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COMMENTARY

The Evolution of Social Beliefs 1960–2016 in the United States and Its Influence on Empathy and Prosocial Expression in Medicine

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Abstract: This perspective surveys healthcare's response to the increased prominence of racial, ethnic, religious and sexual minorities as well as females in American culture. It argues for understanding physicians both as products of the broader society and its changes. Starting in the 1960s, empiric evidence for the rise of reactionary viewpoints in response to major social movements is outlined. Structural reasons for the prevalence of such ideologies within medicine are highlighted. Its negative consequences for minority health are addressed. Finally, the author turns to compensatory strategies to improve the social environment within healthcare. Alternative selection strategies for medical school are proposed, with a stronger focus on empathetic candidates.

Keywords: social beliefs, empathy, diversity and inclusion, social justice, medical school admissions, discrimination, multiculturalism, assimilation

Plain Language Summary

This perspective essay provides insights into how biographical experience, motivation, and personality traits have changed in response to the social turmoil of the 1960s and 1970s. Who we are today is in part a result of our collective responses to that turmoil and may have potentiated a decline in prosocial traits in medical students. The challenges of preparing students are better understood when viewed within the broader social context. We are different and so are our students. The current medical school curriculum and pedagogy deserve scrutiny regarding the effectiveness by which they are acculturating students to medicine's humanistic ideals as the broader society has become more polarized. The rise of social media is used to illustrate how medicine may not have kept pace with the changes in social beliefs. To the extent we fail, our patients and profession suffer. The population of potentially successful medical school students expressing greater prosocial tendencies far exceeds the chosen few. Different selection methodologies will be required while we successfully develop effective strategies.

Introduction

As public discourse has increasingly turned to the American healthcare system, one of many concerns is its ability to offer high-quality care to a diverse society. Sociology and group psychology offer important insights into this dialogue. The medical training environment can be treated as its own subculture with two controlling facts. First, while the code of medical ethics has remained relatively stable over more than a century, actual physician beliefs and attitudes in the US have

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tended to reflect broader social norms. Second, the residency model of training lends residents and attending physicians tremendous influence to transmit not only their medical skills but their ideas and customs as well. A proper understanding of the social attitudes imparted by medical education requires accounting for the impact of social currents during the formative years of physicians' lives. We briefly trace the trajectory of American culture on issues of diversity and pro-social behavior, examine more contemporary manifestations and examine its impact on the current climate of hospital training programs.

As the social and cultural turmoil of the 1960s and 1970s manifested in American youth, researchers began documenting changes within them. Narcissism, individualism, and materialism became more prevalent. After the mid-1970s, people increasingly adopted a belief in a just world (BJW) as their philosophy: that "people get what they deserve and deserve what they get".[1] As a central tenet of the meritocracy argument, BJW provided a ready justification for inequality and status quo preservation during tumultuous times. Collectivism, empathy, and the trust of others started deteriorating, and people who opposed changes to the social order and culture of the 1950s legitimized the existing social system.[2] As societal forces contradicted their beliefs, BJW individuals felt threatened and stressed. Perhaps predictably, their embrace of BJW was associated with a tendency to denigrate, blame, and stigmatize "others"[3,4] as they adhered more strongly to their underlying beliefs[1] and manifest prejudice.[5] Differences in the perception of how "others" (women, LGBT+, immigrants, religious minorities, Asians, Hispanics, African-American/Blacks, Native Americans, Native Alaskans, Native Hawaiians, and other Pacific Islanders) live, believe, detect, and process cues that they perceive as a rejection of their dominance may have heightened people's susceptibility to social stressors.[4] Around the year 2000, the strengthening of all these factors among the American public led some to perceive multicultural pluralism as a threat.[6]

As Americans, we also underwent profound change. The long-term trend of 1970s, narcissism and materialism increased during the Great Recession although collectivism rose and individualism decreased,[7] albeit momentarily, in response to the common economic threat.[8] In the following years, individualism,[9,10] materialism, and narcissism left a lasting impact.[11] The perception that anti-white discrimination exceeds racial/ethnic discrimination progressively increased as "others" began to enjoy greater liberties during the Civil Rights era. The hostile social climate of the period was permissive, as individuals express prejudiced attitudes and behavior more freely.[12,13] Homophily rose as political divisions sharpened along with widening of rifts along racial/ethnicity, age, religion, education, and gender.[14] This same period also saw a rise in hate crimes against racial/ethnic minorities, the LGBT community, the homeless, and immigrants.[15] Immigration from non-European countries (both legal and illegal) increased during the 1980s, raising their visibility. Anti-Semitism sharply intensified as groups previously within the mainstream found themselves considered outsiders.[16]

Experimental evidence suggests that narcissism's rise over the last 40 years would be accompanied by heightened social dominance orientation and indirectly associated with increased prejudice.[17] As expected, narcissists hold more significant prejudicial attitudes toward "others," to the extent that such attitudes satisfy their feelings of entitlement and encourage their desire to dominate and exploit others. Correspondingly, narcissism has been associated with antisocial tendencies, such as interpersonal aggressiveness,[18] negative perceptions of humanity,[19] and unsatisfactory academic performance.[20] Mistrust of others continued its 40-year increase into the first decade of the 21st century.[11,21,22] Importantly, the same period saw a 40% decline in empathy among college students[7,23] just as social anxiety regarding multicultural pluralism as a social motivator was becoming evident. Researchers also documented a decline in dispositional empathy, especially after 2000.[7] Changes were greatest in empathetic concern and perspective-taking,[10] traits which mitigate callousness[24] and prejudice.[25] Lower empathy levels were linked to prejudice against a range of stigmatized targets;[26] conversely, higher levels were associated with lower prejudicial attitudes toward different stigmatized groups.[27]

Toward the end of the 20th century, blatant discrimination was less acceptable.[28] Rather than a marked increase in egalitarian or non-prejudiced views, however, the expressions of prejudice changed (eg, rejecting members of marginalized groups for non-prejudiced reasons).[18,19,29,30] Other more obvious biological falsehoods rooted in slavery continued to influence the treatment of "others"[31] in medicine. The tendency to underestimate the level of income inequality[32,33] and overestimate intergenerational social mobility[34,35] served to provide justification for conscious and unconscious biased attitudes and behaviors. Ambivalent anti-"other" feelings and stereotypes gave rise to selective incivility (microaggressions).[36] Such behavior

toward marginalized and stigmatized groups appears pervasive in our schools and residences.[37,38]

Consequences of Cultural Turmoil

When Fear Became the Lens

After 2000, fear became the lens as dramatic demographic changes (immigration), struggles for equality and social justice by diverse groups (Black Lives Matter, #MeToo movement, Women's March), and the greater visibility of "others" triggered increased social anxiety[39] and nostalgia for an idealized mythical time in America's past. Social organizations[40] and civic engagement,[41] which could have helped mitigate such anxiety, either disappeared or saw a dramatic decline in participation.[42]

The public's response has been to "hunker down" and to perceive "others" as threatening and untrustworthy, and both its economic and social fears have been seemingly catalyzed by the lack of real wage growth in the last 40 years. The increasing prominence of "others" fostered the impression that it has emerged at the dominant group's expense because they believe that the situation was a zero-sum game, a view not shared by minority groups.[43–45] The resulting shift in perceptions provoked an increased opposition to diversity,[45,46] a higher propensity for implicit and explicit bias, and homophilia.[47] For some, the rise of "others" evoked fears of rejection and suppression of white cultural values and norms, as evident in the perceived "war on Christmas" or the resentment of "political correctness".[46]

During the period 2012–2016, social dominance orientation—a marker for prejudice and discrimination—increased significantly.[48] A robust body of literature provides empirical evidence of the widespread correlates of social dominance orientation and its theorized critical role in helping determine the nature of human sociality.[49] Individuals with high social dominance orientation tend to view individuals not as separate entities but as representatives of social categories. Such individuals experience empathetic concern less frequently and to a reduced degree.[50] Further, when confronted with contrary information, they resist changing their stereotype-based judgments.[51] This may account for the increase manifestation of social dominance orientation with clinical exposure[52] with its greater diversity and curricular exposure to social determinants of health (SDH) information.

Prejudice, Discrimination, Implicit Bias

Prejudiced behavior is meant to serve a specific function dictated by the context of its expression,[53] the degree,[54] and means of expression, as well as which components are communicated.[55] The intention or awareness of prejudicial response may be unconscious, although the concept of unconscious discrimination is being increasingly challenged as a fiction.[56–58] At any time, we take different identities and group memberships. Through deontological theory, under professionalism, we provide specific moral/ethical rules suggesting that an action's morality is determined by whether it conforms to a set of professional rules (eg, no patients should face discrimination).[59] We try to make the "ideal physician" ingroup the most salient in professional matters, if not overall. Often, we fail because of the persistence of innate discrimination[60,61] and the lack of moral development[62] (ie, they never learned not to discriminate).

Favorable behavior in accordance with medical school professionalism and SDH instruction,[59] while mostly congruent with practicing physicians' ideals, generates significant dissonance with medical students because of the inconsistency between pervasive faculty misbehavior,[63] professed ideals, and conflicts with personal beliefs. Rather than the wholesale adoption of professionalism, a more nuanced interpretation arises where professional behavior is associated with the self-perception of being a "good person"[64] allowing potential biases to intrude.[65] Moreover, for more than one-third (36%) of medical students (those in the "strong racial bias" category[66]—a rate 30% higher than a comparable segment of the US population[67]), they may exhibit significant internal dissonance to professionalism standards as well. Assumptions regarding positive beliefs or attitudes about marginalized or stigmatized populations may be far from inevitable or responsive to educational efforts.

Unsurprisingly, physician surveys demonstrate that regardless of specialty, an implicit preference for whites is present.[61,68] This finding is important because empathy, the core of quality medicine, actively mediates implicit bias against others, reducing prejudice and discrimination.[25] Polling indicates that one in five Americans explicitly do not believe all men are created equal, a bedrock moral precept in medicine.[69] Medical students and physicians are aware of stereotypes about racial/ethnic minorities.[70–72] Levels of implicit bias against African Americans, Hispanics, and other people of color[72,73] by physicians are

similar across groups and comparable to the general population.[73,74]

Physician biases, both explicit and implicit, matter. The ideological orientations that people have toward diversity have real consequences and exert real influence on inclusion[75] and health equality. Despite the lack of clear-cut offs, higher implicit bias is important as providers with a stronger implicit bias towards "others" have demonstrated poorer patient-provider communication[76] and are more likely to deliver inferior care.[77,78] Implicit bias against "others" significantly impacts patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes.[73] Bias associations are strongest for patient-provider interactions and related health outcomes.[73] Even the small influences of implicit bias in the educational environment can cascade and have significant effects on medical school grades, selections for awards for "others" and ultimately adversely affecting their medical career.[79] Deliberative decisions typical of healthcare decisions are probably not as unconscious as commonly believed.[57,58] Professed good intentions and conscious egalitarian views are not enough to reduce the adverse impact of implicit bias on clinical care,[80] remain associated with bias medical decision-making,[81] and presumably are not enough to mitigate decreases in empathy and the related value of humanism.[82]

Social Media

Medical student involvement with social media is now ubiquitous. Social forces acting through social media has heavily changed the way we get informed and how we shape our opinions. Few appreciate how these platforms foster "somewhat inevitable"[83] or "eventually" form a homogeneous cluster, resulting in assimilation or even amplification of beliefs[84] and homophilic tribal tendencies. In these homogeneous groups, similar beliefs develop that lead to a degradation of the quality and diversity of topics and discussion online. Even within the echo chamber, the formation of highly polarized sub-clusters within the same echo chamber occurs.[85] Fundamentally, individuals want validation of their identity and experiences.[86] Social media alleviates the uncertainty of social interactions motivating individuals to establish shared realities through group identification. Confirmation bias facilitates informational cascades and the aggregation of favored information that reinforces selective exposure and group polarization.[85] It provides a self-saturating reality that is shared absolutely.

Social forces reinforced in "echo chambers" lead to increased strong negative emotions members of one group feel toward another[87] through repetitive approval by their social group and the enhancement of extant tendencies, beliefs, and biases to better align with group norms. Within these bubbles, the communication often surrenders rationality in favor of conformity to the group.[88]

Online expression leads to belief enhancement, makes it less vulnerable to change, activates attitude change and action commitments.[89] Positive endorsements from social media can reduce the persuasive power of counter-attitudinal information from other sources.[90] Greater time in the social media bubble and lower ambiguity tolerance (a characteristic associated greater use of stereotypes,[91] a decline in attitudes toward underserved populations),[92] leads to a significantly higher overestimation of public support for the opinions expressed[93] and greater resistance to change from those views expressed within the bubble. Summarily, those medical students with expressed greater social media exposure likely will experience less receptiveness to educational efforts that present contrary information to their existing beliefs (eg, SDH messaging or interactions with diverse peoples). This is vitality important since poorly designed, targeted, or executed interventions are not just ineffective but reinforce people pre-existing beliefs.[94,95] Current curriculum efforts are often undertaken without consideration of the role social beliefs or how social media may have changed the receptiveness of students. Although it is often undertaken to identify users' behavior on social media for determining targets and tailoring corrections in the form of fact-checking or debunking attempts,[96] attempts to identify the best interventions based upon their social media use and prevalent social beliefs remains speculative.

The "real teacher," who socializes students on what is "actually" valued in medical education and medical practice, the hidden curriculum is replacing the formal curriculum as a foundation of medical training.[97,98] Further, the hidden curriculum fosters the devaluation of the professional group identity and salience, promoting the substitution of personal values in the best of circumstances and the adoption of hidden curriculum values in the worst. Even among those wishing to resist the hidden curriculum, faculty misbehavior and exhibition of conflicting values may undermine their desires.[99] Thus, the more faculty role model discriminatory behavior and values contrary to

established medical values, the greater student implicit bias is found among students.[100]

Hence, to produce students more reflective of established medical values, the curricula must acknowledge the now ubiquitous presence and role of social media and that the hidden curriculum must change. The failure of nearly every effort to eradicate the hidden curriculum has failed because of a misconception of the problem. The problem is not some hidden minority of "bad actors", it is the silent majority that give their tacit approval. The hidden curriculum reflects prevalent social beliefs within the faculty. Therefore, without attitudinal change among faculty or until there's greater willingness to use different selection factors for students and faculty, the hidden curriculum is not going to change.

The identification and selection of applicants already manifesting the desired characteristics seem preferable to selecting applicants not already manifesting those characteristics and trying to change them. Designing the selection process to favor both faculty and students with a sustained history of prosocial activities;[101–103] rejection of academic linearity, the adoption of academic threshold selection will increase the diversity of candidates, and the pool of prosocial students will significantly alter the composition of medical schools[104] toward greater student empathy.[105,106]

Discrimination in healthcare has significant adverse consequences for those subject to bias. Prejudice in healthcare potentially negatively and disproportionately impacts more than two-thirds of the deaths in America[107] and extends beyond the doctor-patient relationship to include healthcare administration,[108] academic and research leadership, and the research agenda.[109] Such differences longitudinally are not insignificant and may account for up to 6 years shorter life expectancy among some "others".[110] Even some upwardly mobile "others" are significantly more likely to experience both acute and chronic discrimination in healthcare than their white counterparts.[111] Differential exposure to unfair treatment explains a substantial portion of the differences in self-rated health in "others".[111] Colorism may account for the more limited findings among Hispanics.[72,112]

Guiding Principles

The fundamental principle that should guide our actions is that all students, irrespective of gender, race, religion, ethnicity, country of origin, sexual orientation have the right to enjoy the full benefits of medical school enrollment.[113–117] Currently, they do not. The discriminatory challenges within medical schools faced by "others" whether conscious or unconscious, makes their educational experience and opportunities unequal.[118] Equality is inseparable from, and dependent on, diversity within our classes.[113–116] Hence, the limited student and faculty diversity of our medical schools is a threat to the diversity of thought and perspectives necessary for the optimal learning environment in medical school,[119,120] for quality patient care, and achieving health equity.

Current medical school environments implicitly value biomedical learning more than empathic behavior.[121–124] Negative role models,[29] a chronic shortage of time (ie, lack of reflective time),[122,123,125,126] and the competitive nature[127] of medical schools act in concert within the hidden curriculum to inhibit empathy development. In this environment, the only empathy exhibited by students is often manipulative, false, and does not facilitate moral values.[128]

Unfortunately, most medical students have had limited experiential exposure to or understanding of "others" to buffer prevailing adverse influences due to rising socioeconomic class inequality[128,129] and rising residential and economic segregation over the past few decades.[45,130-133] For even in diverse neighborhoods, actual contact between whites and "others" remains low.[134] Similar to findings from 2 decades ago,[135,136] a recent national collegiate survey found no consistent development of positive attitudes towards "others".[137] Increased homophily during their freshman year[137] and the deliberate lack of significant interactions with "others" are postulated reasons.[138] Favorable contact with stigmatized groups can change attitudes overcoming students' baseline levels of social dominance orientation, dispositional empathy, or need for cognitive closure.[139] Both the amount and favorability of contact predicts positive implicit and explicit attitudes.[140]

Change

All change begins as personal change. The individual actions of physicians and the collective performance of medical schools result from the consensus of individual decisions and behavioral and sociocultural practices. Each medical school process is shaped by consensually held values, attitudes, beliefs, and cultural ideologies,[49] which, unfortunately, reflect the prevalent beliefs and attitudes of the medical school population and general public.[68,73,74] The force of beliefs that support and lead to the persistence of the hidden curriculum is similarly

propelled by the consensus across constituent groups.[75,141] When more egalitarian views of health equity are more widely accepted among faculty and staff, the more effective those that support such beliefs will be in changing the status quo. Summarily, when the consensus of medical school faculty decides to change the hidden curriculum, it will go away. To the extent physician views continue to reflect those of the general public, such a change is not likely to occur. Each physician, can, however, determine the speed and direction of change by the values, attitudes, and beliefs they elect to manifest rather than just espouse.

Previously successful strategies for the indoctrination of empathetic, humanistic principles and beliefs into students will require revision as those strategies may not have kept pace with the rate of social change. The current medical school curriculum and pedagogy have yet to educate students adequately about stigmatized and marginalized people[142,143] and have not adequately educated students as the broader society has become more polarized and diverse. Novel strategies may be more successful than traditional ones in acculturating millennial students.

Conclusions

Today's medical environment is very different from that of 50 years ago. The cumulative changes that have resulted from the social forces at work in the last half-century in the United States are profound. Our patients differ from the ones in the past, and we have changed too. Millennials, who constitute the bulk of those in training, enter medical school with very different ideas about medicine, its practice, and their patients. The spectrum of values, attitudes, and beliefs this generation hold may be more divergent from medicine's humanistic roots than in previous generations.

"Our future is not in the stars but in our own minds and hearts".[144] Fostering leadership, learning, and empathy between cultures was and remains a central purpose of medical education. In the next 20–30 years, America will be a majority-minority country. This generation of physicians is not prepared to care for the population they will be privileged to care for. While innovations may provide future direction, the problem is present right now, and the situation is likely to get worse in the coming decades to the detriment of the health of the country and our people. The population of potentially successful medical school students far exceeds the chosen few. Different selection methodologies will be required while we successfully develop successful strategies.

Disclosure

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