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Addressing Implicit Bias In Patient Care

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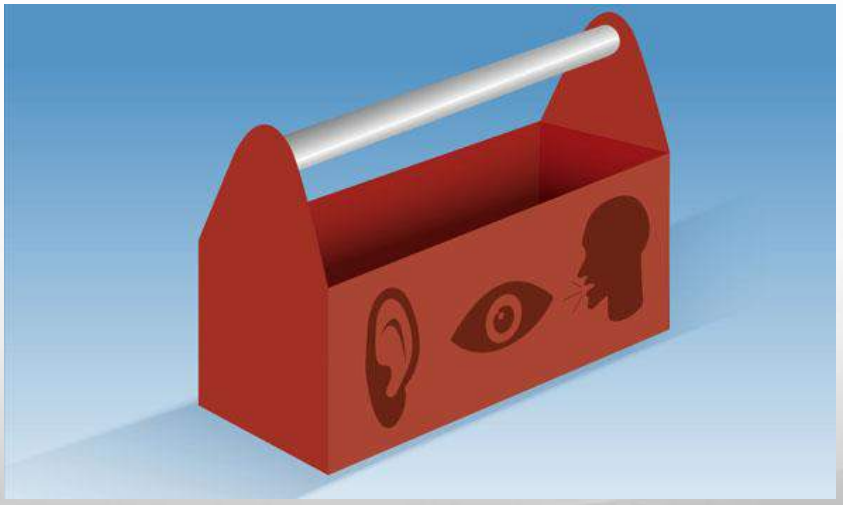
Outline For The Presentation

Examine the psychology of implicit bias as it relates to nursing

1. Verbal and nonverbal forms of implicit bias
2. When does it happen? What does it look like?
3. Discuss strategies for reducing implicit bias

The Automatic Bias Control (ABC) Toolkit



Examples of implicit bias in nursing

(Source: www.microaggressions.com)

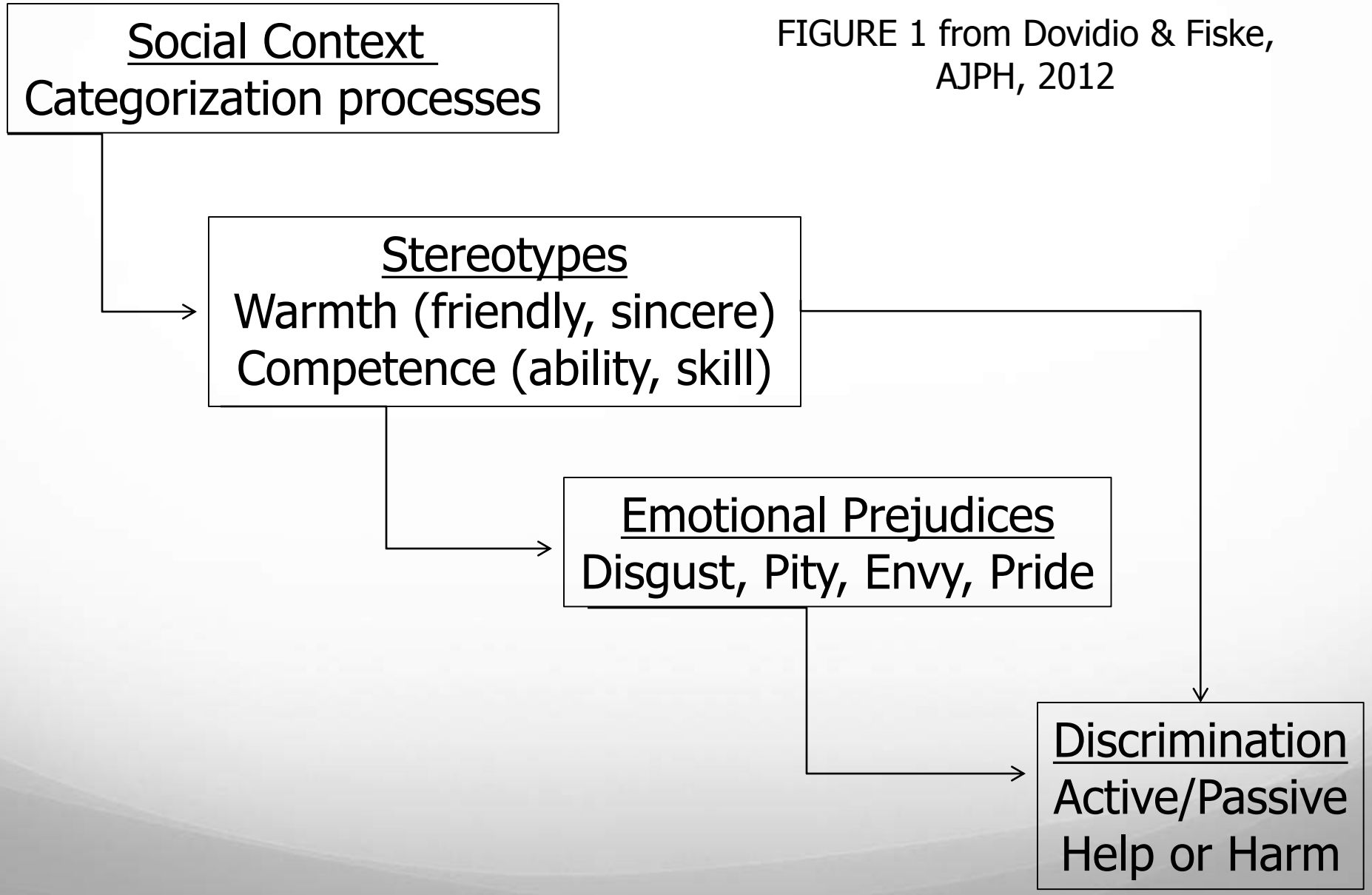
Nurse: Wow, so are you Indian?
Me: Yeah
Nurse: So, you've got a really nice mix going on in there, got anything else in you?
Me: No, I'm just Indian.
Nurse: Omg, I love India! I have this favorite story of these three guys that meet from different castes, you know how the caste system is...

"It's just a phase, you're too young to decide your sexuality, you should just have sex with men till you're sure." Said to me by a sexual health nurse when I was 22 (last year) when I refused contraception.

"When I was 14, I was rushed to the hospital with intense abdominal pains. I was placed in a wheelchair and whisked away from my parents by a young white nurse to get a CAT scan. She wheeled into an empty hallway and then stopped, put the brakes down, and stood in from of me with her hands on the armrests. Inches away from my face she said, "Listen, I know you're pregnant. You better admit it now or your baby will die on that cat-scan table!" Since I was already crying from the pain, I just nodded 'no'. She rolled her eyes and then dropped me off in the room. I ended up having a ruptured ovarian cyst."

The Psychological Steps to Intergroup Bias

FIGURE 1 from Dovidio & Fiske, AJPH, 2012



Is stereotyping patients always bad?

I Am a Racially Profiling Doctor
By Dr. SALLY SATEL (NY Times)

In practicing medicine, I am not colorblind. I always take note of my patient's race. So do many of my colleagues. We do it because certain diseases and treatment responses cluster by ethnicity. Recognizing these patterns can help us diagnose disease more efficiently and prescribe medications more effectively. **When it comes to practicing medicine, stereotyping often works.**

"When it comes to practicing medicine, stereotyping often works"

All stereotypes have a "kernel of truth"; they can be accurate and "functional" for anticipating how to interact with other people.

Two examples of when ***stereotyping*** *is* ***functional*** in patient care:

Epidemiology: the study of the patterns, causes, and effects of health and disease conditions in defined populations (i.e., social groups).

Cultural Competence: an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.

Categorizing a patient as a member of a group, and activating stereotypes or "knowledge about the group's health-related attributes," can help diagnose and treat the patient's condition.

Different ways to use group based information in patient care:

1. Schema-based processing (accurate)

Example from *The Challenge of Serving and Working with Diverse Populations in American Hospitals* by Geri-Ann Galanti, Ph.D. (1991)

A Chinese nurse told me about a Mexican woman who suddenly developed a severe condition requiring immediate surgery. The nurse, knowing that older Mexican women commonly view their husbands as the family decision-maker, told the physician she would call the patient's husband. The doctor told her it was unnecessary, saying that once he explained the situation to the patient, she would undoubtedly sign the consent form. The nurse ignored the physician and called the patient's husband anyway. When the physician finished talking to the patient and asked for her consent, the patient refused, saying she would wait for her husband. Since time was of the essence, the physician could not wait much longer before sending her to surgery. Fortunately, her husband arrived at that moment and convinced his wife to give consent for what turned out to be a successful surgery.

Had the nurse not acted upon her generalization of gender role patterns in traditional Mexican households, the patient's outcome might not have been as positive.

Different ways to use group-based information in patient care:

2. Stereotyping (inaccurate)

Example from *The Challenge of Serving and Working with Diverse Populations in American Hospitals* by Geri-Ann Galanti, Ph.D. (1991)

A 62-year-old female Mexican patient who had a bypass graft on her leg could have suffered serious complications had the nurse not acted, despite his stereotypes. When she awoke in the recovery room she began screaming in pain. Her nurse immediately administered the dosage of morphine the doctor had prescribed, but to no avail. He then checked her vital signs and pulse and found that all were stable. Her dressing had minimal drainage. To all appearances, the patient was in good condition. **The nurse soon became annoyed over her outbursts, stereotyped her as a "whining Mexican female who, as usual, was exaggerating her pain," and took no further action.**

After an hour of cries, the nurse called the physician. The surgical team opened her wound dressing to find a large amount of blood, which was pressing on the nerves and tissues in the area and causing her excruciating pain. She was immediately sent back to surgery. **Had the nurse held on to his stereotype** and the physician not discovered the problem, the patient could have suffered severe complications.

Stereotyping = Health Disparities

Stereotyping can lead to prejudice and unintentional acts of discrimination that create disparities in patient care.

You are most likely to "slip" into stereotyping when:

1. You have little information about a patient except group membership (e.g., an assessment or when "eyeballing" someone in the hallway)

2. You are physically and mentally tired

3. You are cognitively overloaded (multitasking)

4. You are working quickly

Explicit vs. Implicit Bias

Our minds are governed by two systems of thinking (Kahneman, 2012):

System 1: Reflexive system for automatic thinking

- Very fast; Requires little effort and no motivation
- No sense of Agency, Control or Concentration
- Often nonconscious, implicit

System 2: Reflective system for controlled thinking

- Effortful, requires motivation
- Characterized by a sense of Agency, Choice and Concentration
- Conscious, explicit

The Reflexive System 1 Uses Implicit Associations

- Associations = Cognitive links between concepts
- Activate or “bring to mind” one concept, other con[illegible]o

CATEGORIZATION

Stereotypes:

- Non-compliant
- Uninsured
- Risky Health Behavior
- Poor language skills
- Distrustful

Activation of associations happens outside of conscious awareness (implicitly)

…can be at odds with conscious goals

…can influence judgment and behavior

Measuring Implicit Bias

- The Implicit Association Test (IAT)

  Greenwald, McGhee, & Schwartz (1998)

  - Measures strength of association between concepts
  - Based on premise that associated concepts will be easier to categorize together

Measuring Implicit Bias

The Implicit Associations Test (IAT)

Phase 1: Categorize Obese & Thin words

Phase 2: Categorize Good & Bad words

Phase 3: Simultaneous categorization – stereotype congruent

Phase 4: Recategorize Thin & Obese words

Phase 5: Simultaneous categorization – stereotype incongruent

Implicit Bias: Slower reaction time on **incongruent trials** compared to **congruent trials**

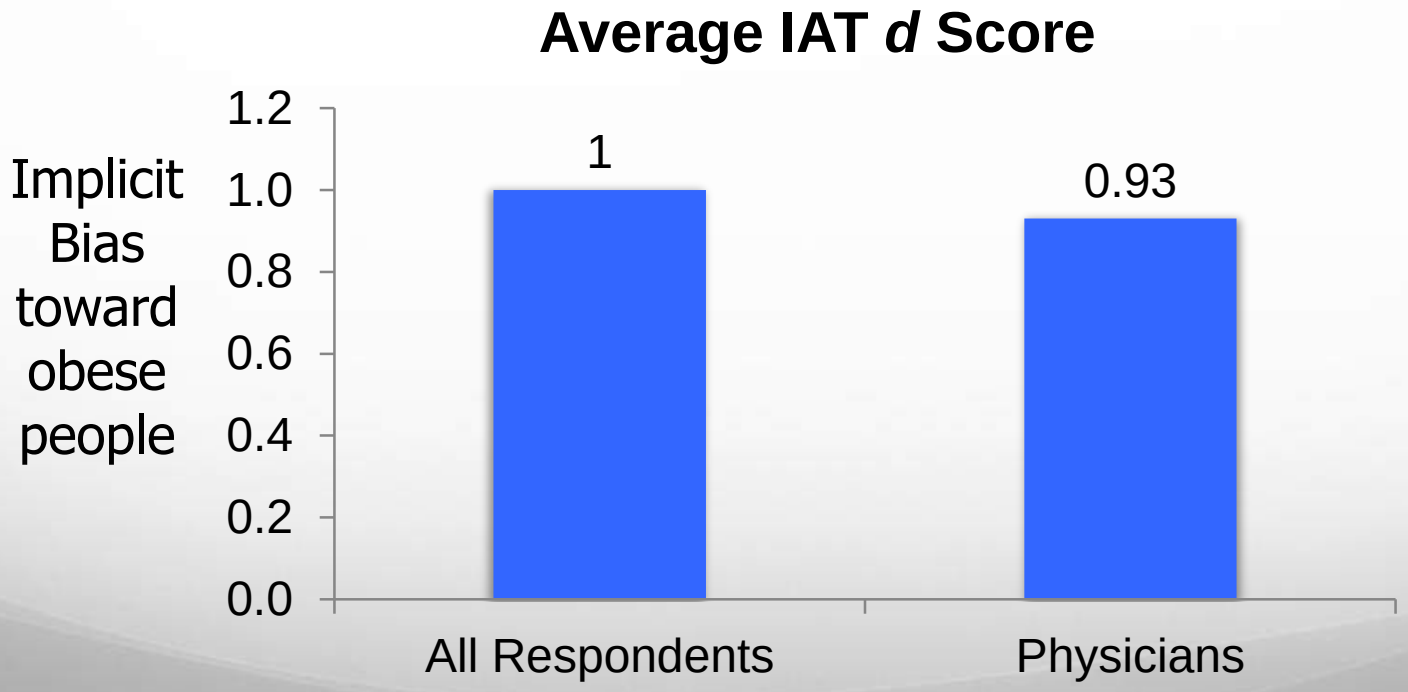
- Metric: *d score* = Incongruent trials – congruent trials
- Positive score = Higher implicit bias

- *d* score does not depend on order of words/faces/stimuli
- IAT has the highest reliability and predictive validity of all implicit measures

Implicit bias against obese people

Sabin, Marini, & Nosek, 2012, Plos One

- 359,261 North Americans (online)
- 2,284 Physicians
- IAT: Thin = good vs. obese = good



Implicit Bias Among Healthcare Professionals

Publication	Sample size	Participants	Target Group	d score
Fitzsimmons (2007)	170	Nursing faculty	Dark v. Light skin minorities	0.35
Sabin et al. (2008)	43	Residents and faculty in pediatrics	African Americans	0.18
Blair et al. (2013)	210	PCPs in family and internal medicine	Hispanics	0.33
Brener et al. (2007)	60	Nurses and doctors in drug and alcohol clinic	Injecting drug users	0.36
Von Hippel et al. (2008)	44	Nurses in drug and alcohol clinic (Australia)	Injecting drug users	0.26
Peris et al. (2008)	1089	Mental health clinicians	“Mentally ill people”	0.17
Siriram et al., (2015)	142	Health Care Providers	Women with lung cancer	.33

Implicit Bias Affects Assessment And Intervention Decisions

Green et al. (2007, Annals of Internal Medicine) 287 internal medicine & emergency medicine residents completed a African-American/White – Good/Bad IAT:

- All read a scenario about an African-American or White patient who was experiencing chest pains related to coronary heart disease.

- Physicians with high implicit bias toward African-Americans were less likely to recommend thrombolysis for the African-American patient than for the White patient who had the same history. (passive harm/neglect)

Sabin & Greenwald (2012, Am Jrnl of Pub Health) 86 pediatricians completed a African-American/White – Good/Bad IAT:

Physicians with high implicit bias towards African-Americans were more likely to prescribe ibuprofen over a narcotic to treat post-surgery pain for a African-American compared to a white patient (passive/harm neglect)

Effect of implicit bias on interactions between providers and their patients

Degree of Explicit Bias

Predicts

Verbal Behavior: What is Said

Predicts

Your view of the Interaction

Degree of Implicit Bias

Predicts

Nonverbal Behavior: How it is Said

Predicts

Their view of the Interaction

Effect of implicit bias on interactions between providers and their patients

Cooper et al. (Am Jrnl of Pub Health, 2012)

- 40 Physicians completed IAT measures of implicit prejudice and implicit stereotyping of African-American patients (African-Americans = non-compliance)

- 211 African-American and 56 White patients of the physicians completed post-visit measures of patient satisfaction

- Audio-taped clinical visits between physicians and African-American/White patients. Coded for nonverbal indicators of bias.

Evidence that implicit bias leaks into interactions between providers and their patients (Cooper et al., 2012, AJPH)

For physicians with higher implicit prejudice against African-American patients:

Coders identified:

- 9% more verbal dominance over African-American compared to White patients
- Less positive emotion toward African-American compared to White patients

Compared to White patients, African-American patients reported:

- 15% lower perceived respect from their physician
- 14% less liking for and 9% lower confidence in the physician

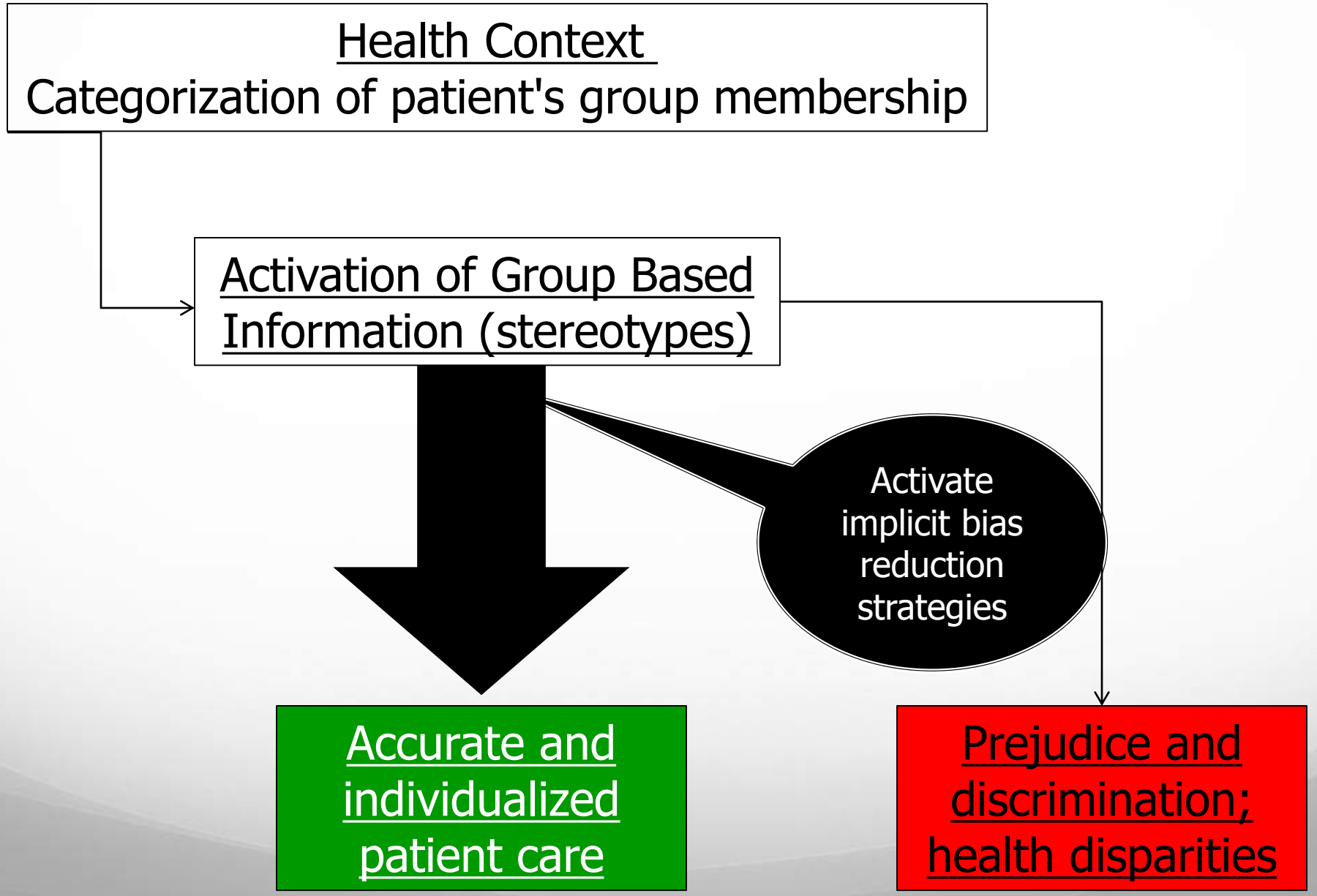
For physicians with higher implicit stereotyping of African-American patients:

Coders identified:

- 20% longer visits and slower dialogue w/ African-American vs. White patients
- But 12% less patient centered dialogue w/ African-American vs. White patients

Compared to White patients, African-American patients reported 10% less trust and 8% lower confidence in their physician

Reducing implicit bias



Strategies for overriding bias

Step 1: Be **aware** of the potential for bias before, during and after contact:

When directly interacting with stigmatized patients

Is this the only time?

Bias also occurs when forming impressions of stigmatized patients in their absence:

- Reading reports/charts/labs
- Discussing a patient with a colleague

Strategies for overriding bias

Step 2: Be **motivated** to control bias

- Initiate a strategy to inhibit intergroup bias
  - Strategies that help you individuate people

Strategy #1: *Activate your* **Egalitarian Goals**

- Goal to be fair, just and impartial toward others

- Egalitarian goal activation directs thought, emotion and behavior toward being fair, just and impartial

Strategies for overriding bias

Strategy #1: The steps to activating **Egalitarian Goals**:

1. Learn to associate stigmatized individuals and groups with the potential for bias:

Upon contact, deliberately think about fairness and justice

- Association activates your egalitarian goals
- Slows down and individuates your thinking

2. Practice makes perfect: Over time, activation of egalitarian goals can become automatic when encountering members of stigmatized groups

Strategies for overriding bias

Strategy #2: Look for a **common identity**

- Identify group memberships, interests and/or activities you share in common with a stigmatized groups
- Re-categorizes out-group members as an in-group members -> positive attitudes & emotions
  - Facilitates partnerships and team work

Strategies for overriding bias

Strategy #2: Look for a **common identity**

Applications:

- Inquire about shared interests, activities, or common group memberships
- Share a related experience or emotion that may resonate
- Offer collaboration or partnerships

Strategies for overriding bias

Strategy #3: **Perspective taking**

Viewing the world through the eyes of a stigmatized group or individual

- Slows processing and induces *empathy*

This is an American Indian patient battling diabetes:

Imagine a day in the life of this person as if you were her, looking at the world through her eyes and walking through the world in her shoes.

Strategies for overriding bias

Strategy #4: Acquire **counter-stereotypic attributes**

- How is this person, family or community different from the stereotypes about their group?

  E.g., is he/she/they competent, warm, and/or positively unique?

- Slows down processing and individuates thinking

<u>Applications</u>:

Ask people about, or look for, counter-stereotypic attributes or behaviors

Reducing Others' Bias

Use the strategies we just covered to reduce implicit bias in other people:

- Activate *their* egalitarian values or goals
- Help *them* see a common-identity
- Get *them* to take the perspective of the group
- Have *them* generate a counter-stereotypic attribute

Interpersonal Confrontation

- Confrontation is expressing, verbally or non-verbally, dissatisfaction with prejudicial and discriminatory behavior to the person who is responsible for a biased remark or behavior

- Research indicates that there are both benefits and costs when using confrontation to reduce bias

Benefits of confronting others about bias

- Confrontation motivates change when it elicits feelings of guilt or sadness.
- Confrontation makes people aware of their biases and, in some circumstances, helps them to self-regulate their behavior

Costs of confronting others about bias

- People who are confronted feel threatened!
- Confrontation can backfire against the group!
- People who confront are labeled as "complainers"

How can you effectively confront people about bias?

Affirm their self-integrity before you confront them

Affirmation = questions or comments that allow people to think about their most positive and cherished qualities

Once self-integrity is affirmed, people are

- less threatened by information that challenges their self-esteem or deeply held convictions
- more open-minded and willing to consider alternative viewpoints

Using affirmation to confront

The "icebreaker approach" to inducing affirmation:

1. Start by asking questions, or making a comment, that allows the person to self-affirm important positive attributes:

   Example: "You did great with some difficult patients today. How did you come up with solution XX?"

2. Confront about bias (Gently!): "I thought there was one patient that might have gone better...."

3. Re-Affirmation question or comment to reduce any lingering threat or negative emotion

Strategies for overriding bias
Bringing it all together

Strategy #5: **Implementation Intentions**

If-Then statements that promote goal achievement

Create implementation intentions to achieve your egalitarian goals by using the strategies reviewed today:

Example: "When I evaluate/interact with members of an stigmatized group, then I will:"

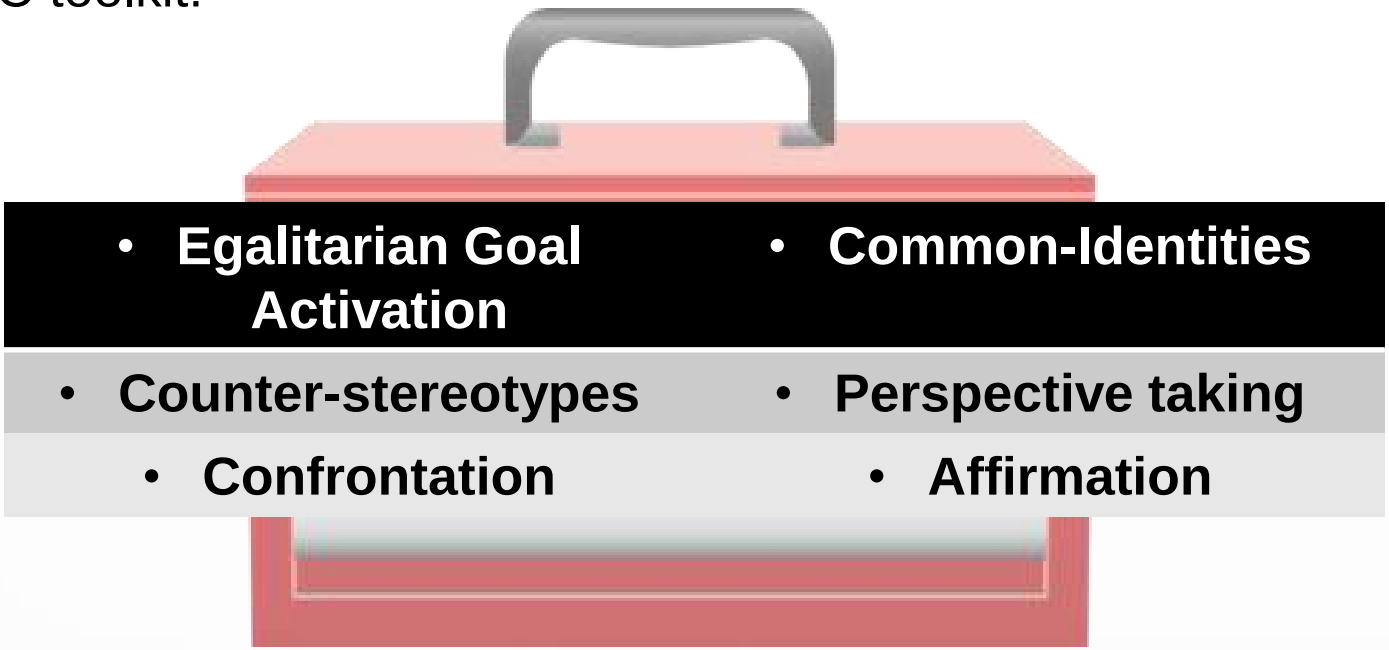
"…. achieve my egalitarian goals by looking for a common-ID and counter-stereotypic information, and by taking his/her/their perspective!"

Take-away Points

- We <u>all</u> have intergroup biases due to cultural exposure
- Implicit (nonconscious) bias is distinct from explicit (conscious) bias
- Implicit bias can leak into judgment and behavior outside of awareness
  - Especially when we have little information and/or are tired, overloaded, or working quickly

Take-away Points

You can <u>control</u> implicit and explicit bias by **making plans** to use strategies in the ABC toolkit:



- All bias reduction strategies require awareness and motivation as you learn to use them
- <u>But with practice</u>, they can become your automatic response to stigmatized patients