Recognizing Privilege and Bias: An Interactive Exercise to Expand Health Care Providers’ Personal Awareness

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Abstract

Problem

Despite increasing awareness of the social determinants of health, health care disparities among sociocultural groups persist. Health care providers’ unconscious bias resulting from unrecognized social privilege is one contributor to these disparities.

Approach

In 2009, Henry Ford Health System initiated the Healthcare Equity Campaign both to raise employees’ awareness of inequalities related to the social determinants of health and to increase their motivation to reduce them. After conducting awareness-raising activities to increase employees’ understanding of the social determinants of health, a curriculum team developed the interactive Privilege and Responsibility Curricular Exercise (PRCE) and incorporated it into a series of trainings. The team designed the exercise to enhance participants’ awareness of privilege in their lives and work, to improve their understanding of the impact of privilege on their own and others’ lived experiences as a step beyond cultural competence toward cultural humility, and to encourage them to leverage their advantages to reduce health care inequities.

Outcomes

About 300 participants of diverse professional and personal backgrounds from across the health system completed the training between the spring of 2009 and the spring of 2012, and many provided qualitative feedback about the exercise. Evaluations showed the exercise’s potential as a powerful learning experience that might enhance a variety of equity- or diversity-related trainings, and also showed that participants considered the PRCE a highlight of the training.

Next Steps

The PRCE is worthy of additional study and could prove valuable to other organizations.

Problem

Peggy McIntosh’s groundbreaking work on white privilege began an important national conversation about unearned advantages that permeate societal inequities. Given the ubiquity of privilege, it must, we believe, also influence health care interactions and outcomes. For example, though overt racism has declined, groups that benefit from social privilege still exhibit implicit biases, feeding into health care disparities. When presented with evidence that inequities persist, disagreement about the causes of disparities or poor health outcomes may remain. To eliminate inequalities, health care providers must acknowledge how their handling of cultural differences impacts patients, and not presume that standards of objectivity, professionalism, and service immunize them from bias. Helping providers recognize their own biases without activating psychological defenses is difficult.

Although well accepted in the social sciences, discussion of privilege appears rarely in the medical literature. The research that is available suggests some promising approaches. Interventions that foster empathy increase providers’ awareness of unconscious racial attitudes and their detrimental effects. Challenging participants’ certainty about the universality of their cultural experiences can open their eyes to the different and valid experiences of others. Intersectional approaches addressing multiple, cross-cutting experiences can broaden providers’ perspectives and improve quality of care. Finally, workshops function most effectively as part of broader initiatives that aim to increase culturally appropriate care.

Henry Ford Health System (HFHS) is a vertically integrated health care organization headquartered in Detroit, Michigan. It employs over 24,000 people and serves a racially and ethnically diverse community that experiences a range of health disparities. In 2009, HFHS launched the Healthcare Equity Campaign to increase awareness of disparities and attempt to remodel the HFHS health care delivery process around the core value of cultural competence. A curriculum team, comprising faculty and staff with expertise in culturally competent care and health equity, intended for the campaign not only to address issues that impact Detroit, a predominantly African American city, but also to be generalizable to many settings, particularly within the United States. Along with other awareness-raising initiatives, they implemented a continuing medical education (CME) program to increase understanding of disparities among health care workers at all levels and in different settings, preparing participants to serve as “ambassadors” of health care equity and advocates of culture change in various business units and locations. Nearly 300 employees, representing a diversity of professional and personal (racial, ethnic, religious, etc.) backgrounds, participated in 15 courses between spring 2009 and spring 2012. The CME program included an overview of health disparities.
data, a cultural identity exercise, and documentary screenings. In creating the curriculum, the team developed and piloted an innovative experiential exercise, the focus of this Innovation Report, that allowed participants to examine their own privilege and unconscious biases.

Approach

Staff members working with HFHS’s Institute on Multicultural Health conducted awareness-raising activities throughout the health system. Participants’ questions, comments, and evaluations indicated a need for training on the impact of privilege and unconscious bias on patient care. We searched the research literature for an experiential exercise that would link participants’ identities to societal privilege and explore how these differed among coworkers, but found no existing tool that would promote these insights. We therefore developed an original tool, the interactive Privilege and Responsibility Curricular Exercise (PRCE), tailored to our needs. We obtained ethical approval for this project retroactively through the HFHS institutional review board, which deemed the project exempt and granted a waiver of consent.

The PRCE’s aim was to raise participants’ awareness of privilege in their everyday lives and work environments and to improve their understanding of the impact privilege has on their own and others’ lived experiences. We believed this exercise would encourage health care workers to leverage their advantages to reduce health care inequities, moving them toward the realm of cultural humility, a state of openness toward understanding and respecting important aspects of other people’s cultural identities. We therefore based the PRCE on Peggy McIntosh’s “invisible knapsack” work which has helped elucidate the unearned, frequently unrecognized privileges that accrue within American culture to people with white social identities.1 The PRCE asked participants to self-select statements of privilege that apply to them. We adapted some of these from McIntosh’s list focused on white privilege,1 and we created others to encompass additional social identities. Each of the 22 statements referenced one or more social categories and experiences reflecting dominant societal norms (Table 1).

We typically conducted the PRCE with about 25 participants, but sometimes with much larger groups. We placed 22 stations around a classroom, each with one statement printed on a card and a bowl containing the same number of pennies as participants. Participants took a small “knapsack” to each station, read the statements, and took a penny for each statement that they felt was true for them. In larger groups, for which moving around would have been difficult, participants received handouts with the 22 statements and circled those that they felt described their own experiences.

The participants of smaller groups who used pennies then stood in groups based on how many coins they had gathered (e.g., 0–5, 6–12, 13–18, and 19–22 pennies). Groupings were flexible depending on the number of participants. The participants of larger groups who completed the handout counted how many statements they circled and stood at their seats when finished. The facilitator then asked participants to sit down according to how many statements they circled and requested, for example, “If you had zero or one statement circled, please sit down.” The facilitator would then pause for participants to sit before asking, “If you had five or fewer statements circled, please sit down,” and continuing through 10, 14, 18, and 20 or fewer statements, finally ending with all 22 statements circled. The facilitator paused after calling each number to allow participants to notice who was sitting and standing.

Debriefing in small groups (of about five participants) began with simple, comfortable questions that graduated to challenge, such as denial, diversion, or anecdotal accounts questioning the existence of societal bias. In response, facilitators reminded participants that they all had some degree of privilege related to being employed in the health care field. Facilitators emphasized the importance of using privilege in just and equitable ways: including everyone in meetings; examining gaps in clinical quality through the lens of privilege and bias; and exhibiting greater cultural humility toward patients.

Some participants, particularly those from groups that traditionally lack privilege, attributed their high “scores” to personal characteristics like confidence, extroversion, hard work, and determination. Such comments reflected the ways in which people with fewer privileges must put forth increased effort or develop coping abilities to succeed in an environment of structural inequities. As this phenomenon recurred in workshops, facilitators began instructing participants to consider not claiming a statement if it was true only because they overcame some barrier.

Outcomes

The PRCE engaged participants in self-discovery that increased their awareness of the privileges conferred upon various social categories. In general, those with more privileges gained insight into their membership in dominant cultural groups, recognizing that everyday activities might be more difficult for others. As described below, experiences unfamiliar to high-scoring participants but well known to those who claimed fewer privileges became accessible to all.

Discussions would sometimes unearth divisive responses that facilitators had to challenge, such as denial, diversion, or anecdotal accounts questioning the existence of societal bias. In response, facilitators reminded participants that they all had some degree of privilege related to being employed in the health care field. Facilitators emphasized the importance of using privilege in just and equitable ways: including everyone in meetings; examining gaps in clinical quality through the lens of privilege and bias; and exhibiting greater cultural humility toward patients.
### Table 1

**Statements Constituting Henry Ford Health System’s Privilege and Responsibility Curricular Exercise, Along With the Social Categories Which They May Reflect**

<table>
<thead>
<tr>
<th>Statement*</th>
<th>Possible related social categories*</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I should need to move, I can be pretty sure of renting or purchasing a home in an area in which I can afford and in which I would want to live.</td>
<td>Race, ethnicity, religion, SES, sexual orientation</td>
</tr>
<tr>
<td>If I ask to talk to the person in charge, I will be facing a person similar to me.</td>
<td>Race, ethnicity, gender, sexual orientation</td>
</tr>
<tr>
<td>If I walk towards a security checkpoint in the airport, I can feel that I will not be looked upon as suspect.</td>
<td>Ethnicity</td>
</tr>
<tr>
<td>If I walk into an emergency room I can expect to be treated with dignity and respect.</td>
<td>Race, ethnicity, physical/mental ability, SES, sexual orientation, body type</td>
</tr>
<tr>
<td>If I walk through a parking garage at night I don’t have to feel vulnerable.</td>
<td>Gender, age, body type</td>
</tr>
<tr>
<td>I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children’s magazines featuring people who look like me.</td>
<td>Race, ethnicity, body type</td>
</tr>
<tr>
<td>I can easily trust that anyone I’m speaking to will understand the meaning of my words.</td>
<td>Education, language</td>
</tr>
<tr>
<td>I can feel confident that my patients/feel that I am qualified upon first impression.</td>
<td>Race, ethnicity, age, gender, body type</td>
</tr>
<tr>
<td>When a customer/patient asks where I’m from, I simply think that it’s because they’re being friendly.</td>
<td>Ethnicity, language</td>
</tr>
<tr>
<td>My employer gives days off for the holidays that are most important to me.</td>
<td>Religion, ethnicity</td>
</tr>
<tr>
<td>I can come to work early or stay late whenever needed and know that my children will be cared for.</td>
<td>Gender, SES</td>
</tr>
<tr>
<td>I can speak in a roomful of hospital leaders and feel that I am heard.</td>
<td>Age, race, ethnicity, gender, language</td>
</tr>
<tr>
<td>I can go home from meetings or events feeling somewhat engaged, rather than isolated, out-of-place, or unheard.</td>
<td>Age, race, ethnicity, gender, language</td>
</tr>
<tr>
<td>I can look at the cafeteria menu and expect to see that the special of the day reflects my culture’s traditional foods.</td>
<td>Race, ethnicity, religion</td>
</tr>
<tr>
<td>My age adds to my credibility.</td>
<td>Age</td>
</tr>
<tr>
<td>My body stature is consistent with an image of success.</td>
<td>Gender, race, body type</td>
</tr>
<tr>
<td>I can bring my spouse or partner to an office gathering without thinking twice.</td>
<td>Sexual orientation</td>
</tr>
<tr>
<td>I can be sure that if I need legal or medical help, my race will not work against me.</td>
<td>Race</td>
</tr>
<tr>
<td>I can take a job with an affirmative action employer without having coworkers on the job suspect that I got it because of my race or gender.</td>
<td>Race, gender</td>
</tr>
<tr>
<td>I feel confident that if I don’t understand something then it wasn’t written clearly enough for most others to understand.</td>
<td>Education, language</td>
</tr>
<tr>
<td>I can feel confident that if a family member requires hospital or emergency treatment they will be treated with dignity and respect even if they don’t mention my connection with the hospital.</td>
<td>Race, ethnicity, physical/mental ability, SES, sexual orientation</td>
</tr>
<tr>
<td>I have no medical conditions or cultural/religious dietary restrictions that require special arrangements or that makes others see me as different.</td>
<td>Religion, physical/mental ability</td>
</tr>
</tbody>
</table>

Abbreviation: SES indicates socioeconomic status.

*All statements in the table without an asterisk were developed by the Henry Ford Health System curriculum team; the statements followed by an asterisk were adapted from selected items in “White Privilege and Male Privilege: A Personal Account of Coming to See Correspondences Through Work in Women’s Studies” by Peggy McIntosh (Wellesley, Mass: Wellesley College, Center for Research on Women; 1988).

*Some members of the social categories listed here may enjoy unrecognized privileges, while others are likely subjected to bias, including unconscious bias, in the dominant U.S. culture. Notably, this inventory of social categories is not exhaustive; many additional dimensions of privilege exist.

Some participants from historically dominant groups, when sharing that they could not claim a statement, felt the fact that they could not claim a privilege disproved the importance of social identities. This response happened most frequently in reaction to the statement "If I walk towards a security checkpoint in the airport, I can feel that I will not be looked upon as suspect." Participants from historically dominant groups asserted that they felt they were routinely chosen for more thorough checks. In these instances, the facilitator responded by first exploring whether these participants felt singled out for a search because of characteristics they possessed, such as ethnicity or religion, which, the participants admitted, was not typically the case. The facilitator then observed that those who attributed searches to their social identities may experience them quite differently.

Women and people of color in leadership positions often shared their perceptions of how others may attribute their success to diversity requirements or affirmative action in employment practices or college admissions. While some said this perception had caused them to work harder to exceed their colleagues’ expectations, the presumptions of inferiority heightened their levels of stress. Accomplished leaders or clinicians sometimes disclosed a lack of privilege which was surprising to others, and their fellow participants expressed a deeper sense of understanding and appreciation in subsequent discussions.

Participants with the fewest privileges expressed feelings of validation for the recognition of the barriers and challenges they face and of gratitude for the attention brought to the issue. Conversely, those with the most privileges expressed a mixture of appreciation for having fewer barriers to overcome and of embarrassment and guilt. We viewed these types of personal revelations among newly trained ambassadors as precursors to both cultural humility and a fresh motivation to promote systems changes.

Participants completed anonymous open-ended CME evaluations and, in some cases, reflection cards on which they recorded the most memorable part of the training. Many participants cited the PRCE as a highlight, mentioning its effect on their
perceptions of privilege and their new recognition of their obligation to address the effects of privilege on quality of care.

**Next Steps**

Some of the most important next steps for the PRCE occur after participants complete the exercise and return to their clinics and classrooms. The PRCE allowed participants to reflect on their recognition of privilege and to consider addressing inequity through:

1. Increased personal awareness of their relative societal position,
2. A realization, after discussing the results of the exercise with others, that the experiences of peers—even those with ostensibly similar professional or societal standing—are unequal and unjust,
3. An enhanced sense of societal structures that bestow privilege unequally across groups, and
4. An exploration of ways to capitalize on privilege to address disparities.

Another task going forward is to address the limitations of the PRCE. The exercise was embedded in a multifaceted workshop within a broader campaign to change HFHS’s organizational culture around health care disparities, making it difficult to isolate its effects. Evaluation comments suggest that the PRCE was especially impactful for many participants; however, assessing the PRCE and the other program elements singly and collectively will allow us to determine the relative impact of each. Also, our results thus far have been purely qualitative, drawn from facilitators’ impressions of group dynamics and participants’ handwritten feedback. Further, our own biases and privileges have undoubtedly influenced the design of the PRCE and interpretation of its results. Although those results, derived from 15 training sessions serving hundreds of participants, lend credibility to the PRCE, additional data—including quantitative measures and statistical analyses—will support continuing the exercise as a promising practice.

We envision the PRCE as a helpful starting point for encouraging health care providers to consider and be more aware of the challenges faced by members of ethnic, racial, geographic, socioeconomic, gender, physical ability, and other groups to which they do not belong. We see this exercise as supporting several of the underlying principles outlined in the Robert Wood Johnson Foundation’s recently released “Culture of Health,” such as “Everyone has access to affordable, quality health care because it is essential to maintain, or reclaim, health”; “No one is excluded”; and “Health care is efficient and equitable.” It would be instructive as well to more definitively assess the PRCE’s effectiveness in fostering cultural competence within a health care organization by applying the guidelines described in “Assessing Change: Evaluating Cultural Competence Education and Training,” a publication issued by the Association of American Medical Colleges. We also support efforts by other organizations to use the PRCE and to study it more systematically.

It is tempting for those of us in health care to assume that evidence-based protocols and best practices place our work beyond the influence of privilege or bias, or to imagine that professional ethics override cognitive shortcuts and biased judgments, but national research reports remind us that health care disparities persist. Health care is not immune to societal inequities; social systems of privilege and power influence health care workers every day, and this influence accompanies us into the hospital, the clinic, the research laboratory, and beyond. Our professionalism is not measured by how well we ignore these influences, but by how courageously we confront their impact on our work. Health care professionals need an improved awareness of privilege and unconscious bias to ensure equity for all. We believe the PRCE holds promise for the furtherance of this essential goal.

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References


