Implicit Bias in medicine

a case based practice guide

APPD Annual Meeting 2017
Boston Medical Center/Boston Combined Residency Program
The Pediatric Residency Program at Duke
Boston Medical Center/
Boston Combined
Residency Program
Sample Cases
Case #1
You are in the ED…

- It is 11:00 PM on a Monday in early Spring
- You look at the ED board and see an 11 year old boy with the name Martin Hernandez
- His chief complaint is abdominal pain
- Vital signs: T 37.5, HR 88, RR 20, BP 98/58
- BMI: 98th percentile
You walk into the room…

- Martin is smiling and watching TV
- There is a doughnut box on the exam table and white powdered sugar on his face
- He is with his mother Gloria
- She is overweight
- She is tapping her right leg and holding his hand
- She is speaking to Martin in Spanish and English
- They greet you in English
Reflection
History of Present Illness

- Abdominal pain
  - Started 3 days ago; epigastric, burning
  - Decreased appetite, but normal PO intake
  - No nausea or vomiting; daily stooling, no melena
Additional History

- Mom is worried he eats too fast
- Mom cannot control the amount of junk food he eats when he is home with his brother
- Mom is specifically concerned about cancer due to family history of maternal great aunt with gastric cancer, maternal aunt with breast cancer, and maternal grandfather with prostate cancer
- He has not attended school since his abdominal pain started
Social History

- Born in Boston
- Parents born in DR; living in Boston for 15 years
- Family is bilingual
- Parents divorced, but in a friendly relationship
- Mostly lives with mom and mom’s boyfriend
- Mom works as a retail clerk M-F from 10am-8pm
- Home alone with brother after school
- 6th grade: good grades and attendance record
Physical Exam

- Heart & Lung: normal
- Abdomen: soft with mild tenderness in the epigastric area; no hepatomegaly, and no masses
- Skin: acanthosis nigricans on the nape of neck and axilla
Perspective Taking Exercise

Imagine yourself in this mother’s shoes
Case Wrap-up

- At the first ED visit, the patient was given a “GI cocktail” and discharged with plan to trial famotidine and follow-up with PMD
- Within the next 10 days, the patient returned to the ED twice and visits his PCP
- He was ultimately referred to GI clinic where profound weight loss was noted and abdominal imaging revealed a large mass, which was later confirmed to be malignancy
Small Group/Individual Reflection

- With the guided imagery and the case unfolding over time, how does who you pictured evolve?
- How did the perspective-taking exercises make you feel?
- Identify the implicit biases that may have impacted the case
- What are the risk factors in this case for discrimination or bias?
- What bothers you about this case?
Case #2
## ED on a Busy Night

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Quick Glance at the Chart…

- 2 year old boy with sickle cell disease
- T 41.2, HR 180, BP 120/60, RR 32, SpO2 96% on room air
In the exam room you see...

- A black toddler sitting on mom’s lap in bed
- He has a sippy cup full of strawberry milk
- He begins to cry as you enter
- He has yellow mucus crusted to his face and dripping from his nose
- Mom stands up as you enter the room
- She is struggling to keep him from climbing over her shoulder and away from you
- She says “my baby needs antibiotics now – don’t you understand this is an emergency?”
Reflection
More about your patient…

- **HPI:** 3-4 days URI symptoms; first fever 1 hr ago
- **PMH:** Hgb SS. Immunizations UTD. On penicillin ppx. Multiple brief admissions for fever with hyper-hemolysis.
- **Social:** Lives with mom in public housing. Formerly in shelter. Dad intermittently involved. Goes to daycare.
- **Further chart review:**
  - Multiple missed visits
  - Notes of skepticism from mother re: initial diagnosis
Perspective Taking

*Imagine yourself in this mother’s shoes*
Timeline

15:00
- Fever and chills

16:00
- Arrives in ED
- Bcx, CBC, retic, CXR, CTX, bolus, Heme notified

17:00
- Fever and chills continue
- Mom refuses to sign admit paperwork

18:00
- Decision made to admit; Mom agrees

19:00
- T 38.9
- HR 160s
- RR 40s

20:00
- T 40.6
- HR 170s
- RR 40s

21:00
- HR 170s
- RR 40s

22:00
- HR 170s
- RR 40s

23:00
- HR 170s
- RR 40s

24:00
- HR 170s
- RR 40s

01:00
- HR 170s
- RR 40s

02:00
- HR 170s
- RR 40s

03:00
- HR 170s
- RR 40s

Negotiations with Mom...
Perspective Taking

What is your motivation to leave against medical advice?
Timeline

15:00
Arrives in ED
Fever and chills

Bcx, CBC, retic, CXR, CTX, bolus, Heme notified

MOM refuses to sign admit paperwork

16:00
Decision made to admit; Mom agrees

Negotiations with Mom…

17:00
Mom and patient leave AMA; she provides phone number and agrees to follow-up in clinic in AM

18:00
T 38.9
HR 160s
RR 40s

19:00
T 40.6
HR 170s
RR 40s

20:00
T 37.8
HR 160s
RR 30s

21:00
ED calls Boston Police

22:00
BCx + GPCs in pairs

23:00
ED calls mother – no answer

24:00
01:00
02:00
03:00
Patient returns to ED with police
Case conclusion

- Blood culture speciated to *S. pneumoniae*
- Received 48 hours of IV antibiotics
- Discharged home with his mother with plans to complete a 14-day PO antibiotic course
Small Group/Individual Reflection

- With the guided imagery and the case unfolding over time, how does who you pictured evolve?
- How did the perspective-taking exercises make you feel?
- Identify the implicit biases that may have impacted the case.
- Identify structural biases that may have impacted this case.
- What are the risk factors for discrimination or bias?
- What bothered you about this case?
Small Group/Individual Reflection

- What are the adverse outcomes for this case?
- Did bias contribute to medical decision making?
- What is the potential role of structural bias and historical racism in this case?

- Perspective taking:
  - For mom, what is the significance of the police coming to her home?
Duke Cases
Case #1
Diana comes to Same Day Clinic with a recurrent yeast infection. Dr. Spaceman is the only physician on duty and is very busy. After Diana explains the problem, Dr. Spaceman asks her if she is sexually active. Diana responds that she is. Dr. Spaceman then asks whether she is on birth control or using protection. Diana says no. The doctor gives Diana a stern lecture on the importance of protecting herself against sexually transmitted disease and unwanted pregnancy. Diana’s face turns very red. She looks down and says nothing. Dr. Spaceman finishes the exam and prescribes medication. Diana leaves the clinic sobbing.”
Doctors perspective

“Diana came into the clinic on a very busy day. When she explained her problem I asked her whether she was sexually active. She said yes. I then asked her the standard questions about using birth control and safe sex. She responded that she wasn’t using protection, and I reminded her of the possible consequences of irresponsible sexual behavior. If I hadn’t, I wouldn’t have been doing my job protecting the public’s health. Diana may have been embarrassed, but I hope the fact that she grew quiet meant that she was thinking about what I said. She really does need to act more responsibly in the future.”
Patient perspective

“I came to the clinic to be treated for a yeast infection. The doctor was obviously very busy, but as soon as I told her that I am sexually active but do not use birth control, she launched into a lecture about STDs and unwanted pregnancies. I can’t believe she talked to me like that! Of course I know about the importance of using protection, but I’m a lesbian. I would have told her if she hadn’t been so self-righteous. She just assumed I was heterosexual and irresponsible, without taking the time to find out anything about me. No wonder people don’t like coming to these clinics… they treat you like you’re the problem!”
Small Group/Individual Reflection

- Does this case seem realistic to you?
- What biases came into play with this interaction?
- What were barriers to their communication in the moment?
- What different approaches could have been taken by either or both of them?
Case #2
Neutral perspective

Michael is a 15 yo African-American male. He was born at 26 weeks gestation and had IVH and BPD. Current problems include spastic diplegia, developmental delay and poorly-controlled asthma. He has been hospitalized for 2 days with an asthma exacerbation. Over the past several years he has had at least 6 ED visits and 2 admissions per year despite increasing doses of inhaled corticosteroids. The team is concerned about non-compliance leading to poor control.

Michael has responded well to inpatient treatment with systemic steroids and intermittent albuterol. The family has had numerous visitors who have had trouble complying with isolation precautions.

The intern goes into the room to review an asthma action plan and smoking cessation recommendations with the mom, Valerie, prior to discharge. Valerie becomes angry during the conversation, stating that they already know how to administer medications and that no one smokes at home. She demands to speak to the attending.
Doctor’s perspective

Michael is a “frequent flyer” with poorly controlled asthma. I’ve heard through the grapevine that the family has been “difficult” during prior admissions, but things were going okay until today. We’ve suspected that they aren’t complying with home medications.

Every time I go into the room, there are different relatives there, so I haven’t really gotten to know Mom. I have definitely smelled cigarette smoke in the room, which is likely contributing to the frequent asthma exacerbations. Michael is on isolation precautions because he had some URI symptoms before he was admitted.

When I went in to go over the asthma action plan with Mom she got really defensive, saying that she was already doing all of this and it wasn’t helping. She got really angry when I discussed smoking cessation and asked to speak to my attending. Good Grief! I was just trying to be thorough!
Mother’s Perspective

“Every time I come here the staff makes me feel like I am doing something wrong for him to be sick so often. This time, the nurse gave us a hard time about having so many visitors when Michael is on isolation. My husband and I both teach school, so my sister has been staying with him during the day. I brought her kids to her after school yesterday. I don’t understand why they have him on isolation anyway. Michael had his flu shot this year, and they didn’t even test him for anything!

Then this doctor came in calling me ‘Mom.’ I’m not her mother! After 13 years of dealing with asthma, I think I know the difference between albuterol and QVAR. No one smokes at our house either. They are just assuming things because we’re black. I think it is his preemie lungs and our old furnace that are triggering his illness. I’m tired of being blamed for Michael’s illness! Is this the way they would treat a white family?”
Small Group/Individual Reflection

- Does this case seem realistic to you?
- What biases came into play with this interaction?
- What were barriers to their communication in the moment?
- What different approaches could have been taken by either or both of them?
Setting up reflections on real experiences

- Take turns briefly sharing your own experiences: inter-cultural conflict with a patient/family
- What happened?
- Did you attempt to resolve it?
- If you didn’t why not?
- How did you attempt to resolve it?
- What cultural proficiency tools/ strategies/approaches might have achieved a more successful outcome?
Discussion Questions for Video Case

- What are your reactions to the video?
- What did the providers in this video do well in their interactions with the family?
- Are there things they missed or could have approached differently?