

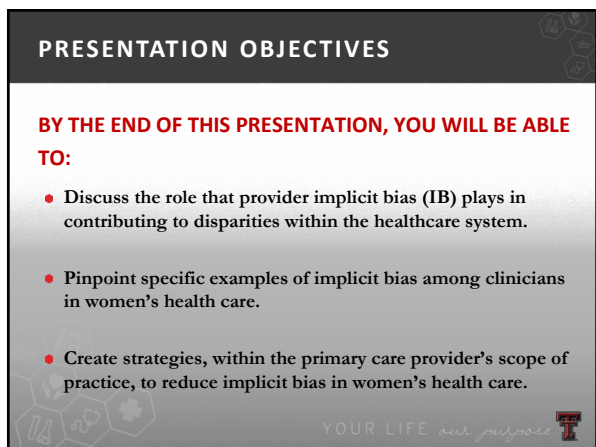


TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
School of Nursing

**IMPROVING ALL OF US:
CONFRONTING IMPLICIT BIAS IN THE CARE OF WOMEN**

Rebecca H. Burpo, DNP, APRN, CNM, FACNM

The slide features a grey background with a pattern of white hexagons. In the top left and bottom right corners, there are clusters of hexagons containing icons: a heart, a stethoscope, a caduceus, and a pair of hands. The Texas Tech University logo is in the top right.



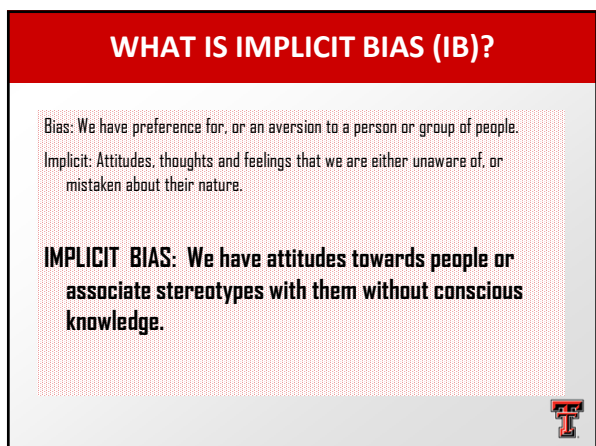
PRESENTATION OBJECTIVES

BY THE END OF THIS PRESENTATION, YOU WILL BE ABLE TO:

- Discuss the role that provider implicit bias (IB) plays in contributing to disparities within the healthcare system.
- Pinpoint specific examples of implicit bias among clinicians in women's health care.
- Create strategies, within the primary care provider's scope of practice, to reduce implicit bias in women's health care.

YOUR LIFE and purpose

The slide has a dark grey header with the title 'PRESENTATION OBJECTIVES'. The main content is on a light grey background with a subtle hexagonal pattern. At the bottom, there is a quote 'YOUR LIFE and purpose' and a small Texas Tech logo.



WHAT IS IMPLICIT BIAS (IB)?

Bias: We have preference for, or an aversion to a person or group of people.
Implicit: Attitudes, thoughts and feelings that we are either unaware of, or mistaken about their nature.

IMPLICIT BIAS: We have attitudes towards people or associate stereotypes with them without conscious knowledge.

The slide has a red header with the title 'WHAT IS IMPLICIT BIAS (IB)?'. The text is on a light grey background with a subtle hexagonal pattern. A small Texas Tech logo is in the bottom right corner.

WHAT IS IMPLICIT BIAS (IB)?

Synonym: Unconscious Bias

This is separate from institutional or structural bias, which refers to the way the entire system operates against certain groups.

But the two are complementary.

A diagram consisting of three red circles. On the left, two smaller circles are stacked vertically, labeled 'Structural racism' (top) and 'Implicit Bias' (bottom). A white plus sign is between them. An arrow points from this pair to a larger circle on the right labeled 'Worse outcomes'. A small 'TT' logo is in the bottom right corner.

BUT THAT'S NOT ME!

<https://youtu.be/1JVN2qWSJF4>

A light blue speech bubble with a wavy border containing the text: "Recognition of implicit bias is not meant to evoke guilt, but to spur on awareness and a commitment to overcome its effects."

Providers Core Value: Equality
Explicit Bias: Rare

A small 'TT' logo in the bottom right corner.

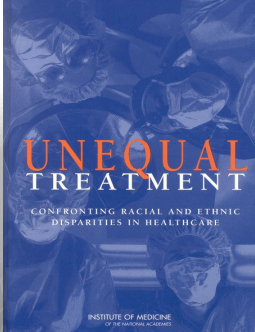
A collage of four photographs showing healthcare workers in various settings: a nurse at a computer, a doctor with a patient, a nurse with a patient, and a doctor with a patient.

ATTITUDES
BEHAVIORS

IMPLICIT BIAS EFFECT IN HEALTH CARE OVERALL

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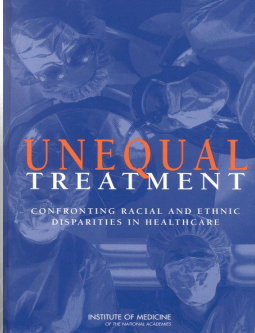
INSTITUTE OF MEDICINE



- Smedley, Smith, & Nelson (2003)
- Health disparities exist in part due to lower quality healthcare provided to racial/ethnic minorities than to White Americans, often due to implicit racial bias among individual healthcare providers.

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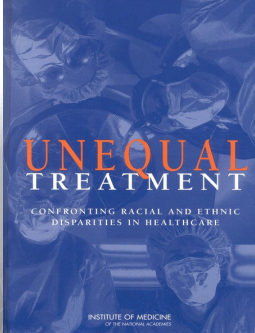
INSTITUTE OF MEDICINE



- Ethnic/racial differences observed AFTER controlling for economic, educational, & access differences.
- AA were perceived more negatively than White patients.
- Treatment recommendations for hypothetical Black patients differed significantly from those provided to White patients.

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INSTITUTE OF MEDICINE



- Ethnic/racial minorities: greater dissatisfaction with their providers, especially if not the same ethnicity.
- Nearly twice as likely to report comm. problems with providers.
- Nearly twice as likely to feel they had been treated with disrespect at a recent visit.
- 14 times more likely to believe care would have been better with someone of their ethnicity

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OTHER PSYCHOLOGICAL BIASES

Harvard: Research on Implicit Bias since 1998 (Implicit Association Test) (23)

Zesticott, Blair, & Stone. (2016). Examining the Presence, Consequences, and Reduction of Implicit Bias in Health Care: A Narrative Review (24)

- Age
- Gender
- Obese individuals
- Sexual orientation
- Lower social class
- Injecting drug users
- Wheelchair users with spinal cord injuries

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LET'S START WITH ATTITUDE!

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ATTITUDES & PERCEPTIONS

- Prefer young, thin, white male patients.
- Associate Hispanics with noncompliance and risky health behavior. (1, 24)
- Stereotype obese people as lazier, more stupid, & more worthless than thin people. (20, 24)
- Blame people for obesity (7)
- Blame patients for being passive (20)
- Regard AA pts. as less compliant and less cooperative than White. (1, 24)
- Associate AA more with being HIV + & with drug abuse. (24)
- Assume AA women are less interested in breastfeeding. (2)

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BEHAVIORS


- Biased behaviors worse in fast-paced, stressful environments with cognitive overload (e.g. E.D., L&D) (1, 13)
- Biased behaviors worse when no established relationship and no care guidelines. (13)
- Medical & nursing students increased their IB during school. (24)
- Providers with high IB had higher talk-time ratio (verbal dominance) with AA patients. (1, 24)

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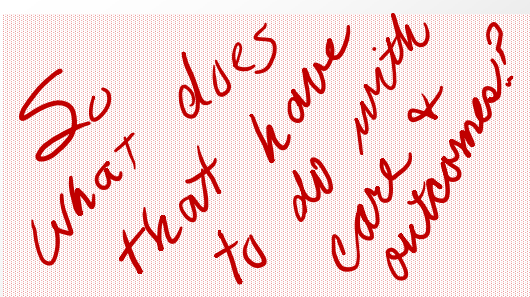
PATIENT PERCEPTIONS


- Less satisfaction and trust with providers who did not connect with them and who talked down to them. (1, 5, 24)
- Preferred language and racial/ethnic concordance. (1, 3, 24)
- Racial/ethnic pregnant minority women perceived disproportionately greater discrimination in the following circumstances (4)
 - Diabetic
 - Hypertensive
 - Uninsured
 - First time mothers



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Research over the past two decades has shown that our unconscious thoughts can impact the quality of care we provide—and we don't even realize it is occurring.




ROLE OF PROVIDERS IN CONTRIBUTING TO HEALTH DISPARITIES



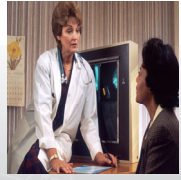
EQUALITY IS A CORE VALUE.

PARADOX : WHY ADVERSE OUTCOMES ?


- Interactions
- Treatment/Care
- Documentation

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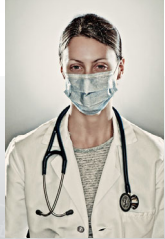
PATIENT-PROVIDER INTERACTIONS



- Disease-centered interactions (5, 17)
 - *Vs patient-centered*
- Non-verbal behaviors (12, 18, 20, 24)
 - *impact interactions with older women;*
- Ad hoc interpreter use (13)
 - *Misinformed >50% of time when family or friends interpret.*
- Informed consent lacking (11, 13)
 - *<10% of primary care visits met definition*

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CARE/TREATMENT



- Less option discussions
- Different treatment decisions for same clinical presentations
- ACOG investigation: OB/GYNs counseled women differently on treatment options, such as contraception, VBAC, and fibroid management. (2)

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DOCUMENTATION



- "My Charts" not understandable
- Documentation often misses patient-reported data that could improve measures. (3, 13)
 - Preferred language,*
 - Sexual orientation,*
 - Gender identity,*
 - Racial/ethnic identity*

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DOCUMENTATION




- Alternatively, biased documentation may contribute to insufficient treatment approaches (15, 17)

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But how do all these impact health outcomes?



EXAMPLES of OUTCOMES Associated with IMPLICIT BIAS

<p>Persons of Color</p> <ul style="list-style-type: none"> • Less access to COVID-19 testing (15) • Fewer cardiovascular interventions (20) • Less likely to receive appropriate cardiac medications (13) • Less thrombolysis (11, 20, 24) • Fewer renal transplants (20) • Less peritoneal dialysis (13) • Less pain medications (12, 20, 24) 	<p>Women</p> <ul style="list-style-type: none"> • Women 3x less likely to receive knee arthroplasty when clinically appropriate (20) • Regardless of ethnicity, women are more likely than men to experience biased interactions and treatment in care overall (1)
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**INTERACTIONS
CARE/TX/OUTCOMES**

IMPLICIT BIAS EFFECT IN WOMEN'S HEALTH



EXAMPLES of RACIAL/ETHNIC DIFFERENCES IN WOMEN'S HEALTH



- Less pain management services (2,24)
- Less diagnostics, minimally invasive treatment, & more severe treatment for leiomyomas in Black women (2)
- More infertility (3)
- Black women more likely to die after diagnosis of breast cancer, cervical cancer, and endometrial cancer. (2,3,18)
- More diabetes-related deaths (3)

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EXAMPLES of RACIAL/ETHNIC DIFFERENCES IN WOMEN'S HEALTH (cont.)



- Paternalistic counseling on family size (19)
- Less access to contraceptive care (2,3)
- Advising more LARCs without options/shared-decision making (19)
- Provider-Resistance to removing LARCs (19)
- Less preconception counseling
 - *in primary care visits with minority women.*

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ETHNIC/RACIAL EXAMPLES IN MATERNITY CARE

- Higher maternal mortality (13, 18)
 - *Blacks 3-4 x more likely to die from pregnancy-related causes*
- Higher maternal morbidity (13)
 - *Blacks have >2-fold risk of severe maternal morbidity*
 - *Blacks have higher PPH, puerperal infection, venous thromboembolism*
- Poorer infant outcomes (2,3,18)
 - *Higher prematurity*
 - *Higher infant mortality*
 - *Fewer well-baby visits after perceived discrimination*

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ETHNIC/RACIAL EXAMPLES IN MATERNITY CARE (continued)

- Less likely to receive progesterone for prevention of preterm birth (13)
 - African-American women
- Less support for VBAC (17)
 - African-American and Hispanic/Latino women
 - OB calculators deduct points
- Less epidural options (13)
 - Hispanic women
- More episiotomies (13)

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ETHNIC/RACIAL EXAMPLES IN MATERNITY CARE (continued)

- More Cesarean births (2,3)
- Less education on breastfeeding (21)
 - African-American women
- Less referral for lactation support (21)
 - African-American women

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But how do we know it's a problem? May be women are happy w/ this.

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HOW WOMEN RESPOND TO BIAS


- Higher treatment dropout
- Lower participation in screenings
- Avoidance of health care
- Delays in seeking health
- Not filling prescriptions
- Lower quality ratings, citing discrimination/bias and mistrust of the provider

(1.5.20.21)

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OK,
How
can we
fix it?



THE GOOD NEWS!

Implicit bias is not a fixed trait.
It can be adapted with deliberate effort.

When we give ourselves permission to improve, we become empowered.



STRATEGIES TO REDUCE

Awareness Behaviors Roving Leadership

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I. AWARENESS

LEARN ABOUT OUR BLIND SPOTS

A. Introspection
B. Education

1. Take IAT
2. Seek C.E. on Implicit Bias
3. Continue educating/reading over time

Reflect

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I. AWARENESS

BE PRESENT

C. Mindfulness

1. Be present at encounter
2. Single task/slow down
3. Set an alarm reminder
4. Make stress your friend
5. Feel gratitude
6. Cultivate humility
7. Accept what you can not change
8. Adopt a growth mindset

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I. AWARENESS

LOOK AROUND

D. Assess your workspace






1. Where do you sit (or do you stand?) to conduct an encounter?
2. Where does the woman sit during the encounter?
3. What supplies, arrangements, set-up demonstrates respect for the visitor?
4. How does your documentation system affect interactions?
5. Does your system allow the woman access to online appointments, information she can understand, her records, etc.
6. How are appointments made and what flexibility is present for unforeseen emergency/difficulties?
7. What message does the artwork in your workspace send?

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II. BEHAVIOR

RELATIONSHIP-BUILDING

- A. Start with individualizing the person.
 1. Preferred name
 2. Identity (Ethnic, gender, sexual, etc.)
- B. Practice reflective listening.
- C. Inquire about social determinants.
- D. Include questions about culture, life, well-being, and experiences.
- E. Take personal notes to remember her at next visit.

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II. BEHAVIOR

IMPLEMENTING THE CARE/TREATMENT:

“Walk a Mile in my Shoes”

- F. Language concordance: live, iPad, phone interpreters (NO Ad hoc)
- G. Use guidelines, checklists, protocols to ensure complete care
- H. Practice shared-decision making, honoring stories & life experience.
- I. Offer full range of evidence-based options.
- J. Give time to consider options; avoid coercion.

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II. BEHAVIOR

IMPLEMENTING THE CARE/TREATMENT

- K. Offer patient decision aids if available**
- L. When discussing disease, address/ask about the emotional impact.**
- M. Avoid "deficit discourse"**
 - 1. Disempowering words that emphasize deficiency, risk, & failure*
 - 2. Over time becomes dominant view and may become the only position*
 - 3. Ignores larger system inequities and oppression*
- N. If woman is pregnant, focus on woman as well as fetus.**

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II. BEHAVIOR

CLOSING THE VISIT

- N. Perform teach back before leaving.**
 - 1. What is my main problem?*
 - 2. What do I need to do?*
 - 3. Why is it important for me to do this?*
- O. Review record/documentation**
 - 1. Identification information complete and accurate*
 - 2. Elimination of wording in encounter note that may bias future care (hegemony)*
- P. Aim for continuity of care with future visit**

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II. BEHAVIOR

- Q. Annual or bi-annual review**
 - 1. Components of preconception counseling*
 - 2. Components of informed consent*
 - 3. How to present risk/benefits*
- R. Create preconception counseling expectations for all reproductive age women**
- S. Invest time in reproductive life plan talk at well-woman visits for all reproductive age women**

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III. ROVING LEADERSHIP

INITIATE CHANGE & IMPROVE QUALITY

- A. Implement quality and safety bundles in workplace
- B. Engage in q.i. project that facilitate disparity reduction
- C. Re-examine institutional/hegemonic practice of fragmentation of
CARE --Worsens poor outcomes for economically disadvantaged women.

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III. ROVING LEADERSHIP

ENACT DIVERSITY

- D. Admit/hire racially, ethnically, and language concordant students/providers/staff
- E. Faculty: Take lead in initiating deliberate, coordinated efforts to address implicit bias among all faculty, students, preceptors, staff.
- F. Faculty: Thread content throughout curriculum. More effective if begins with "power & privilege" first. (8)

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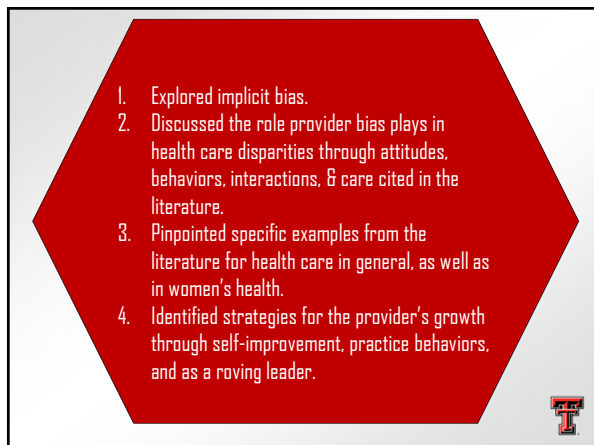
III. ROVING LEADERSHIP

ADVOCATE

- A. Development of institutional councils or committees to create a comprehensive institutional/system approach to dismantling structural racism/bias.
- B. Local, state, federal policies that address social determinants of health and reduction of structural racism.

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1. Explored implicit bias.
2. Discussed the role provider bias plays in health care disparities through attitudes, behaviors, interactions, & care cited in the literature.
3. Pinpointed specific examples from the literature for health care in general, as well as in women's health.
4. Identified strategies for the provider's growth through self-improvement, practice behaviors, and as a roving leader.

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