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Recently I heard a talk on how racial profiling affects the evaluation for stroke. Black patients at a large urban hospital being evaluated for cerebrovascular disease (TIA and stroke) were much more likely to be screened for cocaine and other drugs of abuse than white patients, regardless of age. There were two points of the lecture. One objective was to underscore the importance of checking everyone for these drugs, as they turn up in the most unexpected people. The other was to point out the inherent biases of the doctors, at least at that one hospital, although it is pretty clear that this extends widely. This got me to thinking about other biases that the general public has, but also those we physicians have as well. Many studies have shown marked discrepancies in how different groups get different treatment in our health care system, even when the populations are matched for insurance and economic status. We are all biased. We are all shaped by experience. Many biases are not derogatory. Training in medicine is supposed to help us see each person as an individual, as well as a member of a complex social organization, but bias runs deep and can never be eliminated. Mostly we think of bias as racial or socioeconomic and bad, but some biases are not related to race or wealth.

A heartbreaking example is my patient with an inherited ataxia. He drives his mother to their mutual appointments and sometimes vents his frustrations to me. He was about 40 years old at the time he lost his job driving a vehicle at a warehouse that picked out heavy items from a huge storage area to deliver them to the front of the store. He was evidently safe and a very reliable worker. He was moderately ataxic, but not at significant risk of falling. His speech was slow and slurred. He sounded like he was drunk, as did his mother. He was unable to obtain another job and when he went to the mandatory state retraining, he was directed by the state agency to a program for people with developmental delays. “They think I’m retarded because of how I talk.” He wanted a full-time job doing whatever he could, and the agency tried to place him in a sheltered workshop.

Another patient has severe dystonia and walks bent over, one foot crossing the other in a remarkable manner. Although his walking is very abnormal, he can rollerblade forwards and backwards without a problem. He drove a school bus without incident until a parent saw him walking and called the school, which led to his termination. Rather than a lawsuit based on the Americans with Disabilities Act, he worked two jobs, put a down payment on a gas station and now owns two gas stations with convenience stores and employs his own children full-time.

We’ve all encountered adults who were born with cerebral palsy who have slow, slurred speech, spastic gait and clumsy movements who are intellectually intact. They are as smart or stupid as anyone else. The medical school at Brown has graduated a few. They are usually assumed to be intellectually impaired by most people who meet them for the first time and some do not change their opinions despite evidence to the contrary.

Occult bias is, by definition, submerged. We all know we have biases. We may think that we’ve expunged racial or socioeconomic or gender biases from our psyche, but it’s a lot more likely that we’ve only contained them. There are biases that we are not aware of. One I’ve been interested in, although have not figured out how to study, is the bias towards people rendered parkinsonian by antipsychotic medications. A psychiatrist who specialized in schizophrenia told me of the parents’ plea, “Please don’t turn my child into a zombie.” This reflects the very reasonable fear that the medications will make their child look different, which in this case means, looks like they have Parkinson’s disease, with a “masked” facial expression, slow movements, stooped posture and possibly a tremor. There is
published data revealing that physicians, when shown video vignettes, have a different opinion of patients, just based on their facial expression, depending on how “masked” their facial expression is. The more masked, the more likely the physicians were to consider the patients depressed, less social and cognitively impaired. And this is for people with idiopathic PD, hence an older population, as perceived by physicians, in both the United States and China. Another study reported that PD patients were perceived as “cold, withdrawn, unintelligent and moody.” One hopes that these first impressions don’t last, but Malcolm Gladwell has written books about how subconscious assessments made in a second alter our assessments and interactions.

Most schizophrenics in the western world are treated with medications that routinely cause them to develop some of the features of PD. I can tell you from personal (and published) experience that in the majority of cases it is not recognized. I suspect that many doctors have come to believe that schizophrenics look like they do because of their schizophrenia rather than their treatment. I wonder what the average person thinks of a 20-year-old with a masked facial expression, stooped posture and slow movements, if a physician looking at a 70-year-old with PD automatically thinks he’s cognitively impaired, cold or moody. The stigma of schizophrenia thus extends beyond the disease to include the treatment as well.

We cannot avoid pre-judging people. We must strive to avoid acting on the pre-judgment rather than the actual data, letting the data alter the judgment rather than the judgment alter the data. We must educate and police ourselves better, and, perhaps most importantly, we need to be more sensitive to our patients’ adversities.

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**Disclosures**


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From RIMJ’s Managing Editor: For more information on The Aronson Chair, click here: [http://www.butler.org/aronsonchaircampaign/index.cfm](http://www.butler.org/aronsonchaircampaign/index.cfm)

Dr. Aronson in 2007 receiving Doctor of Medical Science (DMS) at Brown in 2007.

Stan Aronson, MD, in the early years in the 1950s at Downstate Medical Center in NYC.
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The year 1972: Richard Nixon is president, The Dallas Cowboys win the Super Bowl and a population research institute in New Jersey completes a demographic analysis of mankind, concluding that the world’s population stands at 3.6 billion souls.

Until about 1700 the global population (as best as could be calculated) grew very slowly, only rarely exceeding 0.1% per year, and in years of widespread epidemics, dropping significantly. A variety of factors, not the least being improvement in human sanitation, then led to an explosive rise in the number of humans, and by the 20th century, reaching about a 2% increase per year. Barring the unforeseen Malthusian disasters of pestilence and warfare, it was inevitable that deep concerns would then be expressed as to the ecological limits of human growth.

Only three measurable factors determine the human population of a particular region at a particular time in history: The population of, say, Wonderlandia, at the end of year 2013, equals the number of people in Wonderlandia on January 1 of that year plus all of the births during the year, minus the number of deaths, plus the number of migrants entering, and minus the number of exiting migrants during the year 2013.

Demographers, studying the accumulated data have now epitomized human growth as follows: An initial phase, stretching from the earliest of records through the 18th century, with the numbers of births barely exceeding the numbers of deaths, thus resulting in a minimal degree of overall population growth, if at all. And the second phase, wherein the death rates drop while the birth rates, for decades, remain unaltered resulting in a dramatic rise in human population. And finally, a third phase characterized by a rapid tapering off of the birth rate to approximate the death rate, during which time the global population stabilizes with neither excessive growth nor abatement.

Recent human history has indeed complied with these three sequential phases called, by sociologists, the demographic transition. But this transition has varied considerably from region to region. In some developed nations, mortality rates now slightly exceed the local birth rates. But for many of the poorer countries birth rates still far exceed death rates.

The transition from high fertility/high mortality to low fertility/low mortality, envisioned by demographers, is an overly simplified portrayal of global happenings over the many millennia. Mass migrations, prior to the 15th century, certainly altered the cultures, languages and ethnicities of European and Asiatic populations, but the gross numbers of migrants was small when compared with those moving from the Eastern Hemisphere to the Western Hemisphere in the years following the 15th century.

Consider, now, the effects of the sudden introduction of a technical innovation into a developing nation. In 1946, the United Kingdom employed a newly devised insecticide to blanket the forests of one of its colonies, the island of Ceylon. Endemic malaria had caused many deaths particularly in children. The saturation of the island with DDT destroyed most of the mosquitoes of the island and the incidence of malaria diminished precipitously. And thus, in the next decade the island confronted a sharp drop in mortality but no appreciable decrease in fertility, causing a population explosion with no augmented governmental facilities such as schools, playgrounds and hospitals to provide care for the suddenly expanded community. Thus, in the absence of DDT, the decrease in mortality would have been more gradual and the discrepancy between need and availability of support services less compelling.

Beginning in the 1970s, a labor shortage emerged as a result of a very low fertility rate in the developed nations of Europe. Many laborers then migrated, particularly from the developing nations of the Middle East and South Asia; and by the inaugural years of the
21st century, inner cities such as Paris and Amsterdam remained ethnically Parisian or Dutch, while their suburbs were unduly congested with immigrant populations with substantially higher fertility rates than the resident families, leading to inevitable cultural clashes.

It is now four decades later, and how accurate were the population prognostications of 1972? Despite some nasty surprises in global history during these 41 years, the estimate that the world would reach 7 billion by 2005 has been verified. Thus, while social scientists may confidently predict the numbers of humans 40 years hence, this same assemblage of scholars cannot tell on Tuesday what a small handful of humans might do by next Friday.

That same analysis predicted a global population of 10.6 billion by the year 2050. The report did not reveal how the additional 3.6 billion souls will be adequately fed, clothed and housed.

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**Disclosures**
The author has no financial interests to disclose.
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