

Master Clinician Series: Managing Implicit Bias and Its Effect on HealthCare Disparities

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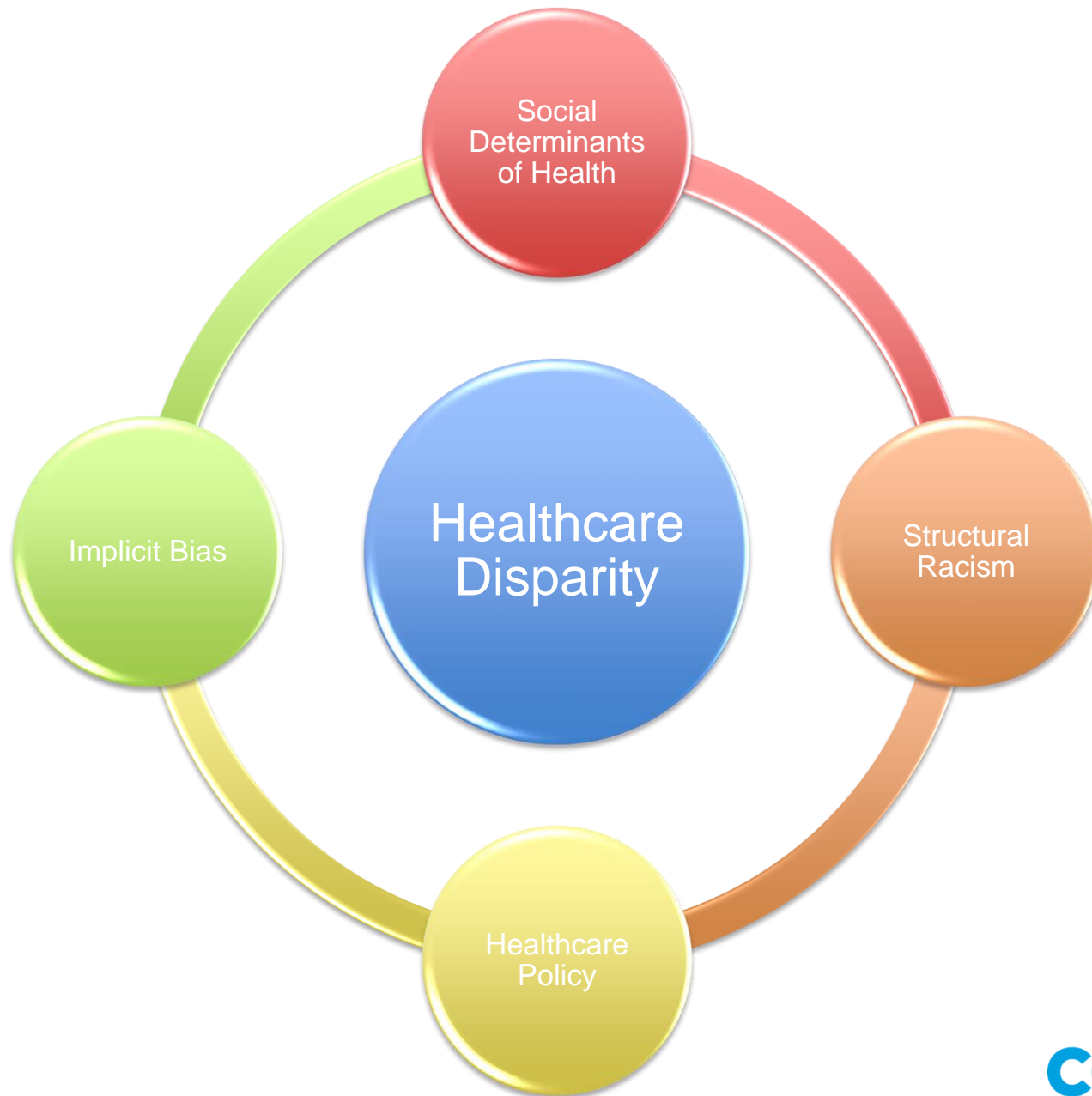
May 21, 2020

→ I have no relevant disclosures



Objectives

- Explore how implicit bias can contribute to healthcare disparities
- Evaluate a framework for how cultural humility and individuation can mitigate the impact of healthcare disparities
- Demonstrate some practical ways palliative care providers can begin to impact health disparities
- Identify the challenges the pandemic maybe posing to communication in communities disproportionately affected by healthcare disparities



Important Terms:

- **Healthcare Disparities:** differences in health care between groups who have economic, social, and environmental disadvantages
- **Implicit Bias:** is the bias in judgment and/or behavior that results from subtle cognitive processes (e.g., implicit attitudes and implicit stereotypes) that often operate at a level below conscious awareness and without intentional control
- **Structural Racism:** societal structures/policies that excludes people from a minority background from accessing and participating in social institutions
- **Cultural Competency:** is the ability to understand, communicate with and effectively interact with people across cultures; gaining knowledge of different cultural practices and world views

Implicit Bias

→ First we need to understand us. Why do we struggle with this?



A full understanding of the sensorial journey combines both routes

What are questions we are trying to answer?

- How does implicit bias affect healthcare disparities?
- How does implicit bias affect in teams?
- How can you manage implicit bias in your team?
- How does implicit bias affect treatment and teams in a pandemic?

Guiding Principles

Implicit Bias:

- Having them makes you human

- They have some utility

- They are malleable

Managing implicit bias:

- Provides a deeper understanding of your reactions

- Returns a sense of control and agency

- Empowering

- Leads to more fulfilling patient/provider/institutional relationships

What are the teams we have to consider?

Team: a group working together to achieve goal

- Provider lead-palliative care team
- Healthcare provider-Patient
- Patient-Caregiver
- Caregiver-Healthcare provider
- Healthcare provider-Healthcare institution
- Patient - Healthcare institution

When thinking about effects of implicit biases in healthcare we often focus on only the provider with the hope that if the provider is aware and manages their biases, that will be the key to an outcome.

Awareness of ones own biases allow for an opportunity have the best possible communication, but may not affect the outcome.

The awareness may lead to better understanding of patient, better patient advocacy, and acceptance of patient's point of view.

Unattended consequences of not addressing implicit bias in healthcare teams is that it erodes the foundation of what is needed to have healthy teams – **TRUST**



Implicit Bias in Healthcare: What do we know?

- In systematic review published in the American Journal of Public Health in 2015 concluded that: “Although some associations between implicit bias and healthcare outcomes were nonsignificant, results showed that implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient outcomes”
- A study showed that racial bias reduces empathic sensorimotor responses to patients complaints of pain

Avenanti et al. Racial bias reduces empathic sensorimotor resonance with other race pain. Current Biology 2010

Hall W. et al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. Amer J of Pub Health; 2015

Implicit Bias in Healthcare: What do we know?

- In a qualitative study of patient–doctor communication found that physicians' implicit pro-White bias on the IAT correlated with Black patients' perceptions of poorer communication and lower quality care
- Black patients were less satisfied with physicians who had low explicit but high implicit race bias, rating them as less warm, friendly, and team-oriented compared to physicians with equal degrees of implicit and explicit bias
- Study showed implicit stereotype based bias contributed to gender differences in the diagnosis of COPD, female patients were more likely to receive a diagnosis of asthma or a non-respiratory problem, while identical male patients were more likely to be diagnosed with COPD with same symptom presentation

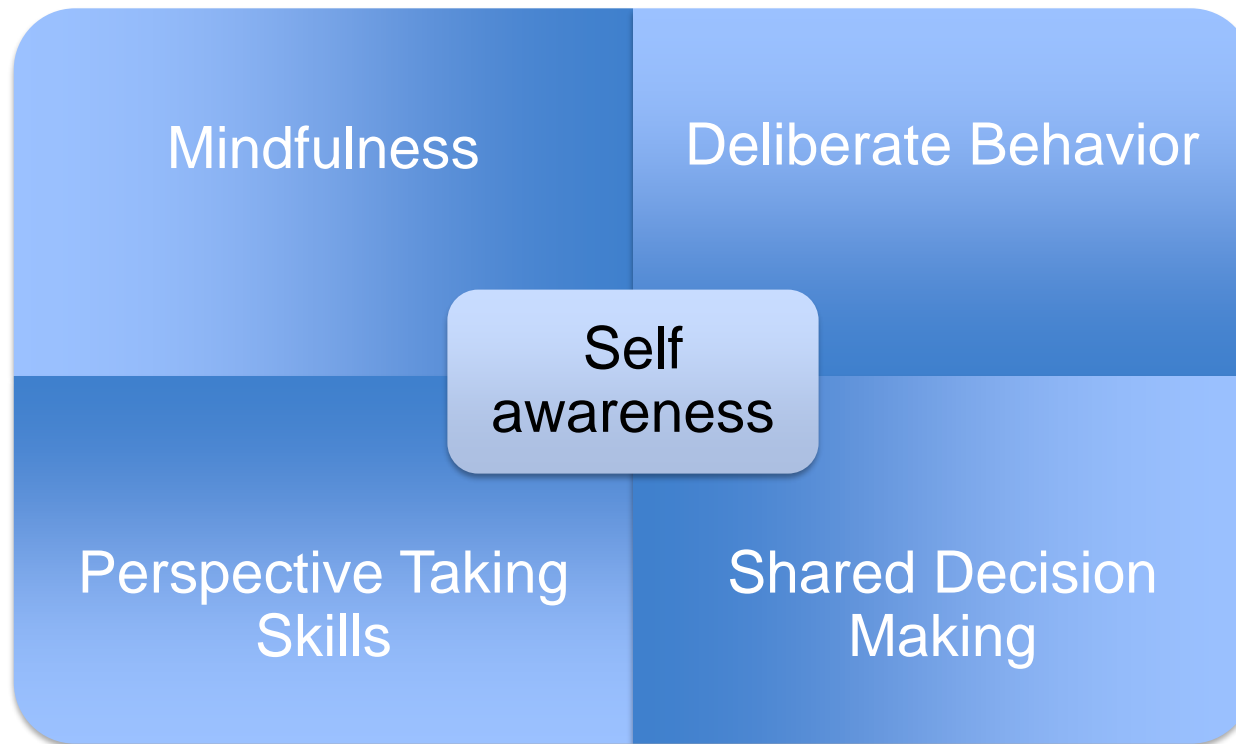
Cooper LA, Roter DL et al. The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health*. 2012;102(5):979–87.
Penner LA, et al. Aversive racism and medical interactions with Black patients: a field study. *J Exp Soc Psychol*. 2010;46(2):436–40
Chapman KR et al. Gender bias in the diagnosis of COPD. *Chest*. 2001;119(6):1691–5.

CASE

- Mr. Jackson is 52 yro male admitted to the hospital for the 5th time in the last 12 months with another COPD exacerbation
- Key elements: (*healthcare trigger words*)
 - “non-compliant”
 - “chronic pain”
 - “disability”
 - “angry”
 - “history of illicit drug use”

You are called by the ER provider, “He is here in the ED, we may have to intubate but he is wanting to leave. He is asking for pain meds. Can you come an figure out the goals?”

Strategy for managing Implicit bias



Self awareness

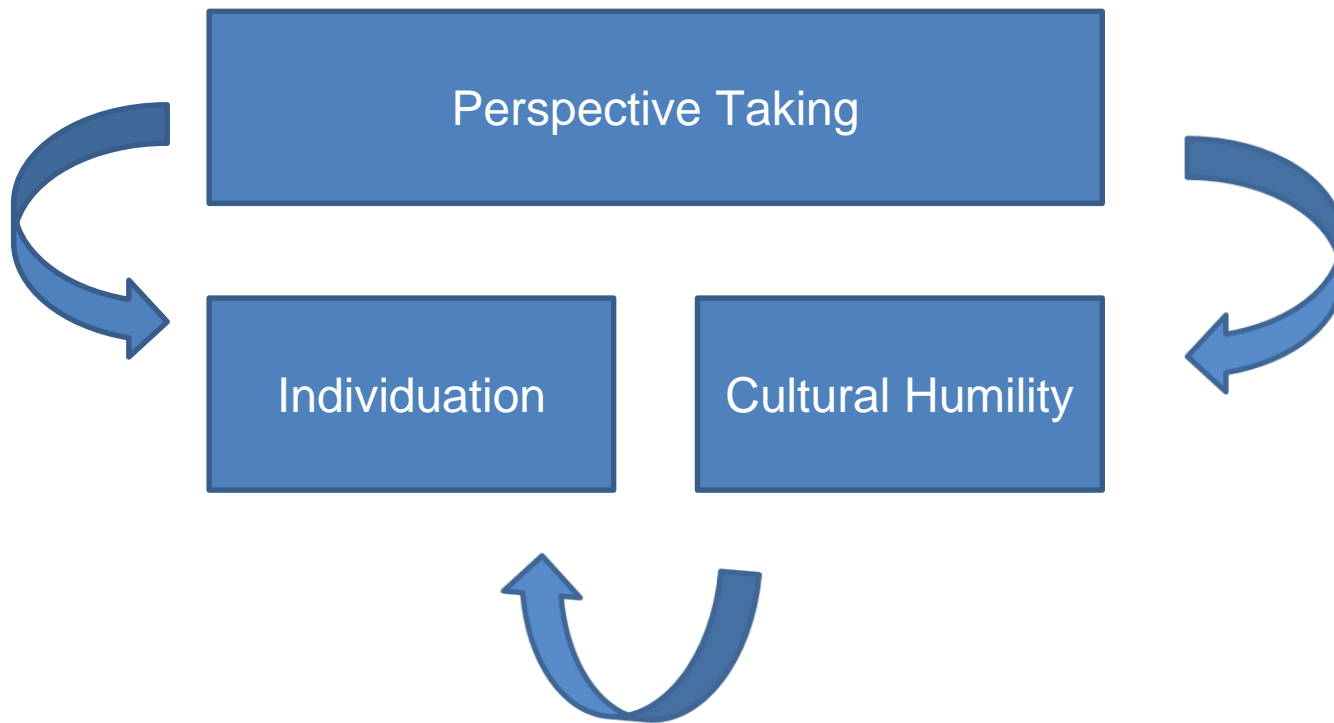
- Study by Michelle Van Ryn published in 2016 concluded that:
 - “Most physicians were unaware of their own biases”
 - “Research shows that unintentional bias on the part of physicians can influence the way they treat patient’s from certain ethnic and racial groups”

- Study in Journal of General Internal Medicine in 2013 reviewed literature on implicit bias pertaining to physicians which concluded:
 - “The contribution of implicit bias to healthcare disparities could decrease if all physicians acknowledge their susceptibility to it, and deliberately practice perspective taking and individuation when providing patient care”

How do you/team develop self awareness?

- The Implicit Association Test (IAT): measures attitudes and beliefs that people may be unwilling or unable to report. It can show an implicit attitude that person may not be aware
 - Confront one's own bias
- Pre-brief: prior to the consult being aware of your feeling (mindfulness)/discuss with IDT team
 - Deactivate the trigger words
 - Awareness how you felt receiving the consult
- Debrief: discuss your case with team members
 - Be open to challenges and different perspectives

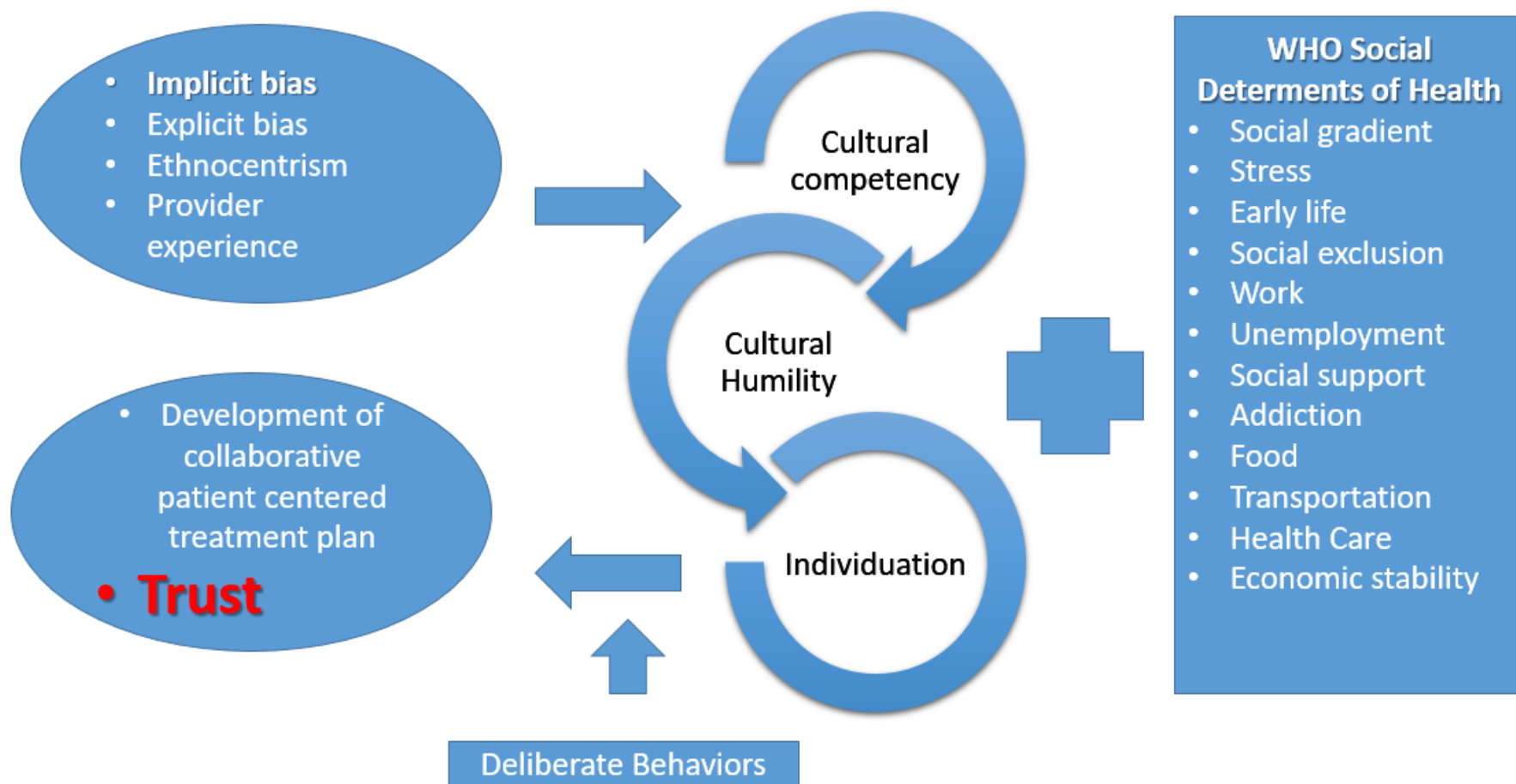
Perspective taking: ability to look beyond ones own point of view to consider how someone else may think and feel



Perspective Taking: “road to empathy”

- Individuation: involves conscious effort to focus on specific information about an individual, making it more salient in decision-making than that person’s social category information
- Cultural Humility: is defined as a person recognizing the limitations of their own understanding of how a person may define their own cultural identity. It’s a humble and respectful attitude towards individuals of other cultures that allows a provider to challenge their own biases and assumptions.

Tying it all together



Case

- Mr. Jackson is veteran and lives in rural Ga with his girlfriend. They have been heating the house with a wood stove, since she lost her job.
- He has been using medical cannabis for chronic back pain (gunshot injury in Iraq) under supervision of naturopathic provider which allowed him to stop opioids, but his supplier has been shut down, GA has no instate dispensaries
- He called the hospital back angry after his last discharge on a Saturday because he was discharged on several medications including opioids and an expensive antibiotic which non of the pharmacies in his area carry and they are not open on Sunday. He lacked transportation back to the hospital.

Case

“non-compliant”
“chronic pain”
“disability”
“angry”
“history of illicit drug use”

- He would prefer to be allowed to have natural death “when the time comes” and he is tired of hospitalizations. Since his girlfriend lost her job he is worried that without his disability she will be homeless
- He has a good relationship with his primary care at the VA. He wants to discuss prognosis with him. Also, he is compliant with the meds his VA PCP prescribes, he can’t fill medication from your system’s specialist at the VA.
- He trusts the doctors here, he just wants to understand what is happening. “They talk to fast, I am not always sure when I am sick. I’ll do it if I have to. I don’t know what my goals are...not to die today. Call Shelia...”

Do we always know what we think we know?

→ A recent qualitative study evaluating views of health disparities experts, community members, and African American patients and care-givers facing serious illness

— **Results:**

- Patients and caregivers: trusted their medical teams; wanted prognostic information communication; and expressed a desire to prepare for the EOL
- Health disparities experts: mistrust, spirituality, religiosity, desire to limit prognostication, and fatalism as barriers to effective advance care planning and more aggressive end of life care which is consistent with past literature base.

Pitfall of leaning too heavily on cultural competency versus leading with cultural humility.

“Even if our behavior doesn’t change the reasoning for it may with time.”

The Mirror Effect: Being mindful of biases allows us to consider that maybe it is not the patient's original feeling but a reflection of what is being shown to them.

*"If I suspect you don't trust me
I will not trust you.
If I suspect you will not talk to me
I will not talk to you.
If I suspect you will not
understand me.
I won't explain to you.
That is how I know you are who I
thought you were" --Kc*

- Study: Physicians were 23% more verbally dominant and engaged in 33% less patient-centered communication with Black pts than with White patients.
- Study: Deficiencies in professional training, ethical care, and clinical competence are underlying contributors to healthcare inequities that result in poor health outcomes for the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community

Johnson, R. L., Roter, D., Powe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient-physician communication during medical visits. *American journal of public health, 94*(12), 2084-2090. Mitchell, A., Somers, M., Bauder, A., & Lewis, D. (2018). Healthcare Professionals Working with LGBTQ Patients. *Journal of Advances in Medicine and Medical Research, 1*-5.

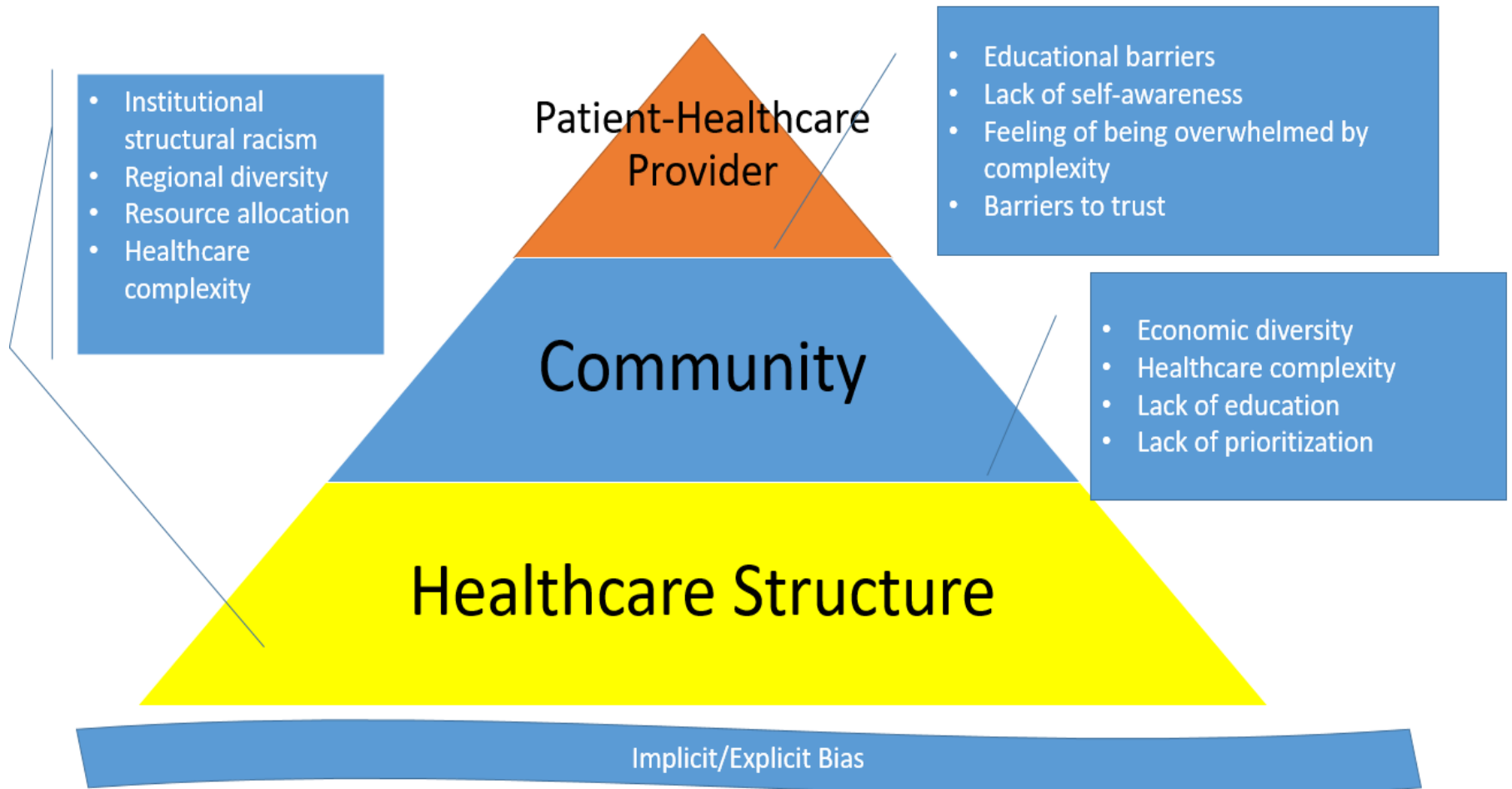
Individuation

- Although a person may belong to certain social class in society that does not mean that they are making decisions based on that framework
- Humans maybe apart of many social constructs the decisions they make under stress maybe made from a different value base, than when they are not under stress
- Cultural humility is vehicle that can get you to individuation
 - “*Cultural humility will help me understand you, individuation helps me understand the you that is making the decision at the time*”

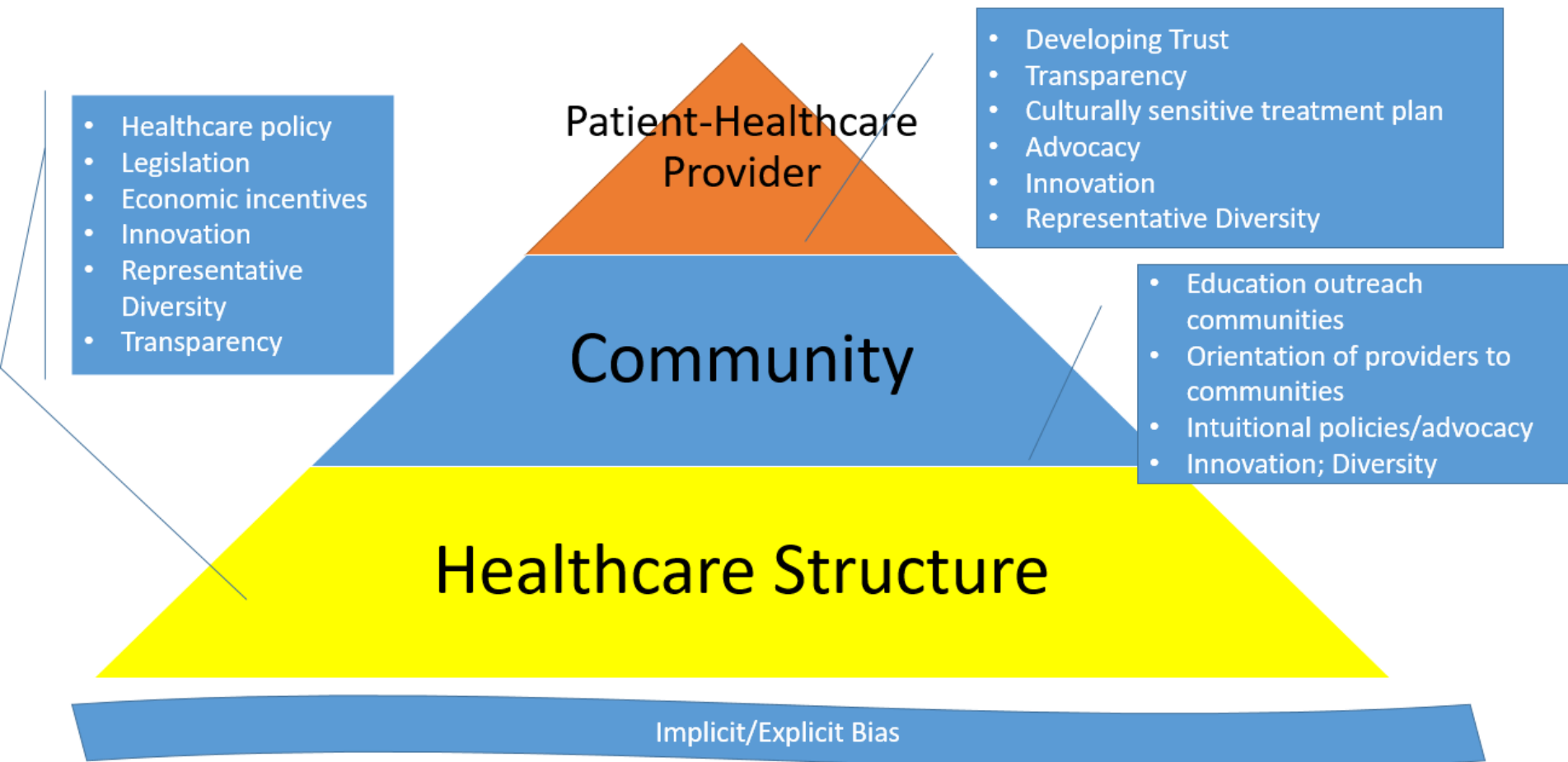
Deliberate Behaviors

- Many physicians and palliative care practitioners possess natural abilities that make them good communicators
- When communication is difficult natural skills may become unreliable, because we are uncomfortable. Relying on consistent communication techniques promote equitable delivery of service that doesn't rely on our feelings & talent
 - *“Fix your face and get your mind right. Feel how you feel, it matters what you do.”*
- Rely on deliberate behaviors such as: greetings, sitting with open posture, therapeutic silence, I am concerned/wish statements, empathic statements, communication tools etc...

Healthcare Disparities Pyramid



Healthcare Disparities Pyramid



What can I do?

→ Healthcare disparities: Healthcare structure

- Developing healthcare policies that focus on mitigating the social determinants of health
- Expanded insurance coverage
- Healthcare educational outreach to underserved communities
- Capitalize on palliative practices that align with goals of healthcare systems
- Financial incentives tied to reaching healthcare targets in underserved communities
- Stable proportional funding for healthcare in underserved communities
- Healthcare structures are created and made up of/by people; thus can be challenged, changed, and altered
 - ***Don't abdicate your own power, if you have an opportunity to get involved in committees, state, and national organizations do so***

What can I do?

- **Healthcare disparities: Community (patient community, healthcare community)**
 - Educational outreach to the communities
 - Faculty and trainee development courses
 - Diversity and inclusion training
 - IAT
 - Faculty and trainee orientation to community, healthcare system, institutional barriers to healthcare
 - ***“Can’t build a house if you have not surveyed the land”***
 - Encourage culture of transparency
 - Foster environment of inclusion and diversity
 - **Promote not only cultural diversity but also diversity of thought**

What Can I do?

→ Healthcare disparities: Patient

- *Name the disparity “Patients and families are not expecting a provider to answer for the injustice of disparities in healthcare but it can be important to acknowledge it and create space for expression”*
- Given the opportunity point out when a disparity exist
- Document fairly: don’t place information in a patient chart the can promote bias without an explanation – be an advocate
- Be proactive: once disparity is identified determine what can be done with in the system to mitigate it
- **Diversity in teams is important, but do not assume ethnic concordance will always ensure trust and connection. Be mindful that humans are multifaceted and have the ability to develop meaningful connections based on an variety of personal factors: religion, occupation, value system etc.....**

Oh and then there's the Pandemic

- Mr. Jackson presents back to the hospital in respiratory distress. He has an advanced directive from his last hospitalization which documented that he has elected to be DNR/DNI. There is documentation that his girlfriend and daughter were present when he completed it and they are at his bedside now. ED physician explains his poor prognosis and reviews his directive with them. ED physician recommends that he not be intubated according to his wishes. He also explains he is COVID 19 +.
 - Girlfriend: “ *Well you know his not going to get one now.*”
 - Daughter: “ *I am the POA you do everything for my father.*”
 - ED physician: “*Call palliative care.*”

Widely reported that COVID 19 is disproportionately affecting communities of color in the US

Structural Racism	Co-morbidities: more prevalent in African American and American Indian/Alaskan Natives
<ul style="list-style-type: none">• Essential worker status• Less access to health care• Less financial wealth• Decreased mobility• Housing segregation• Inadequate investment in communities<ul style="list-style-type: none">- Healthcare- Education- Infrastructure- Public safety	<ul style="list-style-type: none">• COPD• Asthma• Obesity• Heart disease• ESRD-HD• CKD• DM

Possible impact on patient and community perception

- Google search: 76,800,000 related to resource scarcity and allocation results: Few Titles
- The Harm Of A Colorblind Allocation Of Scarce Resources; Health Affairs Blog 4/30/2020
 - The Way We Ration Ventilators Is Biased: Not every patient has a fair chance, a *New York Times* opinion piece by Harald Schmidt, April 15,
 - A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic, by UPMC Endowed Chair for Ethics in Critical Care Medicine Douglas B. White and UCSF's Bernard Lo, published in *JAMA* March 27, with a related [JAMA podcast](#) on March 28

Implications of scarcity Resource allocation discussions

- If allocation of resources such as ICU beds, dialysis machines, ventilators become wide spread during the pandemic there is a concern that policies could disproportionately adversely affect disadvantaged minority communities
- Resource allocation policies that do not take into account health disparities may have this unintended consequence
- Implicit bias is at risk of affecting decision making if there are not safe guards i.e. (implicit bias training for allocation committees, diversity on committees; transparent processes that includes consideration of disparities)

Communication

- Tools we use to guide conversations implies an basic implicit trust- unspoken contract
 - “ I will ask you these questions and you have the agency to answer or not, there will be no adverse consequences from our conversation”
- Fear, societal racism, social class disparity, scarcity of resources may strain the boundaries of this contract
- Primary problem you may not know when this is happening
- Implicit/Explicit biases flow both ways in any human encounter.
 - Addressing only one of the parties biases may inhibit effective communication

Proposal- Pre Conversation Tool/Guide

1. Exploring:

- Take time to learn about the person who is the focus of the discussion
- Understand the place they hold in society, family
- Get a sense of what will be lost (the impact of their death)
- Ask to invite to the discussion with anyone who the patient/family feels will have strong opinions concerning their medical decisions

2. Name it:

- If there is no concern for resource scarcity; name that decisions are not being made based on resources availability, but recommendations are based on patient best interest
- If there is a concern be transparent, truth is hard but it can deepen trust/respect even when it is unpleasant
- Name that it may be hard to know what to trust

Proposal- Pre Conversation Tool/Guide

3. Reassure:

- State the terms of the contract out loud. “ I am here to help you navigate these decisions and I am invested in your goals. There is no a wrong answer. We are asking because we want to know how to support you. I am going to give you our medical opinion, because you should have all relevant information when making a decision...”
- Show of respect for their answer: We don’t have to agree, but we can always be respectful
- If the patient and family do not have a choice, make it clear that the conversation is to share information and to understand their point of view and comfort
- Be open to showing what you are going to document or share the tool “this what we are going to cover, are you open to covering this today or I am worried for you/love one is getting sicker, we should cover this today”

Proposal- Pre Conversation Tool/Guide

4. Acknowledge:

- Acknowledge the gravity of what your about to discuss
- Mentally keep the gravity of what we are asking of people and their caregivers, what we are asking them to accept
- We will have to accept the unintended consequence of resource allocation may damaged trust in communities - we will have to plan for healing
- Primary difficulty that these conversation take time and we often feel like we don't have it. Conversation that goes poorly will take more time to repair, than investing in a conversation that goes well.
- Sometimes we may not see the utility of the outcome from a difficult conversation; until we have seen the patient's course through

Summary

- Implicit bias may not be cause of healthcare disparities but may lay the foundation for their perpetuation
- Trust is the bedrock of every relationship personal and professional
- Identification of ones own biases can allow for better understanding of social interactions with patients and may remove the unintended barriers they create
- Concept of cultural humility and individuation are important tools to use when managing healthcare disparities
- Communication concerning EOL and resource allocation in communities affected by healthcare disparities may require special sensitivity

Thank you!