

Diversity and Inclusion Committee

The Role of Bias in Performance Evaluations and Inclusion the Workplace

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Bias is a prejudice for or against something or someone, related to their gender, race, ethnicity, religion, sexual orientation, disability, socioeconomic status, or any other entity. While frequently viewed as a negative construct that only affects narrow-minded individuals, the reality is that bias is pervasive. In the realm of our profession as emergency medicine providers, bias affects our patients' access to health

care, our trainees' education, and our own compensation, promotion, and professional fulfillment. This article discusses how bias affects the latter two entities from a specific standpoint; performance evaluations.

Performance evaluations are commonplace in both the educational and care-delivery environments, with a prevailing belief that performance evaluations are of high quality, which is false. We assume that an observation of a performance is the most accurate way to assess an individual's performance, without the acknowledgement of how bias affects these observations, and affects the accuracy of evaluations.

While bias may be explicit or implicit, implicit bias is more difficult to address, as it does not necessarily align with declared beliefs, making it harder to identify and change. While positive bias in which we tend to favor our own group is natural, it should not justify driving an action in which other individuals are discriminated against.

Examples for bias include:

- "Halo effect," in which our impression of an individual (how likeable they are) affects our evaluation of their work
- "Confirmation bias," in which we look for elements in the individual's behavior that fit in with our presumptive understanding of their abilities, and use those elements as evidence of their performance, rather than looking at the whole picture
- "Contrast effect," in which we compare an individual's performance to that of others, rather than the predefined performance standard.

An interesting study by Dayal, et al., was published in *JAMA* in 2017, and examined over 33,000 evaluations of 359 emergency medicine (EM) residents, based on the EM milestones.¹ Although both female and male residents started their residency with equal milestones, by the end of their residency, male residents attained an average of 0.15 milestones more than the female residents; equal to three to four months of training. Although the study does not offer a specific explanation for the reason behind this apparent lag, the authors offer the discrepancy in evaluation as a leading cause, rather than an actual difference in performance.

Another study analyzing gender differences in qualitative evaluations of EM residents sheds some light on the culprit; the words used to describe an ideal emergency medicine resident are traditionally male descriptors:

decisive, independent, confident, and takes charge, to name a few.² It is no surprise that female residents were falling short when the ideal descriptor is that of a male, rather than a gender-neutral standard.

Taking a step away from performance evaluations in medicine and into a wider realm, the issue persists. Women are more likely to be praised for being relationship-oriented (compassionate), whereas men are more likely to be praised for being task-oriented (analytical), despite their equal performance on more objective measures. While both are positive traits, they speak to different expectations of the individual, and when it's time to advance at the workplace, the analytical individual is more likely to get a promotion than the compassionate one.^{3,4}

This discrepancy in the focus of evaluations becomes an even bigger issue with women who violate gender stereotypes and display traditionally male qualities, termed the "backlash effect."⁵ Women are expected to

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be communal: cooperative, supportive, and connected. Men are expected to be competent and dominant: self-reliant, ambitious, independent, competitive, decisive, and aggressive. Women who display communal trends are liked but viewed as less competent, and those who display agentic traits are viewed as competent but not liked, as they are insufficiently feminine. In either case, women are discounted on their ability to become adequate leaders, while men with identical behaviors are judged less harshly on this "lack of niceness." It is worth noting that this backlash effect related to expectations of being communal is not limited to gender relations, but extends to other systems of inequality, such as race.

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These are only some examples from the literature regarding inequality in evaluating the performance of non-majority individuals in the workplace, a sad truth that must be addressed in order to have true inclusivity, as diversity does not exist without inclusion. The unfortunate reality of many institutions is that they focus on recruitment of non-majority individuals and hold them against the biased ruler that defines success. This results in a disparate assessment of achievements, and hindering of the advancement of these individuals in the workplace.

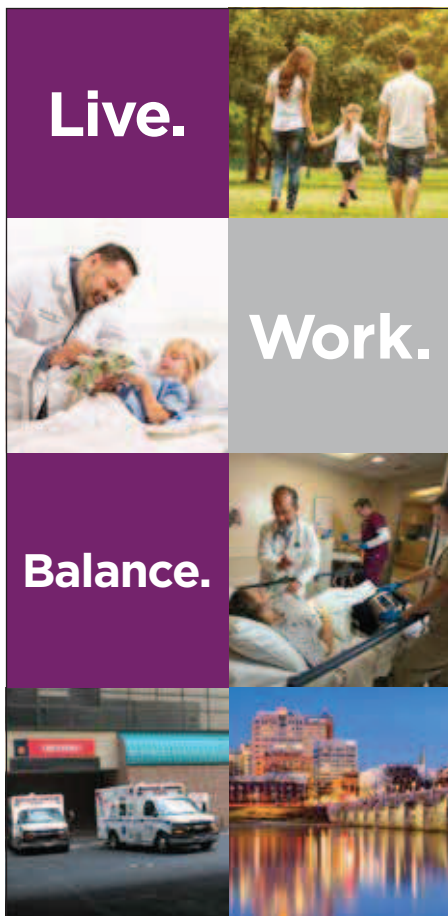
Identifying a Solution

Moving from identifying the problem to identifying a solution can be as simple as starting a conversation at your institution. Many individuals are unaware of how bias affects their perceptions and evaluations, and think of it as “someone else’s problem.” Awareness of the problem is the first step to change. The second is to examine how you complete your own evaluations of learners, superiors, and colleagues. Are you being biased? Are you evaluating these individuals based on the tasks and learning goals expected (as should be), their likeability, or by comparing them to their peers? If you are in a position of power and are on the receiving end of evaluations, keep your eyes open for patterns in evaluations that may allow you to identify bias. Taking it one step further, you may choose to revamp the tools that are used to evaluate your own trainees and staff, using non-biased clear wording that measures what is intended, and conduct faculty training on completing these evaluations.

Bias exists, and we must systematically dismantle how it affects performance evaluations, as these evaluations are essential for the retention and advancement of residents, physicians, and health care providers alike. Until this is recognized and addressed, we will not have equity, despite having diversity. ●

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