

## **Addressing Bias Through Mitigation**

### **A Toolkit for medical educators in UME, GME, and Faculty Development**

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#### **Objectives for use of this toolkit:**

- Define common terms used in discussing implicit bias and mitigation strategies
- Identify strategies for mitigating implicit bias in pre-clinical and clinical settings
- Identify strategies for addressing witnessed discrimination and microaggression

#### **Foundational Definitions for use with Toolbox<sup>1, 2</sup>:**

**Implicit Bias:** attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.

**Explicit Bias:** attitudes and beliefs we have about a person or group on a conscious level, related behaviors are conducted with intent. At its extreme this is expressed through physical and verbal harassment or exclusion

**Racism:** a form of explicit bias that is intentionally directed against a person or people on the basis of their membership of a particular racial or ethnic group, often one that is a minority or marginalized

**Microaggression:** a statement, action, or incident regarded as an instance of indirect, subtle, or unintentional discrimination against members of a marginalized group such as a racial or ethnic minority.

**Macroaggression:** Large-scale or overt aggression toward those of a certain race, culture, gender

**Microinsult:** Statements that demean a person's racial heritage or identity, often thought of as subtle insults and subtle snubs, frequently unconscious, but clearly convey a hidden insulting message to the recipient

**Microinvalidation:** Statements or behaviors that exclude, negate, or nullify the psychological thoughts, feelings or experiential reality of a person of color.

**Microassault:** Explicit racial derogatory behaviors characterized primarily by a verbal or nonverbal attack intended to hurt the victim through name-calling, avoidant behavior, or purposeful discriminatory actions.

Equity: fairness, people receiving what they need based on their individual circumstances  
Equality: sameness, people receiving the same thing, not based on individual circumstances

Diversity: The various visible and invisible human identities, including demographic

Inclusion: thoughtful creation of policy, norms, environments that accommodate and value diversity

### **Mitigation Strategies - Implicit Bias**

- I. **Define Egalitarian Goals:** The goal here is to define your belief system for equality in the medical care you provide. This will allow for more specific reflection on factors that push you towards acting outside of your conscious goals for care.
  - A. Start by defining what equality in your medical care means to you. Write out your egalitarian goal for providing care.
  - B. Reflect on a time that you did not act in accordance with this goal. Work through the following prompts
    1. Can you identify what factors contributed to this event?
    2. Are there factors that you can control in future encounters?
    3. Are there factors that are out of your control?
  
- II. **PAUSE Framework<sup>3</sup>** - goal to be used at the time of a patient encounter to acknowledge when implicit bias may be impacting our actions and to create a framework for addressing this bias in real time.
  - A. **P**ay attention to what's happening beneath the judgements and assessments
  - B. **A**cknowledge your own reactions, interpretations, and judgements
  - C. **U**nderstand the other possible reactions, interpretations, and judgements that may be possible
  - D. **S**earch for the most constructive, empowering, or productive way to deal with the situation.
  - E. **E**xecute your action plan
  
- III. **Re-categorization**
  - A. Ask questions of patients that help identify common interests, activities, or shared identity.
  - B. Example:
    1. A student or resident is seeing a patient for the first time in the outpatient clinic. The patient has a past medical history of traumatic spinal cord injury resulting in paraplegia and chronic pain. The trainee identifies a strong implicit bias towards patients with a diagnosis of chronic pain.
    2. The faculty or trainee can prompt recategorization by identifying standard questions that are unrelated to the trigger for implicit bias (in this case a

specific medical diagnosis). The questions should help to develop the trainees' understanding of the patient on a personal, social, or emotional level that connect the patient to the physician - for instance common hobbies, interests outside of their medical care, etc.

3. This allows the trainee to refocus their attention on a more holistic view of the patient and avoid focusing only on an area of bias.

#### IV. **Collect counter-stereotypical information**

- A. Helps to reveal a patient's individual attributes and over time can "turn off" or lessen unconscious bias/association
- B. Change the language - instead of saying "all patients in X group are Y" (which is invariably a stereotype) instead say "some patients with X experience Y" - this reframing challenges the notion of large group norms
- C. *Examples could including learning about the patient's community and/or prominent figures within the community*

#### V. **Systemic Change**<sup>4</sup>: defined as 'change that pervades all parts of a system, taking into account the interrelationships and interdependencies among those parts' (*an example: creating hospital-wide caps on physician-patient ratios on inpatient services to decrease burnout*)

- A. **Fatigue & Stress Reduction**
  1. "Fast Brain" versus "Slow Brain" approach to clinical reasoning and medical decision making
    - a) In times of stress we use our fast brain - rely on pattern recognition to facilitate quick decision-making. Good for clinical emergencies, troublesome for bias mitigation
    - b) Slow brain allows us to consider counterpoints and alternative scenarios to explain a clinical presentation. We use this more in times where we experience less stress
  2. Strategies such as mindfulness to mitigate fatigue and burnout may promote a "slow brain" approach.
  3. Structuring staggered admissions, team caps, or physician-patient ratios may allow for manageable clinical workloads to facilitate "slow brain" approach
- B. **Community Engagement**
  1. Prompts re-categorization and counter-stereotypical information
  2. Develops cultural humility
- C. **Cultural Humility**
  1. There is no finite body of knowledge on a given culture
  2. Acknowledges that there is much we do not know
  3. Commitment to lifelong process of learning
    - a) Engage in self-reflection and self-critique

- b) Develop and maintain mutually respectful and dynamic partnerships with communities

### **Mitigation Strategies - Witnessed Bias**

- I. **ERASE Framework<sup>5</sup>** - developed as a framework faculty can employ when witnessing or responding to mistreatment of trainees. May be used at UME or GME level.
  - A. Expect that such events will happen and prepare accordingly.
  - B. Recognize the mistreatment.
  - C. Address the situation in real time.
  - D. Seek support after the event and Support your team-members
  - E. Encourage a positive culture.
  
- II. **Simulated patient encounters** - resident education on responding to discrimination<sup>6</sup>
  - A. Targeted first year Internal Medicine residents, but applicable across UME, GME, and faculty
  - B. Employed 4 standardized scenarios to practice communication skills related to responding to patient bias towards health care workers.
  - C. Focused on communication strategies based on four themes<sup>7</sup>:
    1. Assessment of illness acuity
    2. Cultivation of therapeutic alliance
    3. Depersonalization of the event
    4. Ensuring a safe learning environment
  - D. Pilot study found an improvement in learner confidence in responding to bias
  
- III. **WELL Toolkit<sup>8</sup>** - Toolkit and slide set that includes stem cases and structured frameworks for faculty and residents to use when responding to microaggressions.
  1. Responding to Micro-Insults or Micro-Invalidation
    - Inquire
    - Paraphrase/Reflect
    - Reframe
    - Express the impact of the statement
    - Express one's preference
    - Redirect the conversation
    - Use strategic questions
    - Re-visit
  2. Responding to Micro-assaults<sup>7</sup>
    - Assess Illness acuity
    - Cultivate a therapeutic alliance
    - Depersonalize the event

- Ensure a safe learning environment for trainees

IV. **The PRISM® Toolkit**<sup>9</sup> - a proprietary toolkit that tries to train individuals on root causes of bias and habits to decrease bias. Small studies have shown benefits in multiple areas including reducing unconscious bias and stereotyping and increased social connectedness.

- **Perspective-Taking:** The practice of imagining other people's experiences to strengthen collective identity and social cohesion.
- **pRosocial Behavior:** The practice of cultivating kindness, empathy, optimism, gratitude, and joy.
- **Individuation:** The practice of differentiating individuals from group-based stereotypes by cultivating curiosity.
- **Stereotype Replacement:** The practice of noticing negative stereotypes and replacing them with real-life positive examples.
- **Mindfulness:** The practice of noticing and being aware of the present moment.

Resources for this Toolkit:

1. Merriam-Webster Dictionary. 2020 Merriam-Webster, Incorporated. <https://www.merriam-webster.com/>
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3. Ross, H. *Everyday Bias: Identifying and Navigating Unconscious Judgments in Our Daily Lives*. London, United Kingdom: Rowman and Littlefield, 2014.
4. Aragón, A., Macedo, G., & Carlos, J. (2010). A 'systemic theories of change' approach for purposeful capacity development. *IDS Bulletin*, 41(3), 87–99
5. Goldenberg MN, Cyrus KD, Wilkins KM. ERASE: a New Framework for Faculty to Manage Patient Mistreatment of Trainees. *Acad Psychiatry*. 2019;43(4):396-399.
6. Eisenberg EH, Kieffer KA. Use of Simulated Patient Encounters to Teach Residents to Respond to Patients Who Discriminate Against Health Care Workers. *J Gen Intern Med*. 2019;34(5):764-768.
7. Whitgob EE, Blankenburg RL, Bogetz AL *Acad Med*. 2016 Nov; 91(11 Association of American Medical Colleges Learn Serve Lead: Proceedings of the 55th Annual Research in Medical Education Sessions):S64-S69.
8. Gonzaga, AM. et al. *Microaggressions*. WELLToolkit. 2020. <https://www.chp.edu/-/media/chp/healthcare-professionals/documents/faculty-development/microaggressions.pdf?la=en>
9. The PRISM Toolkit. BE MORE with Anu 2020. <https://bemorewithanu.com/resources>