from the relevant institutions.

Table 2 Characteristics of study respondents

Participant	Age	Sex	Self-described race/ethnicity/nationality	Profession
1	55	Male	Born in Hawaii, Chinese	Physician at Children's Hosp.
2	56	Female	Canadian (Irish and English)	Research Fellow
3	65	Female	Jewish	Psychotherapist
4	67	Female	Jewish ("but not religious")	Primary Care Physician
5	50	Male	India	Geriatric Service Line Mgr.

Instructor	Age	Sex	Self-described race/ethnicity	Profession
1	65	Male	White ("pure WASP")	Prof. of Cell Biology
2		Female	Mestiza (Italian and Peruvian)	Psychologist
3	70	Male	African-American (Southern)	Prof. of Medical Education

Under the Hood: Beyond the Stated Rationale

The philosophy of the course was broadly consistent with what Shaw and Armin (2011) have called "ethical self-fashioning," an effort to recognize racist or prejudicial thoughts in herself/himself and to expunge or at least master them. They, along with Jenks (2011), tie ethical self-fashioning to the individualizing tendencies of the neoliberal state, arguing that structural forces are not sufficiently challenged when the problem of bias is constructed as an individual rather than a collective problem. The faculty development course we observed, however, showed few of these tendencies. Rather, the decision to focus on unconscious bias through introspection was in response to anthropological critiques of the reductionist uses of culture in previous cultural competence efforts, a practical concern that the fast-paced world of medical education left no room for self-reflection, and a deep exploration of the "state of the art" research on the nature of prejudice.

The lead founder and director of the course, Gary, is a professor of biological science who has long been a leader in medical education reform. A self-described "pure WASP" born in Connecticut, he led a major transformation of the medical curriculum in the mid 1980s and served as a Master of one of the medical school's student societies for many years. These high profile roles earned him respect and esteem throughout the medical community, which many participants cited when speaking of their decision to join the course. In addition to a new focus on more interactive, case-based learning, the medical curriculum reform involved a strong emphasis on exploring the patient–doctor relationship and locating modern medical practices in their social contexts. The faculty development course we observed was in part an outgrowth of these efforts.

Gary justified the framing of the faculty development course in terms of unconscious bias in the following way:

> The literature shows that because of the inattention to parts of that story and not understanding that context of the patient and the world view of the patient, means that you miss things, and therefore your reconstruction of what's wrong with the [patient's] molecules can be wrong and if it's someone that's outside

> your experience, outside your world view who lives in a blind spot of yours, who you have certain negative feelings about that you don't even know you have them, they will have [a] worse outcome as a result of your inability to see that and hear really what they're saying.

According to Gary, unconscious aspects of the self can negatively impact patient care when they generate negative feelings of which you are not consciously aware. These "blind spots" need to be discovered and minimized to reduce bias, improve patient care, and ultimately reduce disparities in care.

Gary was convinced of the power of uncovering blind spots in part by his own biography. He became emotional when speaking about the experience of seeking treatment for his daughter who has a mental illness. For the first time he was looked at as an object of derision and blame for his daughter's illness. The experience of being stereotyped by medical professionals profoundly awakened Gary to the problem of bias and stereotyping. As a result, he began to think more deeply about issues of racial bias:

> So you know big, big awareness." For me the race thing personally was not in my face. I mean it was in terms of having to teach and think about these black students that were suddenly in my class and I had to teach them and they didn't know the language that I was using so we had to sit with each other and figure out how we were going to talk to each other. And you know, figure out how to respect each other. That was the bottom line. And it turned out to be great…they taught me more than I taught them, needless to say.

Gary had not thought about race much, but his experience on the other side of a label made him realize that he may have been unconsciously labeling and stereotyping black members of his biology courses. After this renewed awareness, he felt he interacted much better with his black students. Moreover, the specific design of the faculty development course was deeply inspired by the personal awakening to his blind spots.

Once convinced of the value of this approach, he spent many years planning the structure of the course and battling an often resistant medical school to implement the course. He put together a team of people to work on this effort and consulted with outside organizations with expertise on designing anti-racism curricula. Eventually he and his team obtained a modest level of funding and institutional approval to craft voluntary courses for both medical students and faculty focusing on unconscious bias.

Gary teaches the course with two close colleagues and collaborators, who helped design the course and share different levels of responsibility in different years. Anthony, an African-American surgeon born in the Southern United States, played a less prominent, although key role in designing the course. Unlike Gary, who was motivated to find the course by awakening his own unconscious bias, Anthony was motivated by his role as a longtime advocate for increasing racial diversity in medical schools and improving cultural competence in medicine. He is also involved in national efforts to bring medical educators together in conferences to improve their own cultural competence and to return to their own institutions as leaders in this area.

Anthony told us that most doctors do not realize, even now with all the publicity, that they may be treating their patients in disparate ways. This contributes to great inertia and a resistance to change, which make instituting efforts to improve the situation particularly difficult. Convincing people to focus on bias reduction is difficult considering scientific uncertainty about potential solutions. "People would much rather deal with how to do a nice surgical incision," he said. "When you have to control the bleeding in a surgical procedure or learn to get a needle in the right place, you say, 'Here's what you have to do'. It's really hard to do that with culturally competent care."

Given these forms of resistance to cultural competence, Anthony was motivated to improve overall awareness of the importance of diversity and to encourage greater recognition of the value of difference. We now have a "diverse ecology," he said, "but we can do better to learn to understand and be comfortable and effective working across gender teams, or across racial teams, so that we take advantage of that." He is convinced that this would not change by osmosis, which is why he pushes so hard for increased cultural competence education at the medical school and nationally. He believes cultural literacy is just as important as scientific literacy, and that all should have some fundamental skills of cross-cultural interaction. Moreover, unlike Gary, Anthony is less focused on introspection and self-awareness. Instead, he promotes the recognition of difference and the improvement of cultural literacy and cross-cultural communication.

The third co-founder and course instructor, Felicia, is a psychologist born in Peru. She came to the course with a more individualistic understanding of bias than Anthony. Similar to Gary, she feels that in general, our "maps of the world" tend to be static and impermeable to new experiences. One of her primary goals in designing the course was to create an opportunity for dialog that would disrupt attendees' normal way of thinking. She spoke powerfully of how her own perspectives were "disrupted" as a 16-year-old young woman.

Growing up in Peru, a country that was primarily Catholic, she thought that everybody in the world was Catholic. She was inspired by liberation theology and was involved in a variety of campaigns for social justice. One day at a meeting, her friend introduced her to a Marxist atheist who changed the way she viewed the relationship between altruism and religious belief. "He was such an interesting human being," she said, "the things he was doing were much more interesting work than any of us. We were on literacy campaigns, and when he said he was an atheist it was not part of the frame. I was doing this so that I could go to heaven and this guy does not believe anything happens after death." She was transformed by his sheer generosity, which she contrasted with her own selfish desires for "something after death."

In designing the course, Felicia sought to create opportunities for such transformations among the faculty attendees. Crucial to this effort was the generation of a "safe-space" in which attendees could tell their own stories of self-discovery in a non-judgmental environment. She described her motivations in the following way:

> Maybe we can think about how we can create those disruptions a little bit more, to plan for them in a way that people do not recoil or feel that they are being attacked. How do you balance that in a safe way because they may feel like you are attacking them that they have to change? That atheist was not imposing his beliefs he was just telling his story…There was no fear. There was nothing in the way. It was just this story that went 'woooosh' and then suddenly changed my map of the world.

Felicia spoke with the co-founders of the course about the need to facilitate such "transformational" stories during class session. Instead of assigning "a thousand academic papers," she thought it would be wonderful if they could "invite those stories into the classroom because that is the place where the frames are constantly challenged." The key challenge faced by the instructors of the course, she believed, was to find ways to minimize the emotional stakes and encourage the open and honest sharing of experiences.

Although the three founders of the course come from different backgrounds and had distinct motivations for their involvement in the course, they shared a strong commitment to equity in medicine and the overall goals of the course. This helped them build trust with one another and work well together despite the cross-cultural nature of their team work. During the course the instructors never explicitly considered the possibility that their own cultural or racial biases could seriously impact their ability to work together or to effectively teach others about reducing unconscious bias. However, they did speak to us at length during our interviews about their own histories of self-examination with regard to their own biases. In general, the instructors acknowledged their own biases in the past but felt as if they had significantly changed their views over time. They considered themselves relatively bias-free, with the occasional blind-spot.

During the course instructors also participated in exercises alongside other course attendees, demonstrating their own efforts to actively engage with their own biases. It is possible that cultural and racial bias among the instructors of this course and instructors of other similar courses could negatively impact classroom dynamics and teamwork. We did not observe any such negative effects in our research, however. In our view, instructors of bias-reduction courses should actively seek to eliminate their own biases before engaging in this type of work. Otherwise, notions of bias will always be directed at "them" and never to "us".

Motivation to Participate in the Course

The attendees we spoke with arrived for the first class meeting with clear motivation to improve their abilities to handle issues of bias and diversity in their roles as clinicians and teachers. They self-selected into the class based on their own interest in the topic rather than any departmental or institutional requirement. The course was completely voluntary, the only inducement being the modest CME credit, free on-campus parking, and free pizza. Unlike the psychiatric residents studied by Willen et al. (2010), who were required to enroll in a cultural training course, the

voluntary structure of our faculty development course largely excluded those inclined to be hostile to the idea of cultural competence or to the idea that unconscious bias is a problem in medicine today. This created a course composed of individuals with an open mind and a desire to learn about issues of culture, race, ethnicity, and medicine, and who were motivated to improve their ability to communicate about these topics with the medical students they teach. Notably it did not produce a group of enrollees with vast amounts of experience with issues of culture, race, and ethnicity.

It was precisely the lack of such experience and a desire to better handle diversity that motivated many of the attendees to take the course. For example, Barry, a retired primary care doctor born in New York who still teaches medical students, spoke of the challenge posed by the increasing racial, ethnic, cultural, and gender diversity of the medical school students he teaches. When asked what motivated him to join the course, he responded:

> An awareness that this country is more and more diverse and that I didn't really know how to deal with this on a personal and professional basis. I was curious about what people were doing. A specific issue arose when we were doing assessments of our students. If you just looked at them you would see what a diverse group they are. It's astonishing. Of the six I'm teaching this year, and this is routine now, only one of them is an American born white male. One is a Native American, two of them are white American born women, one is an African American woman, and one is an African born man, and this is typical of medical students now. And I was curious how to deal with this when I teach. I know how the admissions committee is dealing with it, they are going out and recruiting a diverse group of students and there is little discussion within the school about what this means for what we have to teach people.

According to Barry, when he started practicing more than 40 years ago, "virtually everybody was a white male, U.S. born non-immigrant and now it is totally different. It has no resemblance to what it was." He didn't know how to deal with these changes on a personal or professional basis and was curious to know how others approached the issue.

In a post-course interview, Barry reflected on additional moments in his career when he has had difficulty responding to the diversity of his students, moments that motivated him to join the faculty development course to improve in this area. For example, while teaching a course on patient–doctor interaction (PD1), Barry would regularly bring in one of his former patients to teach a segment on alcoholism. For 4 years in a row, the former patient—a scientist who holds multiple Harvard degrees, is gay and in a long-term relationship, and has been sober for 5 years—would give a very compelling and lucid account of his recovery experience to the class of young medical students. After one of the sessions, Barry casually mentioned to his class that one of the only reasons he brings him in for the segment is that he is, "the kind of person that you guys can identify with." One of his students, an African-American woman, objected. "She called me on it," Barry recounted, "She

said no, 'I can't identify with him, he has all of these resources, and I grew up in a community in which these resources aren't there'."

Barry felt terrible about his mistake and in the following class apologized and tried to make it a teaching moment. Instead of teaching the class, he only provoked additional reflections on the ways in which assumptions of similarity compromise educational effectiveness. Barry recounted one of these poignant responses:

> One of the other students, a Native American who grew up on a reservation in New Mexico and intends to return home there, said that he is terribly nervous about the education he's getting because he's not learning anything about the people he's going to spend his life with… At the world's most famous medical school, he's getting inferior and inappropriate education for what he's going to deal with. And it was a real eye opener.

The student felt that the medical school was not recognizing his ethnic background and that he was being taught a brand of medicine that did not take into account the particular needs of his community. For Barry, the response from both of these students opened his eyes to the importance of difference and provoked him to join the faculty development class to learn more about how he can more effectively accommodate it in the future.

The desire to improve his engagement with diversity predisposed Barry favorably to the course and its core mission and philosophy. He ultimately viewed the course as a success and, in a post-course interview, stated that one of the things he learned from the course was to be very careful about making assumptions about his students. "That's been a real consciousness raiser," he said. "They are top medical school students, you can be sure that when they entered college they had near perfect SAT scores, that's all true. But we've all grown up, all of us, in different families…we all identify [as doctors], but they have had different lives."

Clara, a Canadian-born clinical researcher and instructor, also went into the course with little experience with diversity. In a post-course interview she said that she "went into it completely blind" and "had no clue" how important it was. She understood that there were "different people and that different people have different perspectives," but she "didn't really appreciate how much it actually influences people's everyday experiences."

Like Clara, Raj, a geriatric primary care specialist born in India, was motivated to join the course by the different learning styles he observed among his students. He noted, "students were learning in different modes, and that teaching depends on who is involved in the teaching and who is receiving." He saw that "sometimes the teachers focus on certain parts of the class, certain segments—they are picking a couple of students in the class." The students in his own classes "have different backgrounds," he said. "There is all this variability. People have different perceptions and biases in teaching. That's the primary reason why this course would help me."

Rachel, a psychologist born in the United States, told us she was motivated to join the course by the Jewish tradition of social justice and her long-standing interest in different cultures. She saw the course as a tool for making the teaching of medical students "as unbiased from the standpoint of culture—including race,

gender, etc.—as possible." Rachel sought new ways to "restructure PD1 to make students more culturally competent," and was particularly drawn to the issue of bias because it is something that is "very, very close" to her heart.

Larry, a pediatrician born in Hawaii who identifies as Chinese American and a complete "New Englander," was not drawn to the course for the possibility of exploring his own unconscious biases or to learn about the importance of diversity and cultural difference. He witnessed the transition from the days of the "old greats, mostly white males, but sometimes females" who "left their mark on all the textbooks and oil paintings on the wall to the current generation, with 55 % females and 30–40 % Asian minority," and felt that the medical students he teaches have "mostly been exposed to the idea of gender and ethnic differences and would not have such a monolithic view of medical culture." His primary motivation for joining the course was to develop resources and teaching techniques for other forms of difference such as social class that are not universally seen as important. He was "hoping for some more challenging things" and was "expecting the unexpected."

Pedagogical Strategies for Creating a Safe Space

Course instructors employed a number of pedagogical strategies to create a safe space in which attendees could speak freely and honestly about their feelings and experiences. Instructors told us that the key goals of the course—self-reflection, self-awareness, discovering, and dispensing with "blind spots," and the discussion of often shameful past experiences of bias—could only be accomplished through interactive exercises and the creation of a non-judgmental environment in which everyone feels comfortable expressing their views with little fear of mockery or embarrassment.

One strategy was to break the class into small groups for interactive exercises. The instructors viewed this as a way to move away from abstract discussions of the readings towards a more intimate discussion about how these issues affect each individual. Gary, the lead instructor of the faculty development course, described the dilemma they face:

> Can we get them into an experiential exercise and have them be open affectively and at the same time remembering certain principles or concepts that were put forward in the papers? That has been very hard and I'm not sure… we struggle with that and try to bridge them. What we do is we make the ground safe for intellectualizing about things and we lose the affective and everybody is very comfortable sort of talking about 'it' and 'them' and 'outside.' That's much more comfortable than talking about 'me' and 'inside.'

In the course we observed, the risk Gary articulates concerning (over)-intellectualizing was minimized by de-emphasizing the assigned readings. Little class time was devoted to discussion of the readings and the atmosphere of the class was not particularly academic. This approach—whether by design or not—encouraged course members to focus on the work of introspection and the sharing of personal experiences.

There is more emotional risk in expressing yourself in large group settings where students and faculty often avoid broaching controversial or deeply embarrassing personal experiences. According to Gary,

> Students don't like the big groups so much. They feel that sometimes they put out something and then somebody else says something and then somebody else says something and the passionate statement they made was not reacted to. Maybe it was noticed, maybe it wasn't. They just got no feedback about it; there was no interaction around that. And so no one said, you know, 'oh you asshole' or, you know, 'you're wrong', but if you're taking a big risk in saying something and then, it's like you didn't even speak, then that's not good.

Gary said the instructors struggle with how to "slow people down" and "allow for silence" so the class can reflect on something that was said. "Silence is good," he said, "It is important to allow time for someone to react to something that is said before you introduce your new idea or different idea.

Classroom Dynamics

During the second meeting of the course, the day's lesson began with a video case vignette featuring a patient with sickle cell disease seeking pain medication from a doctor followed by discussion among the entire class. The video resonated with many members of the class, triggering a discussion of stereotypes and the best way to make the difficult decision about whether to prescribe medication to patients when their medical necessity is uncertain. The discussion, while nuanced and complex, was ultimately unfocused, with members of the class shouting out answers, interrupting one another, and leading the discussion in a number of different directions.

One member of the class noted that the problem is "not as one sided as you think," suggesting that some of the blame falls on the patient when these clinical encounters go awry. "Patients may send subtle signals of non-compliance," another said. A third member of the class suggested yet another complication, wondering whether "some patients might respond to pain differently than others." He said that in his experience, patients from the Mediterranean often have very loud responses to pain while other cultural groups respond to the same pain in a silent manner. This last point provoked rapid response from other members of the class who questioned whether it was appropriate to generalize about patients from an entire geographic region. One warned that you have to be careful and separate out differences between cultures from differences within cultures, while another argued that you really could not make the decision without completely understanding the individual.

This large group discussion was typical of others throughout the course, especially when using videos to illustrate academic concepts such as culture. Members of the class tended to tell stories from clinical experiences they observed to illustrate their positions, but those with minority opinions were often overshadowed by competing stories illustrating a different view. Notably, group discussions tended to feature fewer autobiographical stories, instead featuring case examples of right or wrong behavior. Competing stories were often left without resolution as the

Fig. 1 Images of cultural objects used in "totem" exercise

class moved on to different subjects. The large group dynamic seemed to prevent the types of sustained dialog and deep introspection instructors sought; "transformative" experiences rarely occurred in large group discussions.[5]

In contrast to the unstructured large group discussions, the next two exercises we observed illustrated the effectiveness of the small group strategy. The "totem" exercise asked that attendees bring a single "cultural object" that holds some meaning to them and represents their cultural background to class. The genogram exercise asked attendees to draw a genealogical diagram of their family tree with elements of pride and shame listed in the various boxes.[6] For both exercises, the class was divided into small groups to work on their genograms and share the meaning of their cultural objects.

The goal of the totem exercise was to push people to think deeply about their own culture from a variety of perspectives. While they were not explicitly told this, their objects could represent their ancestral heritage, their current interests or their family's favorite activities; the variations were endless. During the following week the class broke into small groups to discuss the objects and their personal significance. Items ranged from a schoodoodle (fried dough), symbolizing French Canadian culture, to a T-shirt with the word "Helloucaust" to symbolize the tragedy of the slave trade in African-American history, to the combination of a camping tent and stethoscope to symbolize the nomadic people of the Jewish diaspora as well as the culture of medicine (Fig. 1).

[5] The problems we observed during large group discussions occurred despite efforts of the course directors, who were all experienced instructors with training in discussion leading, to maintain order during the discussions. The course directors were equally skilled in managing large and small group discussions, yet the small group discussions were more effective.

[6] "Totem" is a descriptive label we use to describe the exercise. In the course it is referred to as the "Cultural Object" Exercise.

The members of my group (SH) were at no loss for words, describing their items in detail and using them as a conduit to share their life histories and what is truly important to them. It seemed as if some would never stop talking and we would run out of time for others to talk. Having forgotten to bring a special object from home, I (SH) improvised, pulling my driver's license out of my pocket and using it to symbolize how much my hometown and neighborhood in southern California have shaped my sense of self. I described the community's working class nature, its ethnic and racial diversity, and its laid back and friendly atmosphere. I then reflected on how growing up in that environment motivated me to become an academic specializing in racial inequality and how my own personality was shaped by the relaxed California culture as opposed to the hustle and bustle of East Coast meccas like Boston and New York. But I did not stop there; I continued to ramble for five more minutes about how my family has for many generations valued the outdoors and how I grew up hunting and fishing with my father. I spoke about how my family's lack of religious belief and lack of ethnic identity left us isolated with few formal ties to the broader community.

The simple task of discussing the meaning of a single item opened the floodgates for me to explore various aspects of my identity that I hold dear. Others in my group and in the class did the same, including one member of the class who brought in the *New York Times*, the *New Yorker*, and the *NY Review of Books* to symbolize the intellectual culture of New York City—which he elaborated into a discussion of the "Jewish-Left Liberal" and ended with a distinction between "the positive and negative aspects of theology versus psychology." The totem exercise successfully provoked extensive public introspection, exactly as instructors had intended. But for me (and perhaps my classmates) it was a matter of representation and "showing off" rather than an exercise in transformational empathy and learning about the other.

After the small group discussions concluded, we reconvened as a class and briefly shared items we brought with the entire class. The instructors then asked the class to transform and classify the narratives of each object into a narrower set of "cultural lenses" with which the story and item could be understood. After each object was briefly discussed, they asked the class to raise their hand and identify which lens best fits the object. When compiled together (Table 3), we can see that the objects and narratives fell into a diverse set of "lenses" that interestingly corresponded to the various different definitions of culture the course instructors were trying to articulate and teach, moving from larger, group-based levels of aggregation to smaller, more individual levels of aggregation. The lenses ranged from ethnically oriented lenses involving food (Haitian coffee mortar) or expressive culture (the poetry of Robert Burns) to transnational lenses involving immigration (letters written between separated spouses after migration) to localized geographic lenses (New York City and Southern California) and lifestyle lenses (bike helmet). The display of lenses across levels of aggregation helped open the eyes of some members of the class who previously tended to think of culture at larger levels of aggregation in national, ethnic, or racial-group terms. In the post-exercise discussion, members of the class spoke of culture in very local terms, referring to

Table 3 Cultural meanings of totem items

Object	Lens
Helmet	Class, political
Coffee mortar	Food—mortar to prepare coffee in Haiti-hidden here. Home country.
Picture of Caracas	Third culture kids lens
Book of Bicentennial—Canada	Canadian identity = "not American
	Border Lens
Box of recipes: Jewish tradition	Collection from whole family/gender lens
	White, upper class
Shiva God of destruction	Hindu culture (way of life, not religion)
	Four directions
T-shirt-Helloucaust	African-American history (minorities, genocide)
	Political activist lens
Book of Robert Burns	Scottish culture: drink, music, poetry of Scotland
Book dad made	
Schoodoodle (fried dough)	French Canadian culture (increased awareness in the context of another culture-increased importance when among the few)
	Holiday
	Class
NYT, New Yorker, NY Review	N.Y.—(the positive and negative aspects—theology vs. psychology)
	Jewish-Left liberal (Geographic location, cultural contradictions, cultural ethnicity, political lens)
Tent/stethoscope	Nomadic peoples (Jewish). Diaspora. Medicine the most constant lens
Thigh-bone trumpet ½ femur	Music and religion
	Culture collection
Wedding ring	Connection between the individual and the group. A bridge. South Korean immigrant and Catholic
Drivers License	Geographic location: neighborhood: low SES, integrated, 99 % bused, AA and Latino. Laid back, friendly
	Production of lived experience
Korea Pottery	Korean history. Assaulted culture: invaded, assimilated (Political power dynamics–cross cultural relationships)
Letters	Immigration lens. Connection to lost past/history
	One of many other objects. Not a static lens

the medical community as "an island" where nearly all of their social contacts are located and where they are most "comfortable."

The instructors were successful in eliciting diverse views of culture from the class and did so organically without having to list them on the board ahead of time. The intimate story telling took place in the small group portion of the exercise, while the intellectual abstraction and "teaching" took place when the full course convened to categorize the narratives into the appropriate cultural lens. This

combination appeared more effective in achieving the course goals than large group exercises.

Another goal of the small group exercises was to facilitate introspection and to encourage members of the class to recognize their own cultural backgrounds as significantly contributing to the way in which they engage with their students and patients. Another small group exercise the following week promoted this goal through "Cultural Genogram," a teaching tool developed by marriage and family therapists to "promote cultural awareness and sensitivity by helping trainees to understand their cultural identities" (Hardy and Laszloffy 1995, p. 228). The genogram is a hand drawn sketch of a family tree adorned by different patterns and symbols to identify the gender, culture of origin, and a variety of what are referred to as "pride/shame" issues that characterize the cultural groups associated with various members of your family.[7]

At the end of the second session of the course, attendees were asked to prepare their own genograms at home prior to the next week's meeting. Attendees were told at the beginning of session three that they were "starting a personal and collective journey of self-reflection," using the cultural genogram as a "tool for self-understanding." The sharing of genograms will "help us to understand the multiplicity of values and beliefs into which we have been socialized," the instructors said, and "help us to begin discovering our similarities and differences."[8]

The course broke up into small groups to discuss their genograms before reconvening as a group for debriefing and more discussion. For the small groups, course members were told to keep in mind a series of questions to animate their discussions: "What are some significant differences that emerge within your family genogram? What was the *meaning* associated with those differences? What were/are the rules about talking about differences?"

In the small group discussions, people focused most intently on migration narratives, different countries of origin in their backgrounds, and the overall diversity in their family trees. Less focus was placed on the pride/shame indicators and the organizing principles of their cultures of origin. Although it was impressive to see the different patterns across boxes symbolizing an intercultural union, there was debate over just how meaningful the distinctions were between the various cultures of origin. This was especially true for those of mixed European origin with little recent migration history. It was not clear how much meaning should be placed, for example, on a French/Irish/Dutch mix, four or five generations prior. Culture

[7] According to Hardy and Laszloffy, "pride/shame" issues are aspects of a culture that are sanctioned as distinctly negative or positive and derive their meaning from the basic organizing principles of a culture. They are similar in that both organize the perceptions, beliefs, and behaviors of group members. However, the critical distinction between the two is that pride/shame issues punctuate behaviors as negative or positive, while organizing principles do not (1995, p. 229).

[8] The description of the genogram exercise on the course syllabus was introduced by the following quotations: "The consciousness of what one really is entails 'knowing thyself' as a product of the historical process to date which has deposited in you an infinity of traces, without leaving an inventory" (Antonio Gramsci), and "To the extent that this tacit knowledge is not open to self-reflection, we are unable to talk about our own culture. We do not see it unless we are in a cross-cultural situation that makes us visible in our differences…through the eyes of others" (Marcelo Pakman).

was more present for course members who were born outside of the United States, racial minorities, and those of Jewish descent.

My personal impression of the exercise as I constructed my own genogram was that it was overly reductionist in the way it required participants to associate cultural traits with broad culture of origin labels. The way the assignment was introduced and described in the Hardy and Laszloffy (1995) publication left little room for variation that was not along an "easy to color" category of gender or culture of origin. Unless associated with the broad group, it was difficult to find a way to discuss differences in education or social class or region within the United States (such as the South). These differences did not fit well within the structure of the assignment. This is in stark contrast to the cultural object exercise, which left substantial room for unique and more localized markers of identity and cultural meaning.

Despite the instructors' best efforts and intentions to create a safe space for discovering and giving voice to biases, the on-the-ground classroom dynamics were not, on the whole, confessional or revelatory in nature. Clara, the Canadian-born clinical researcher and instructor, found it "helpful to realize I do have a culture" but also noted that the course was not "terribly personal" for her. That is, exploring her own experience through the course exercises did not set off fireworks of self-discovery, yet they did promote an awareness of her own position culturally as it relates to others. Larry, the pediatrician, found the introspective exercises less compelling. During his interview, he complained that his fellow participants were "already of a similar persuasion." As a result, "it felt like there was not a confrontation or so much of a steep learning curve that people were willing to dig out painful or difficult biases."

Interestingly, although Larry did not engage in transformative self-reflection or the uncovering of blind spots in the course, he engaged in very meaningful reflection during his post-course interview. Larry revealed that he has long struggled with feelings of bias towards patients of lower social class backgrounds. He sees many patients from overseas with chronic illness as well as patients from culturally distinct, low-income towns nearby. He knows them very well, but does not "feel that close" to them. He is fascinated by their social histories, which are mostly very dysfunctional, but he "doesn't know exactly what to do with them." He said he has the same problem with Asian patients when they are "not of the same class, so it's not just racial. It's mostly social class." Larry told us his feelings of class bias are most likely to surface when treating children, often with single-parents, who have ADD or autism-spectrum disorder. He struggles to empathize with mostly inner city children who "can't cope" and says that the issue "just overwhelms me… And I don't know what to do with it and I try to back away from it." Larry has so much difficulty dealing with this issue in part because he holds much different standards for the way his own children were raised, standards he traces to his own Asian cultural heritage. He expects his kids to be "quiet and well-behaved, and excel in school, and no questions asked."

Larry's story is notable because it is precisely the type of introspective story the genogram exercise is designed to elicit; yet it was only revealed in our post-course interview. By refraining from discussing his own class bias with others in the

course, Larry ultimately contributed to a dynamic in which participants did not "dig out painful or difficult biases." In Larry's case, at least, the course was not a "safe space"[9] in which to reveal perspectives that might be embarrassing or shameful. After all, his views toward the behaviors of his poor patients were not informed by a lack of awareness, but an active attachment to his own set of values that he holds up as the standard that others should follow. This opens him up to scorn or blame for his viewpoints, rather than recognition or praise for achieving a "new awareness" that is likely to change his future behavior.

Discussion

The interactive nature of the exercises and the "safe-space" of the small groups we observed in this faculty development course combined to effectively accomplish many of the instructors' pedagogical goals. Class members began to think in a more nuanced way about culture, seeing it as more than a list of traits associated with large groups of people identified by nation, ethnicity, religion, or race. They learned to see their own personal backgrounds in "cultural" terms, which helped them think about "blind spots" they might have which can negatively impact patient care. Importantly, this was not the case for all attendees, as Larry's experience reveals.

The course's specific focus on introspection implied a path to behavior change through self-discovery that liberated individuals of responsibility or blame for their actions. The course did not function as an indictment of racism in medicine or present material that would provoke strong emotions of guilt or defensiveness in the attendees. The course founders placed the reduction of *unconscious bias* in the title of the course to ensure that this "can of worms" was not opened (Willen et al. 2010). Despite the instructors' encouragement of "transformational moments," they presumed a cognitive rather than an emotional mechanism of attitude and behavior change. In their view, when one discovers elements of oneself that are similar to the "other," this newfound awareness can generate empathy and reduce the possibility of bias. In such cases, it is prior ignorance, not active malice that is responsible for biased actions. In this way, individual perpetrators of bias escape blame for their actions because their behavior was "unconscious" or implicit rather than motivated by crude racism, hatred, or fear of the other (Greenwald et al. 2002). This shifts notions of blame (and legal culpability) away from individual motivations of behavior towards a broader society-wide transmission of norms and attitudes (Kang and Banaji 2006).

While it is possible that the development of "safe-spaces" for the discussion of uncomfortable topics such as social bias can generate substantial room for self-reflection and behavior change through "transformational" moments that "change your map of the world," we should remember what is left out of the discussion when such "no-blame" discourses are employed. The deep psychological and

[9] The very notion of what constitutes "safe space" must also be considered as deeply culturally informed. The spaces that one considers to be "safe" ones in which to share shameful, embarrassing, or personal experiences will be affected by cultural norms.

cultural origins of bias that are cognitively recognized by individuals like Larry, who actively seek ways to manage and suppress them, are not being directly confronted. This is of great consequence considering the large body of sociological and social–psychological research showing that social bias is multidimensional, with roots in social and cultural learning, interests-based attachments, as well as socio-emotional dimensions of affinity/revulsion and inclusion/exclusion (Bobo 1999). Treating the problem of bias, much less *unconscious bias*, as primarily a function of a lack of self-awareness is likely insufficient to address the diverse sources of bias in our society. In addition, when a "safe space" fails to emerge (as in Larry's case) and painful biases are not articulated, participants may be left with a feeling of self-loathing because they cannot get over their culturally patterned attachment to bigoted behavior.

That said, such an approach clearly has value. Our research shows that for those with little past exposure to issues of race, culture, gender, and other forms of bias who also show an active interest in learning more about these issues and improving their cross-cultural and interpersonal interactions with students and patients, the introspective approach to reducing unconscious bias can be effective—especially if executed with a smart pedagogical strategy of interactive exercises in small group discussions.

It is unlikely, however, that one course can be all things to all people. An important lesson we draw from this faculty development course is that it may be beneficial to distribute different types of cultural competence courses throughout the ecology of training programs. Those with greater levels of experience with diverse patient and student populations may be bored with a course that focuses on broad sources of bias such as race, ethnicity, gender, or culture, but may be challenged by a course that focuses more closely on social class or sexual orientation.

For those more interested in practical tips for teaching or improving their interactions with patients, a course more closely targeted to the particular exigencies of their daily work might be more appropriate. As I (SH) have shown in other work, there are many micro-emergent cultural categories that are animated in the course of medical practice (Hannah 2011a). Doctors often categorize their patients on the basis of specific behavioral profiles and use these labels to generalize to other patients who share their characteristics. This can become a source of bias or differential treatment in the course of their clinical practice as their interactions with such patients becomes routine. Categories such as violent or "rowdy", non-compliant, or presenting with particularly perplexing conditions such as generalized abdominal discomfort, can develop into salient sources of bias for physicians—not due to lack of awareness of their significance, but due to hyper-awareness as a result of their own intimate experience with the challenges they present in their day-to-day work (Hannah 2011a). In these instances, shorter, more focused courses focused on managing special cases of bias might be more appropriate.

It may be useful to think of three broad categories of courses to reduce social bias in medicine that correspond to the three broad sources of prejudice articulated by the social science literature. In the *social learning* category, there would be courses, like the faculty development course we examined here, focusing on self-awareness and cultural learning; in the *interest* category, there would be courses focusing on

practical forms of bias related to exigencies of providers' daily work; and in the *socio/emotional* category there would be courses focusing on crude, conscious forms of racism and bias against stigmatized groups in society.

Courses focusing on the socio/emotional components of bias would be well-suited for physicians like Larry who are conscious of and emotionally conflicted and disturbed by their biases and desperately want to change. The faculty development course we examined promoted self-awareness, cultural biography, and the more passive nature of bias. As a result, it focused primarily on the social learning aspects of prejudice, which alienated those with active biases they were afraid to share and wanted to eliminate. Larry, who was biased toward lower class individuals as well as those with "emotional problems," may only have been interested in addressing these biases because they were directed towards groups that are not as strongly protected by social sanctions against inferior treatment. It is more socially acceptable to criticize poor or emotionally unstable patients than it is to openly express racial animus. Indeed, instructors of the faculty development course remarked that members of their classes are most likely to speak of unconscious bias towards gays and lesbians, who remain among the most vulnerable groups in society.

A remaining challenge is to find ways to incentivize interest in bias-reduction efforts among those who hold strong, conscious bias against the most socially protected groups. This is especially difficult considering the negative emotional reactions that can occur in mandatory training courses where even the most bigoted cannot opt out (Willen et al. 2010). Creating safe-space through introspection for a no-blame discourse is not likely to be effective in a mandatory course with attendees who are likely to be hostile to the enterprise, whose source of bias is not necessarily located in social learning, and/or who have no pride/shame dimensions in their genealogy sufficient to generate comparative empathy with the outgroup against which they are most strongly biased.

Additional work should also be done to improve our understanding of how bias-reduction efforts are translated into action. The goal of this course was to encourage medical school instructors to explore their own unconscious biases so they can more effectively teach their students to do the same. The ultimate goal of this process is for medical students to more effectively treat patients in an unbiased manner. This multilevel process should be explicitly addressed in bias-reduction courses and efforts should be made to translate teaching efforts into action and to measure how effective they are at achieving the ultimate goal of improved care for disadvantaged patients.

Pedagogical efforts to reduce bias are caught astride academic engagement (which presumably "trickles down" to the real world) and patient engagement (which has more immediate effect). While the instructors of this course felt they were working on "their corner of the problem" of health disparities by academically engaging their colleagues, they implicitly acknowledged that the effects of the course must operate over time across different levels of interaction. Although far removed from patient interaction, they were convinced that their efforts would ultimately improve quality of care (or else they would not be so invested in the course!).

Given that we only examined this course we cannot know for sure how their pedagogical approach or model of behavior change might vary in these different settings. Many of the participants we observed are actually involved in teaching similar courses to their own medical students, and are also involved in teaching medical students in "patient-doctor" classes focusing on clinical interaction and presentation. It may be worthwhile to construct an explicitly comparative study in the future that longitudinally follows a panel of medical students taught by participants in the "reducing unconscious bias" faculty development from their own classes on bias and clinical interaction to their own clinical practices in the future. This would enable a comprehensive examination of different levels of motivation, anxiety, responsibility, and accountability involved for faculty and their students. What matters for the two groups is different: the person's health, on the one hand, and the students' educational quality, on the other hand.

Conclusion

This article adds to a growing list of efforts by social scientists to better understand and address the problem of health disparities. A number of recent works, many appearing in this journal (including this issue), have critically examined the structure and growth of cultural competence in medicine. We end here by situating our research within the context of these recent contributions.[10]

Our results suggest a different conceptualization of cultural competence than Shaw and Armin (2011), who argue that the growing focus on ethical self-fashioning is "becoming detached from its social justice roots as it becomes rationalized by and more firmly embedded in the operations of the health care marketplace." The faculty development course we observed similarly focused on ethical self-fashioning, yet maintained a steadfast commitment to social justice. Although it constructed the problem of health disparities narrowly in terms of unconscious rather than conscious bias and sought to facilitate a "no-blame" discourse so that individuals would be free to explore their own cultural identities and negative biases, this was by design (see also Hirsch 2003). The degree to which this approach was successful (or not) depended more on the composition of its target audience than on the specific merits of its approach.

The instructors were well aware of the panoply of cultural competence efforts and their respective theoretical and pedagogical justifications. They had done their research and felt that theirs was the approach that would be most successful in reaching their target audience, medical school instructors and students. They were not attempting, as Shaw and Armin (2011) might suggest, to consciously or unconsciously skirt difficult structural or institutional issues. They were, in our view, addressing their own corner of the problem. For example, they did address the

[10] Tervalon and Murray-Garcia (1998), Good et al. (2003), Taylor (2003), Campinha-Bacote et al. (2005), Shaw (2005), Carpenter-Song et al. (2007), Smith et al. (2007), Graves et al. (2007), Lo and Stacey (2008), Burovoy and Hine (2008), Murray-Garcia and Garcia (2008), Ring et al. (2008), South-Paul and Like (2008), Carter-Pokras et al. (2009), Willen et al. (2010), Jenks (2011), Shaw and Armin (2011), Kirmayer (2011), Like (2011), Good et al. (2011), Hannah (2011b), and White (2011).

issue of social class explicitly in weeks nine and ten of the course. However, this discussion focused on socioeconomic status as another potential source of interpersonal bias rather than a large political and economic structure that strongly patterns health status and health care quality in the United States.

It is clear that micro-aspects of the self, as embodied by one's own cultural orientation and individual feelings of bias, are important determinants of different kinds of treatment that can contribute to health disparities. Equally important are structural concerns, including the historical reality of racial-group discrimination, socio-economic inequality, and the institutional and cultural structure of health care delivery in the United States (Good et al. 2003; Metzl 2012). We need not put down the efforts of those working at the micro-level in favor of praise for those engaging with macro-level structures. What is most elusive for disparities researchers and for sociologists and anthropologists interested in health and health care equity is a theoretical and empirical base of knowledge that illuminates the connections between the two and suggests what can be done differently/better. During class and in the post-course interviews, the limits of focusing on social–psychological processes as a means to reduce disparities was not specifically discussed, nor were any strategies for integrating a micro-sociological approach with more macro-structural factors. In our view, a more comprehensive approach to cultural competence education should be considered in the future.

The contemporary push for cultural competence in medicine should not be seen as a contest for the "best" or "most effective" solution to the problem—or an either–or contest between introspection and social justice, between individual versus group identities, or between structural or interpersonal dynamics. Instead, cultural competence should be seen as developing into a mature, diversified marketplace with a variety of niche specializations to best suit the realities of particular social and organizational contexts—a marketplace ripe for innovation.

Recent debates about cultural competence have also addressed the relative value of focusing on notions of cultural difference versus an explicit focus on racial-group identity. Jenks (2011) suggests that greater emphasis on cultural differences might be a way to avoid dealing with the more difficult issue of race. However, in the faculty development course we observed, there was a general focus on bias, both as a result of cultural difference and race.

Unlike the trainings observed by Jenks, the instructors of our course were relatively agnostic to the source of that bias, whether race, cultural difference, gender, sexuality, or social class. They did not actively downplay the importance of race—or other significant, sociologically constructed social groups in favor of focusing on individual traits. As the genogram exercise showed, course members were actually pushed by instructors to connect their individual traits with their larger group-based identities.

Despite the use of the genogram to connect traits with identities, their agnostic approach to the source of bias had the larger effect of reframing the question of bias away from the ethnic pentagon of racial and ethnic group identities toward other forms of discrimination. Course members were more likely to reveal their "blind spots" of past biased behaviors when dealing with issues of gender or sexual

orientation rather than when dealing with the "can of worms" that discussions of race can become (Willen et al. 2010).

The agnostic approach to bias also had the side effect, however, of illuminating the importance of the culture of medicine. Once the understanding of bias was expanded beyond the realm of race, ethnicity and other large group-based social identities, course attendees were free to think about culture in terms of institutions and organizations that also have unique value systems capable of producing powerful forms of bias (Good et al. 2003, 2011).

This agnostic view places all potential sources of bias on an equal playing field and allows the particular composition of the course to dictate what forms of difference are meaningful. This approach is resonant with current trends in sociology focusing on the general process of boundary construction and maintenance (Wimmer 2008; Brubaker et al. 2004; Lamont and Molnár 2002; Hannah 2011a). In this view, the most salient form of difference in a given social setting is an empirical question that should be explored rather than assumed. In racialized societies such as the United States, race is likely to be an important factor in most social interactions but may not always be so.

This is especially the case when powerful institutional cultures are dominant within a given social sphere. As Good et al. (2003) have shown, the bias toward time and efficiency and the hierarchy of valued knowledge inherent in the contemporary culture of medicine can produce unequal treatment even when conscious and unconscious bias are not present (Smedley et al. 2003). Cultural competence programs with an agnostic approach to bias need not minimize the importance of race. In fact, they may open the door to a more comprehensive exploration of the various factors involved in producing racially biased results. This also leaves space to explore important non group-based forms of bias, for instance against pain-medication seekers, non-compliant diabetics, lower class children of single mothers, and others that emerged in the faculty development course we observed. In the future, we hope that practitioners of cultural competence will focus deeply on the sources of bias, create a variety of programs well suited to each, and remain agnostic about their goal.

References

Bobo, Lawrence D.
1999 Prejudice as Group Position: Microfoundations of a Sociological Approach to Racism and Race Relations. Journal of Social Issues 55(3): 445–472.

Bobo, Lawrence, James R Kluegel, and Ryan A. Smith
1997 Laissez-Faire Racism: The Crystallization of a Kinder, Gentler, Antiblack Ideology. *In* Racial Attitudes in the 1990s: Continuity and Change. Steven A. Tuch and Jack K. Martin, eds., pp. 15–42. Westport, CT: Praeger Publishers.

Brubaker, Rogers, Mara Loveman, and Peter Stamatov
2004 Ethnicity as Cognition. Theory and Society 33: 31–64.

Burgess, Diana, Michelle van Ryn, John Dovidio, and Somnath Saha
2007 Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology. Journal of General Internal Medicine 22(6): 882–887.

Burovoy, Amy, and Janet Hine
2008 Managing the Unmanageable: Elderly Russian Jewish Emigres and the Biomedical Culture of Diabetes Care. Medical Anthropology Quarterly 22(1): 1–26.
Campinha-Bacote, J., D. Claymore-Cuny, D. Cora-Bramble, J. Gilbert, R.M. Husbands, R.C. Like, R. Llerena-Quinn, G. Francis, F.G. Lu, M.L. Soto-Greene, B. Stubblefield-Tave, and G. Tang
2005 Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of the HRSA Centers of Excellence. Health Resources and Services Administration, March, 2005, http://www.hrsa.gov/culturalcompetence/roleofcoes.pdf.
Carpenter-Song, Elizabeth A., Megan Nordquest Schwallie, and Jeffrey Longhofer
2007 Cultural Competence Reexamined: Critique and Directions for the Future. Psychiatric Services 58(10): 1362–1365.
Carter-Pokras, O., D.A. Acosta, D. Lie, S. Bereknyei, H. DeLisser, P. Haidet, A. Gill, C. Hildebrandt, S. Crandall, K. Kondwani, and S. Glick
2009 Practice What You Teach: Curricular Products from the National Consortium for Multicultural Education for Health Professionals. Focus on Multicultural Healthcare, July 2009, pp. 8–11.
Dovidio, John F., and Samuel L. Gaertner
2004 Adversive Racism. Advances in Experimental Social Psychology 36: 1–52.
Dovidio, John F., Louis A. Penner, Terrance L. Albrecht, Wynne E. Norton, Samuel L. Gaertner, and J. Nicole Shelton
2008 Disparities and Distrust: The Implications of Psychological Processes for Understanding Racial Disparities in Health and Health Care. Social Science and Medicine 67(3): 478–486.
Gaertner, Samuel L., and John F. Dovidio
2005 Understanding and Addressing Contemporary Racism: From Adversive Racism to the Common Ingroup Identity Model. Journal of Social Issues 61: 615–639.
Good, Mary-Jo DelVecchio
1995 American medicine, the quest for competence. Berkeley: University of California Press.
Good, Mary-Jo DelVecchio, James Cara, Byron J. Good, and Anne E. Becker
2003 The Culture of Medicine and Racial, Ethnic, and Class Disparities in Healthcare. *In* Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., pp. 594–625. Washington, D.C.: National Academies Press.
Good, Mary-Jo DelVecchio, Sarah S. Willen, Seth Donal Hannah, Ken Vickery, and Lawrence Taesing Park, eds.
2011 Shattering Culture: American Medicine Responds to Cultural Diversity. New York: Russell Sage Foundation.
Graves, D.L., R.C. Like, N. Kelly, and A. Hohensee
2007 Legislation as Intervention: A Survey of Cultural Competence Policy in Health Care. Journal of Health Care Law and Policy 10: 339–361.
Greenwald, A.G., M.R. Banaji, L.A. Rudman, S.D. Farnham, B.A. Nosek, and D.S. Mellott
2002 A Unified Theory of Implicit Attitudes, Stereotypes, Self-Esteem, and Self-Concept. Psychological Review 109(1): 3–25.
Hannah, Seth Donal
2011a Clinical Care in Environments of Hyperdiversity: Race, Culture, and Ethnicity in a Post Pentad World [Ph.D. dissertation]. Cambridge: Sociology, Harvard University.
2011b Clinical Care in Environments of Hyperdiversity. *In* Shattering Culture: American Medicine Responds to Cultural Diversity. Mary-Jo DelVecchio Good, Sarah S. Willen, Seth Donal Hannah, Ken Vickery, and Lawrence Taesing Park, eds., pp. 35–69. New York: Russell Sage Foundation.
Hardy, Kenneth V., and Tracey A. Laszloffy
1995 The Cultural Genogram: Key to Training Culturally Competent Family Therapists. Journal of Marital and Family Therapy 21(3): 227–237.
Hirsch, Jennifer S.
2003 Anthropologists, Migrants, and Health Research. *In* American Arrivals: Anthropology Engages the New Immigration. N. Foner, ed. Santa Fe, NM: SAR Press.
Jenks, Angela
2011 From "Lists of Traits" to "Open-Mindedness": Emerging Issues in Cultural Competence Education. Culture, Medicine and Psychiatry 35(2): 209–235.

Kang, Jerry, and Mahzarin Banaji
2006 Fair Measures: A Behavioral Realist Revision of "Affirmative Action". California Law Review 94: 1063–1118.
Kirmayer, Laurence J.
2011 Multicultural Medicine and the Politics of Recognition. Journal of Medicine and Philosophy 36(4): 410–423.
Kirmayer, Laurence J.
2012 Rethinking Cultural Competence. Transcultural Psychiatry 49: 149–164.
Lamont, Michèle, and Virág Molnár
2002 The Study of Boundaries in the Social Sciences. Annual Review of Sociology 28(1): 167–195.
Like, R.C.
2011 Educating Clinicians About Cultural Competence and Disparities in Health and Health Care. The Journal of Continuing Education in the Health Professions 31(3): 196–206.
Lo, Ming-cheng M., and Clare L. Stacey
2008 Beyond Cultural Competency: Bourdieu, Patients and Clinical Encounters. Sociology of Health & Illness 30(5): 741–755.
Metzl, Jonathan
2012 Structural Competency: New Medicine for the Institutional Inequalities that Make Us Sick. Symposium held at the NYU Department of Social and Cultural Analysis, Friday, March 23.
Murray-Garcia, J.L., and J.A. Garcia
2008 The Institutional Context of Multicultural Education: What is Your Institutional Curriculum? Academic Medicine 83(7): 646–652, http://www.ncbi.nlm.nih.gov/pubmed/18580080.
Ring, JM, JG Nyquist, and S Mitchell
2008 Curriculum for Culturally Responsive Heath Care: The Step-by-step Guide for Cultural Competence Training. Oxford/New York: Radcliffe Publishing.
Shapiro, Johanna, Desiree Lie, David Gutierrez, and Gabriella Zhuang
2006 "That Never Would have Occurred to Me": A Qualitative Study of Medical Students' Views of a Cultural Competence Curriculum. BMC Medical Education 6: 31.
Shaw, Susan J.
2005 The Politics of Recognition in Culturally Appropriate Care. Medical Anthropology Quarterly 19(3): 290–309.
Shaw, Susan, and Julie Armin
2011 The Ethical Self-Fashioning of Physicians and Health Care Systems in Culturally Appropriate Health Care. Culture, Medicine and Psychiatry 35(2): 236–261.
Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson
2003 Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, D.C.: National Academy Press.
Smith, W.R., J.R. Betancourt, M.K. Wynia, J. Bussey-Jones, V.E. Stone, C.O. Phillips, A. Fernandez, E. Jacobs, and J. Bowles
2007 Recommendations for Teaching About Racial and Ethnic Disparities in Health and Health Care. Annals of Internal Medicine 147(9): 654–665.
South-Paul, JE, and R.C. Like
2008 Cultural Competence for the Heath Workforce. *In* From Education to Regulation: Dynamic Challenges for the Health Workforce. D.E. Holmes, ed., pp. 123–152. Washington D.C.: Association of Academic Health Centers.
Taylor, Janelle S.
2003 The Story Catches You and You Fall Down: Tragedy, Ethnography, and "Cultural Competence". Medical Anthropology Quarterly 17(2): 159–181.
Tervalon, M., and J. Murray-Garcia
1998 Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. Journal of Health Care for the Poor and Underserved 9(2): 117–125, http://info.kaiserpermanente.org/communitybenefit/assets/pdf/our_work/global/Cultural_Humility_article.pdf.
White, A.A. III
2011 Seeing Patients: Unconscious Bias in Health Care. Cambridge, MA: Harvard University Press.
Willen, Sarah S., Antonio Bullon, and Mary-Jo DelVecchio Good
2010 Opening Up a Huge can of Worms: Reflections on a "Cultural Sensitivity" Course for Psychiatry Residents. Harvard Review of Psychiatry 18(4): 247–253.

Wimmer, Andreas
2008 The Making and Unmaking of Ethnic Boundaries: A Multilevel Process Theory. The American Journal of Sociology 113(4): 970–1022.
Yan, Miu Chung
2005 How Cultural Awareness Works: An Empirical Examination of the Interaction Between Social Workers and Their Clients. Canadian Social Work Review 22(1): 5–29.