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Exclusive Webinar Presentation

Does Hidden Bias Impact Clinical Care?

Presented by Janice A. Sabin, PhD, MSW, and Nina M. Crowley, PhD, RDN, LD

Continuing Education Webinar

Implicit Bias in Health Care

Janice A. Sabin, PhD, MSW

- **Affiliations:** Research Associate professor, Dept. of Biomedical Informatics/Medical Education, UWSOM Center for Health Equity, Diversity & Inclusion, and University of Washington.
- **Disclosure:** Dr. Sabin has no relevant disclosures to report regarding this program.

Learning Objectives

1. Identify situations in which provider bias may impact clinical care.
2. Understand the unique nuances of interacting with obese patients and counseling them about weight.
3. List five strategies to improve communication and minimize the impact of bias on interactions with patients.

Where Implicit Bias May Operate in Health Care

- Clinical (health care disparities, treatment)
- Hiring (diversity)
- Evaluation of others
- Promotion (career advancement)
- Health Professions curriculum design/content (what is left out?)
- Health professions admissions (diversity)
- Committee assignments (organizational decisions and policy)
- Grant review process
- Peer review decisions

Discrimination in Health Care

Discrimination in health care:

"differences in care that emerge from biases and prejudice, stereotyping, and uncertainty in communication and clinical decision-making"

Smedley et al., 2003

Discrimination: Weight

- 53% of overweight/obese women report inappropriate comments from their doctor

Puhl & Brownell, 2006

- 50% of providers viewed obese patients as awkward, unattractive, ugly and noncompliant

Foster et al., 2003

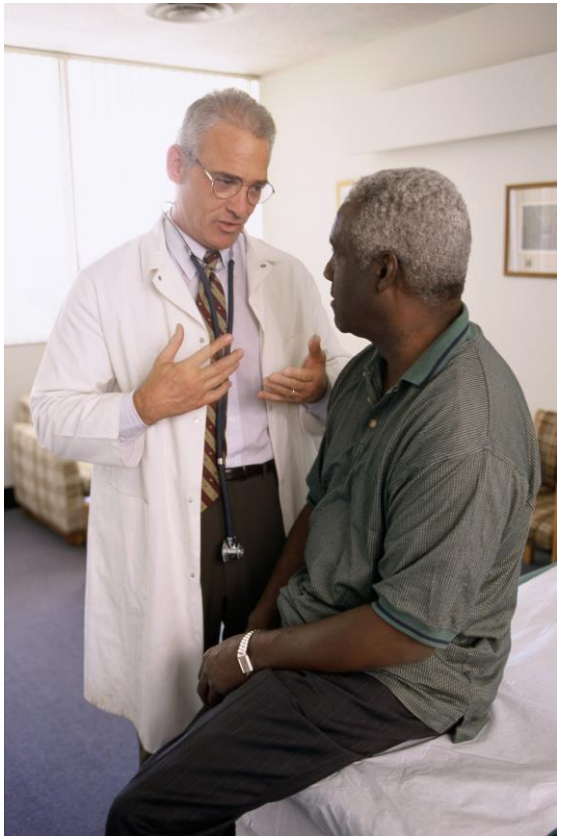
- Moderate amount of “fat phobia” among dietitian students, rated obese patients less compliant than non-obese patients

Puhl, Wharton & Heuer, 2009

Discrimination: Race

African American patients' perceived discrimination associated with:

- Poor patient satisfaction
- Poor adherence to physician recommendations
- Poor general health and mental health



Penner et al., 2009

Patient Perceptions of Discrimination

Perception of discrimination in health care is related to:

- Delay in seeking care
- Mistrust in provider/system
- Patient stress level
- Adherence to treatment
- Continuity of care

The Science of Implicit Bias

First Impressions

- Assess first impressions of a person as attractive, likeable, competent, trustworthy, and aggressive
- Exposure to a face for one-tenth of a second was enough
- Judgment did not change with increased of one second, confidence in the judgment increased
- We make snap judgments about people
- This is how our minds work

Willis & Todorov, 2006

Implicit and Explicit Beliefs

Explicit Attitudes and Beliefs

Can report

Rational

Higher level thinking

Implicit Attitudes and Beliefs

Automatic
Hidden
Unaware

Lower level thinking

Greenwald & Banaji, 1995, Banaji & Greenwald, 2013

Implicit and Explicit Beliefs

- Implicit bias is common
- Implicit and self-reported attitudes and beliefs may differ, and a person may be unaware that they hold contradictory beliefs

(Nosek et al., 2007; Burgess et al., 2007)

- Even those holding egalitarian values may hold negative implicit attitudes and beliefs

(Banaji & Greenwald, 2013; Dovidio & Gaerner, 2000)

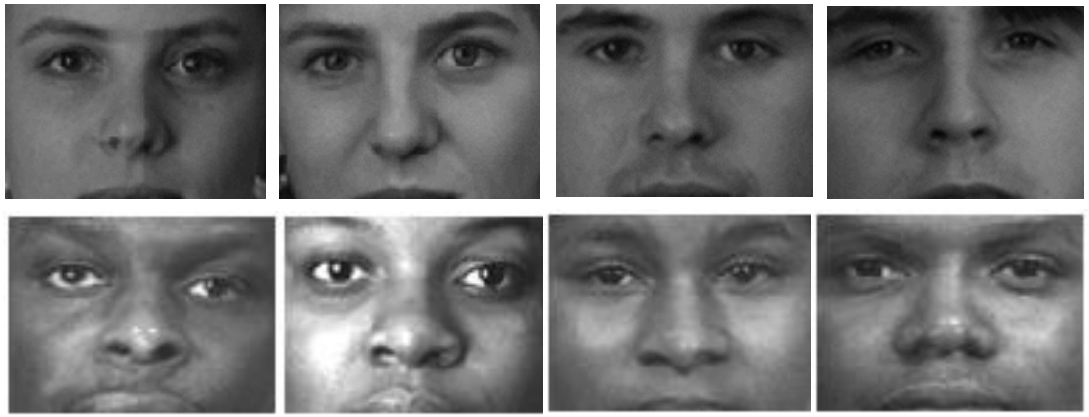
Racial Bias is Contagious

- Just observing a biased person express subtle negative bias toward a black person may shift our own racial bias
- Others' biases may "creep into our minds and infect our behaviors"
- Viewing another person engaged in discrimination can, without your awareness or consent, shape your own racial bias
- Authentic pro-black regard among employees in an office is more than just a ''good thing to have'' or the ''right way to be.'' **Racial bias is a communicable attribute**
- Other biases may also function this way

Willard, Isaac & Carney, 2015

Measuring Implicit Bias
The Implicit Association Test (IAT)

A widely used, indirect measure of implicit social cognition



Project Implicit®

Greenwald et al., 1998

Implicit Bias: Race

If there is a quicker association of

with the concept of “good” than

with the concept of “good”

Nosek et al., 2007

Weight IAT

“Fat people” and “Thin people” visual images

Good: Joy, Love, Peace, Wonderful, Pleasure, Glorious, Laughter, Happy

Bad: Agony, Terrible, Horrible, Nasty, Evil, Awful, Failure, Hurt

Other Areas of Bias





Implicit Bias and Behavior

- A meta-analysis of 122 studies of IAT - behavior correlations, found that IAT measures of implicit attitudes are a better predictor of behavior than are self-reported attitudes **in socially sensitive areas**

(Greenwald et al., 2009)

- **IAT not a diagnostic**

Implicit Bias and Decision-Making

Despite egalitarian beliefs, individuals may show biased behavior in certain situations:

In health care:

- Clinical ambiguity
- Heavy workload
- Fatigue
- Pressure of time

Croskerry, 2010

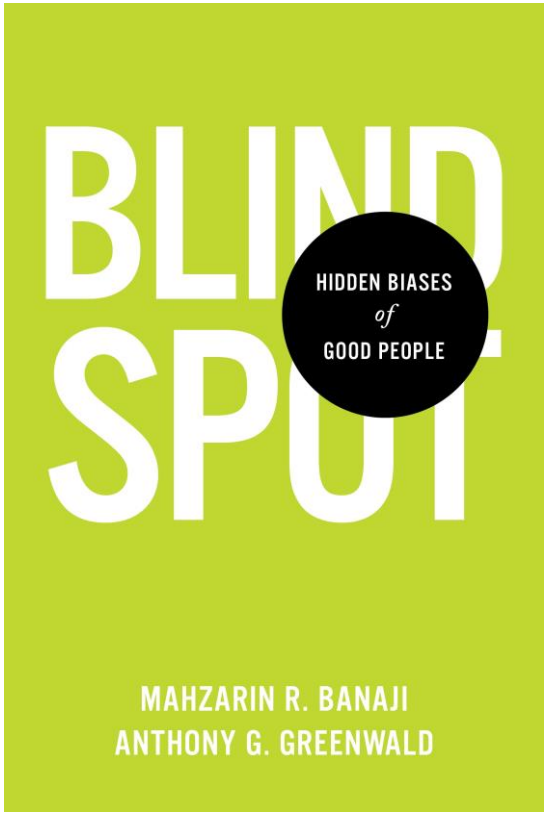
Summary

- Implicit attitudes and beliefs are hidden
- Implicit bias is common, even among egalitarian individuals
- Ambiguity, fatigue, heavy workload are conditions in which implicit bias may affect decision-making

How Implicit Bias Operates in Health Care

The Case of Carla the Quilter (2013)

"We have discovered that most people find it unbelievable that their behavior can be guided by mental content of which they are unaware."



The Case of Carla the Quilter (2013)

Carla, a woman in her late 20s, was rushed to the emergency room by her boyfriend.

She had cut her hand on glass bowl as it slipped to the ground and shattered.

BF told the ED resident that quilting was very important to Carla and worried about damage to her fine motor control.

Banaji & Greenwald, 2013

The Case of Carla the Quilter (2013)

The resident stated that he was confident the hand would heal well if he could “just stitch it up quickly”.

The Case of Carla the Quilter (2013)

As the doctor prepared Carla's hand, a student volunteer walked by and recognized Carla, who in addition to being a quilter, was also an assistant professor at Yale.

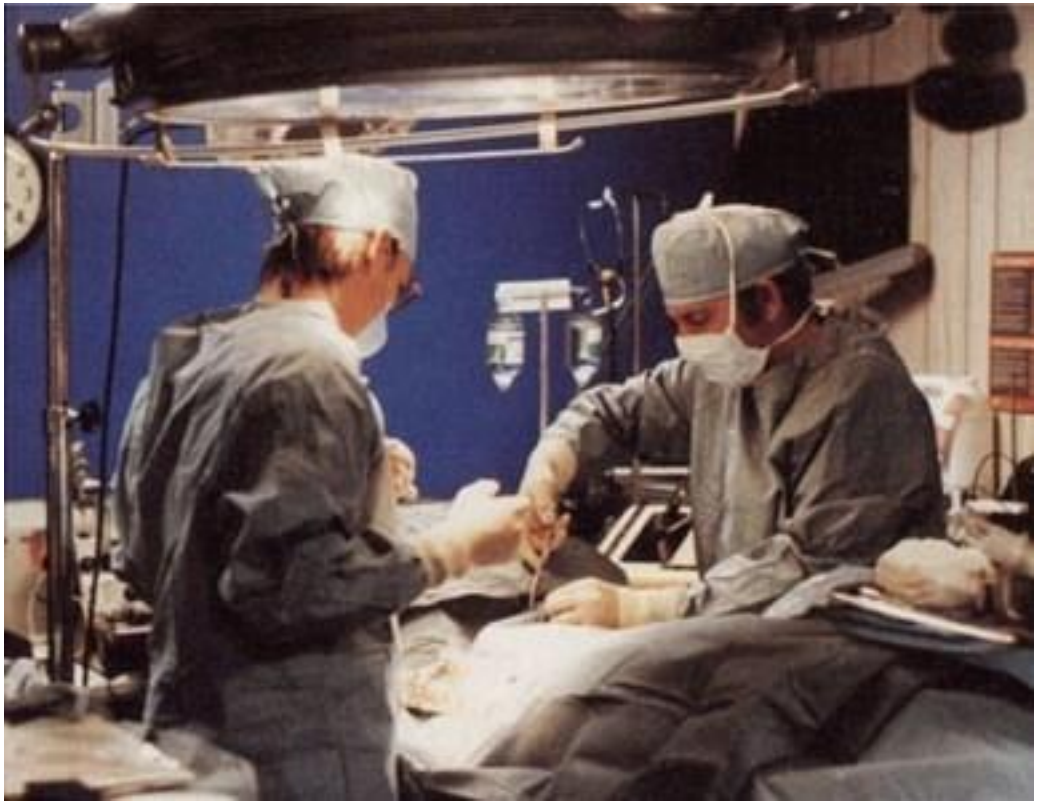
The Case of Carla the Quilter (2013)

The ED doctor stopped
in his tracks and said,
“You are a professor at Yale?”

The Case of Carla the Quilter (2013)

Within seconds Carla was headed for the surgery department and the best hand surgeon in Connecticut was called in.

After hours of surgery Carla's hand was restored to pre-injury function.



Hidden Discrimination

- Carla the quilter vs. Carla the professor is a case of **in-group favoritism**
- Okay care versus elite care
- In-group favoritism can increase “the relative advantages of those who are already advantaged”

Greenwald & Pettigrew, 2014; Banaji & Greenwald, 2013

Evidence: Implicit Bias in Health Care

- In the past decade many studies assess whether provider implicit bias exists, show implicit bias exists among providers
- Studies on the association of provider implicit bias with clinical treatment and health outcomes – the results are mixed
- Few studies measure real world care

Green et al., 2007; Sabin et al., 2009, 2012,2015; Cooper et al., 2012; Blair et al., 2014

Implicit Race Bias in Clinical Interactions

Real-world clinic visits, primary care, 90% physician, 269 patients, Baltimore


For Black patients stronger clinician implicit bias favoring white over black Americans associated with:

- Lower patient positive affect
- Patients' less liking of the clinician
- Less confidence in clinician
- Lower perceived respect from clinician
- More clinician verbal dominance

Cooper et al., 2012

Weight Bias Among Providers

- Sabin, J. A., Moore, K., Noonan, C., Lallemand, O., & Buchwald, D. (2015). Clinicians' implicit and explicit attitudes about weight and race and treatment approaches to overweight for American Indian children. ***Childhood Obesity,*** 11(4), 456-465.

- Sabin, J. A., Marini, M., & Nosek, B. A. (2012). Implicit and explicit anti-fat bias among a large sample of medical doctors by BMI, race/ethnicity and gender. ***PLoS One,*** 7(11), e48448.

Implicit and Explicit Anti-Fat Bias

Project Implicit data, MDs, others in society, by gender, weight, (N= 359,261)

- General population, strong implicit and explicit anti-fat bias, prefer “thin people” rather than “fat people”
- N= 2,284, MDs, Very strong **implicit and explicit anti-fat bias**, prefer “thin people” rather than “fat people”
- Variations:
  - Females show less weight bias but still strong
  - Obese (BMI ≥30) people, obese (BMI ≥30) MDs show less weight bias

Sabin et al., 2012

Providers Indian Health Service

- 2 areas Indian Health Service
- November 2011 – April 2012
- Providers who see children and adolescents (N=134)
- Family medicine, nurse practitioner, physician assistant
- Online survey : Project Implicit
- 1. National Indian Health Service IRB, 2. University of Washington IRB

Study Measures

- **Race IAT (Native American/European American) words**
  - Native American: Cherokee, Sioux, Native American, Navajo
  - White American: White American, Anglo, European American, Caucasian, Good/Bad words
- **Weight IAT**: silhouette, Good/Bad words

- Perceived barriers to intervention with obesity
- Weight management approaches
- Perceived competence in treating obesity

Study Results

- N=75, Response rate 56%
- Age: mean= 48 years, Gender: 55% female
- 67% medical doctors, 26% nurse practitioners, 4% physician assistants
- All patients American Indian/Alaska Native
- Years in practice mean= 14 yrs
- Years in current position mean= 7 yrs
- 55% of providers reported that 30-59% of child/adolescent patients overweight
- 25% of providers reported > 60% of child/adolescent patients overweight

Results

- Continuing education diversity: 61%
- Continuing education child obesity: 43%
- Self-rated “competent” in weight management:
  - child (53%)
  - adolescent (68%)
- Discuss weight at well child visits: 89%
- “I have success in treating pediatric overweight”: 31% agree

Implicit/Explicit Results

Implicit

- Strong weight bias: N= 56
- Weak race (NA/WA) bias: N= 58

Explicit

- Weak weight bias (favoring thin): N= 63
- Moderate race bias (favoring NA): N= 62

Treatment Behaviors

- Race IAT, Weight IAT, race explicit, weight explicit, age, female, white, diversity edu, > 70 patients/week **did not predict** treatment behaviors, referral/prescribing patterns

- Continuing education about obesity **did predict self-reports of competence** “treating overweight children and adolescents” and **success** in “treating pediatric patients for obesity”

Recognize How Implicit Biases Create Barriers

- Snap judgments
- In group favoritism
- Feeling more comfortable with and confident in people who share one's own culture
- Positive and negative stereotypes that influence perceptions of competence

Strategies to Interrupt Implicit Bias

Good intentions are not enough

- Collect data, monitor equity
- Reduce discretion- objective processes
- Promote workforce diversity
- Role modeling
- Improve communication
- Education
- Accountability (individual, institutional)

Collect Data

- Collect data organizational, individual levels
- Monitor equity – find patterns, ongoing process
- Measure differences
- If differences exist explore why
  - Differential treatment
  - Biased perceptions
  - Cultural differences

Develop Objective Processes

- Reduce discretion and subjectivity in decisions
- Develop standardized, objective processes
- Create standardized decision tools
- Follow clinical guidelines

Develop Organizational/Individual Accountability

- Survey stakeholders
- Employee/student diversity (numbers)
- Organizational climate survey
- Equity in student assessment (gender, race, ethnicity other)
- Assign responsibility
- Continuous improvement

Review Discussion Points & Check In With Your Own Biases

Nina Crowley, PhD, RDN, LD

Affiliations: Metabolic and Bariatric Surgery Program Coordinator, Medical University of South Carolina, Charleston South Carolina.

Disclosure: Dr. Crowley has no relevant disclosures to report regarding this program.

Give Less – Get Less

- Lack of emotional connection
- Less respect
- Less time
- Less information
- Less patient-centered language

- Less satisfaction with their care
- Less adherence
- Less trust
- Worse outcomes

Beach et al., 2006; Bertakis & Azari, 2005; Bogart et al., 2004; Martin et al., 2005; Huizinga et al, 2009

How To Talk About Obesity To Foster Communication & Behavior Change

Communicate Carefully

- Stereotype threat response
- Discussion of weight
- Out with ‘obesity’
- In with People first language
- Consider compliance & adherence
- Health literacy

Stereotype Threat Response

- **Stress response when aware of being perceived in a stereotypical way**
  - Heightened cortisol reactivity, C-reactive protein, and blood pressure
  - Impaired ability to communicate effectively with provider
  - Weakened ability to recall new information
  - Reduced ability to stick with treatment plans and avoid follow up care
- **Clinic Cues**
  - Medical equipment, gowns, exam tables, or waiting room chairs
  - Regularly being weighed
  - Constant discussion of weight loss

Almeida et al., 2011; Burgess et al., 2010; Dickerson & Kemeny, 2004; Steele et al., 2002; Tomiyama, 2014

Wait, Don't Talk About Weight?

- **Often people think that by getting to a 'normal body weight', they will remove themselves from the stigmatized group**
  - Treatment focused on weight and numbers may perpetuate dysfunctional thinking, eating patterns, disordered eating
- **Weight-inclusive approach**
  - Focus on health, rather than weight
  - Facilitates a less stigmatizing environment and improves outcomes
    (without potential harm)
  - Focus on specific lifestyle changes/health behaviors to improve
  - Focus on behaviors they can control not outcomes they can't

Phelan et al., 2015; Puhl & Brownell, 2003; Tylka et al., 2014

Out With 'Obese'

Least Stigmatizing / Blaming Words	Most Stigmatizing / Blaming Words
• Weight • Unhealthy weight • High BMI	• Fat • Morbidly Obese • Obese
Most motivating for weight loss	**Least motivating for weight loss**
• Unhealthy Weight • Overweight	• Fat • Morbidly Obese/Chubby

Puhl et al., 2005; Obesity Action Coalition toolkit, 2016

In With 'People First' Language

- **Respectful communication using 'People-First Language'**
  - Creates positive, productive discussions in health care settings about weight and health

    - *"The woman was affected by obesity." - instead of - "The woman was obese."*
    - *"The man with obesity was on the bus." - instead of - "The man on the bus was obese."*

  - *"Could we talk about your weight today?"*
  - *"How do you feel about your weight?"*
  - *"What words would you like to use when we talk about weight?"*

Feldman et al., 2002; Fruh et al., 2016; Kyle & Puhl, 2014

Compliance & Adherence

- **Behavior chain of events**
  - Perceived responsibility
  - Change is difficult
  - Provider frustrated and blame patient for failing to adhere
  - Patients frustrated
  - NO change occurs!
- **Labeling patients as 'non-compliant' or 'non-adherent'**
  - Noncompliance = view that problem is **patient's behavior** rather than **provider's approach** to care
- **Consider conversations with patients, providers, and written**

Bodenheimer et al., 2002

Counseling By Advice Giving?

- **You *know* what they *should* do to reach their goal**
- **Yet knowledge is of limited value if not applied**
- **Handouts and websites don't help people change**
- **What does help people change?**
  - Person-focused counseling
  - Patient-centered care
  - Shared decision making
  - Empowerment approach
  - Self-care model

Hurtado et al., 2001

Embrace Health Literacy Concepts

- Use simple, everyday language
- Keep message to 2-3 main points
- Write key instructions for patients to take home
- Include pictures
- Solicit questions effectively from patients
- Use ‘teach back’ on main points

Coleman et al., 2013

Check In With Your Bias

Changing Bias Is Like Changing Behavior (It's Hard)

- Implicit bias - "habit of mind"
- Habit awareness + strategies for new behavior = increased self-efficacy in behavior change
- Awareness alone is not sufficient to reduce the automatic, habitual activation of stereotypes and the subsequent impact of implicit bias in medical decision-making

Chapman et al., 2013

‘Strong Preference For Thin People’

- Motivation for becoming a nutrition professional
- Desire to be thin (personally)
- Personal struggles with weight and body image
- Training to ’teach’ or ’advise’ people about the ‘right’ way to eat
- Formal curriculum doesn’t prioritize counseling skills or weight bias
- Expectations/assumptions from the patient about provider weight/appearance

Puhl et al., 2013

Yes, You

- **Dietitians are just as vulnerable to weight stigma as other health care providers**
  - Even dietitians, who play a very important role in obesity management, may be prone to weight-related stigma
  - Younger professionals had more weight bias than older
  - Higher provider BMI linked to less negative attitudes
- **Negative biases and assumptions about larger-bodied people impair communication and lead to the exact behaviors that we are trying to help them change!**

Puhl & Brownell, 2006; Schwartz et al, 2003

What Can You Do About Your Bias?

- Awareness
- Empathy
- Trust/Partnership
- Self-efficacy
- Check yourself
- Counseling skills
- Policy change

Assess Awareness

- **Recognizing your own bias**
  - Self-reflection
  - Try the Implicit associations test (IAT)
- **Welcome the complex etiology of obesity**
  - Highlight environmental/external (biological, genetic, metabolic, social)
  - Question the energy balance model
  - Beware of sole cause or personal responsibility explanations
- **Assess your Assumptions**
  - Assumptions and blame about ’fault’ impact communication and don’t impact how you treat them!
  - Making snap judgments closes the door to complexity of the science

Crandall, 1994; Danielsdottir et al., 2010; Hall et al., 2012; O’Brien et al., 2010

Build Empathy

- **Perspective-taking**
  - Conscious attempt to envision another person's viewpoint
  - Can reduce implicit bias in social interactions
- **Individuating**
  - Conscious effort to focus on specific information about an individual, making it more salient in decision-making than that person's social category information
  - Specific, individuated patient information prevents providers from filling in partial information with stereotype-based assumptions

Batson et al., 2003; Phelan et al., 2015; Teachman et al., 2003

Build Trust and Partnership

- **Trust building**
  - Patients must believe that you:
    - Will be helpful, guiding them through to resolution of the issues that trouble them
    - Will keep them safe from blame, anger or hurtful comments
    - Will nourish positive feelings of hope and self-esteem
  - Use motivational interviewing to normalize experience
    - "It is normal to feel nervous about sharing details about your eating habits"
  - Discuss issue of honesty
- **Partnership building**
  - Work toward a common goal on the same team

Fiscella et al., 2004; Wanzer et al., 2004

Elicit Self-Efficacy

- **Increase self-efficacy**
  - "I can do it"
- **Address patient's judgmental language about themself**
  - Develop self-compassion to improve health
- **Increase positive outcome expectations**
  - Pros outweigh the cons
  - Decisional balance

Finch et al., 2005; Puhl et al., 2016; van Ryn et al., 2011

Check Yourself

- **Exposure/contact therapy**
  - Actively provoke bias through virtual encounter and interaction
- **Counter-stereotypical exemplars**
  - Exposure to individuals who defy stereotypes
- **Personal stress management**
  - Emotion regulation
  - Deep-breathing

Dovidio et al., 2003; Kemeny et al., 2012; Lillis & Hayes, 2007; Phelan et al., 2015; Hull et al., 2008

Counseling Styles

- Mindfulness Training
- Intuitive eating
- Motivational Interviewing
- Coaching
- Health at every size model (HAES)
- Non-weight based goal setting
- Acceptance-based counseling

Anderson, Weight Stigma in the Nutrition Counseling Setting toolkit, 2015; Armstrong et al., 2011; Carels et al., 2007; Puhl et al., 2016; DiLillo et al., 2003

Stigma Reduction Strategies

1. Consider that patients may have had negative experiences with other health professionals regarding their weight, and approach patients with sensitivity.
2. Recognize the complex etiology of obesity, and communicate this to colleagues and patients to avoid stereotypes that obesity is attributable to personal willpower.
3. Explore all causes of presenting problems, not just weight.
4. Recognize that many patients have tried to lose weight repeatedly.
5. Emphasize behavior changes rather than just the number on the scale.
6. Offer concrete advice (eg, start an exercise program, eat at home, etc, rather than simply saying, “You need to lose weight”).
7. Acknowledge the difficulty of lifestyle changes.
8. Recognize that small weight losses can result in significant health gains.
9. Create a supportive health care environment with large, armless chairs in waiting rooms, appropriately-sized medical equipment and patient gowns, and friendly patient reading material.

The Obesity Society toolkit, 2016

Here are some examples of the *types of questions to ask* using a motivational interviewing style when assessing ambivalence and motivation for lifestyle changes in patients who are overweight or obese:

How ready do you feel to change your eating patterns and/or lifestyle behaviors?

How is your current weight affecting your life right now?

What *kinds* of things have you done in the past to change your eating?

What strategies have worked for you in the past?

Some people talk about part of them wanting to change their eating patterns, and part of them not really wanting to change. Is this true for you?

On a scale from 1-10, how ready are you to make changes in your eating patterns?

How much of you is *not* wanting to change?

What was your life like before your weight increased?

How much does it worry you that you might return to old patterns of eating?

What makes you feel like you can continue to make progress if you decide to?

What are your hopes for the future if you are able to become healthier?

How would your life be different if you lost weight and adopted a healthier lifestyle?

http://biastoolkit.uconnruddcenter.org/toolkit/Module-2/2-07MotivationalStrategies.pdf

Protect From Bias With Policy

- Alter clinic environment to create setting where people with obesity feel more accepted
- Change the clinic 'norm' by changing policy to re-norm weight bias
- Challenge negative weight-based stereotypes
- Zero-tolerance policy for use of derogatory language
- Condone use of respectful 'people-first' language
- Avoid labeling people by any disease
- Encourage weight-inclusive approach

Phelan et al., 2015; Tylka et al., 2014

Take Homes

- You are not immune
- Consider the complex etiology of disease
- If you build your communication skills, patients will connect and let you help = a win win for everyone!
- Train the next generation
- Educate yourself: Weight stigma awareness week #WSAW2016- September 26-30, 2016!

Questions?

Janice A. Sabin, PhD, MSW

sabinja@uw.edu

Nina Crowley, PhD, RDN, LD

crowleyn@musc.edu

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