Ethics and Implicit Bias in Health Care: Exploring the Process of Acknowledging, Accepting, and Addressing Implicit Bias

Presenter: Susan Holmes-Walker, PhD, RN

It is my honor to introduce our webinar today titled Ethics and Implicit Bias in Healthcare Exploring the Process of Acknowledging, Accepting and Addressing Implicit Bias. Our presenter today is Dr. Susan Holmes-Walker. Dr. Holmes-Walker is the owner and founder of the Solon Group LLC and is a registered nurse in the state of Michigan and Florida. Dr. Holmes-Walker has experience as an adult pain clinical nurse specialist, case manager, and risk specialist. Please read more about her presenter in the handout, but before I turn it over to Dr. Holmes-Walker, I'm going to review a few slides.

These are her disclosures regarding today's course. You can view these in the handout if you would wish. And these are the limitations and risks associated with today's class. Again, this is in your handout, so review as you need to and at this time I'm going to be turning it over to Dr. Susan Holmes-Walker. Thank you for that welcome and it's a pleasure to be here.

Along with my work in pain management, I have also worked in diversity, equity and inclusion and other areas which help to inform some of the background for this presentation today. So as you stated, the title is Ethics and Implicit Bias in Healthcare Exploring the Process of Acknowledging, Accepting and Addressing it and I'm looking forward to some engaged discussion during the presentation. As far as the limitations and risk this content is educational in nature to meet the requirements for licensure of behavioral health professionals. This learning event does not focus exclusively on any specific product or service. The information is based on evidence based research and guidelines from federal healthcare agencies.

Limitations of the content and most severe common risk is that new evidence is always evolving to update the presented information. Efforts have been made in recent years to intervene on the social determinants through interventions at the individual, community and policy levels. Individual and cultural considerations should be explored.

So as we begin to progress into the presentation, I wanted to share the learning outcomes for this event. After this course, participants will be able to describe how implicit bias can impact the care provided to people seeking assistance for behavioral health related issues and concerns. Identify one's own implicit bias and perform self reflection to determine the root cause of these beliefs. Identify three strategies to prevent implicit bias from impacting the provision of of empathetic care to the people for whom we provide care.

So this graphic is something I like to use in the majority of my presentations. It helps to remind us that quite honestly, we have very little to do with what impacts life expectancy for the people who come to us seeking care. It basically says 80% of what influences your life expectancy happens outside of the healthcare system. So what we have to keep in mind is that our interactions will only have a 20% impact on the life expectancy of the people that we interact with in our professional capacity. So it's very important that we have a high level of quality with the goal of helping these individuals we come across to be successful when they return to their home environment, wherever or whatever that may be, and whatever they may call home.

And a premise of this entire presentation is that we have to accept individuals how they are and try to figure out how we can effectively help them to improve their current health conditions.

So the first part of the presentation is talking about exploring it. And when we say explore it, we are talking about implicit bias and some of the ethical considerations that go along with it. Some key terms that I wanted to define and share with you are implicit bias, emotional intelligence, and cultural intelligence. We'll discuss the definitions of these terms as we proceed through the presentation. I would like you to keep these terms in mind.

I would also like you to reflect on your personal experience with each of these specific key terms.

Implicit bias is a term that most of us have heard of in a professional capacity, personal capacity, as we go through our daily walks of life. A definition found by Fitzgerald at all is that implicit bias, or IBM as we call it as we proceed through the presentation, is attitudes, stereotypes, and unconsciously held thoughts that may appear in interpersonal situations. And when we say interpersonal situations, that can be professional and personal interactions with people as we go about our daily life, unconsciously held negative thoughts, which in healthcare professionals may lead to inaccurate or compromised clinical decisions. And this implicit bias in healthcare professionals can cause an erosion of trust between health professionals and patients or the people we care for due to poor interpersonal interactions and biased behaviors. So we all know that a lot of times it's not what we say when we're interacting with people who are seeking care, but it's how we say it.

And we are not truly tapping into our interpersonal communication skills if we can't see that when we're having a conversation with someone who is seeking care, that our body language, our facial expressions, and all of those things cannot oftentimes lead to a person feeling that we may have some type of feeling about this person coming for care, the particular issue that they have, and how we're going to help them. So we have to remember how that nonverbal communication also can impact how people perceive us. The next key term I wanted to talk about is emotional intelligence or eq. This is the capacity to be aware of control and express one's emotions and to handle interpersonal relationships judiciously and empathetically. Emotional intelligence, otherwise known as eq, helps us better understand what motivates others.

Lastly, EQ counts for twice as much as IQ and technical skills in determining who will be successful. So having this capacity to be aware of, control and express emotions is just as important as having a high level of intelligence or specific task related skills needed in a particular occupation. A high level of emotional intelligence plays an important role in improving diversity, equity and inclusion in mental health care and medical health care. I recently had a discussion with a colleague who said they didn't

necessarily embrace emotional intelligence because they felt that it was a concept that you either have it or you don't. You take a test, you receive feedback on your level or your score and there's nothing that can be done about it.

But I pose the question to them that emotional intelligence is similar to any other type of ratings that we receive as a person. You take the information you're given, you can do some individual work to try to improve that score. And that I do believe you can indeed, indeed improve your emotional intelligence. Once you understand the components of it and aspects of it, then you can definitely improve the level of emotional intelligence that you have. There are five components of emotional intelligence.

Those are social skills, self awareness, decision making, self regulation, and empathy. So when you look at these five different components, some of them you may or may not be able to improve your emotional intelligence overall, but with precise and intentional effort to improve your ability to interact or social skills, your self awareness of how you feel about particular situations or people and all of these things, even if you improve one aspect of one of these five components, then your overall emotional intelligence can definitely improve.

A newer term that I've come across is this concept of cultural intelligence or cq. It's the ability to work well in culturally diverse environments. It involves a combination of cultural awareness, sensitivity, humility and competence. It decreases biased decision making. And successful attainment of cultural intelligence, or CQ is enhanced when individuals have at least a moderate level of emotional intelligence.

As I said, this is a newer term that I've come across and I believe most of us may be more familiar with the term cultural competence. And by shifting to using the word cultural or the words cultural intelligence, it's a shift to making care more culturally responsive. And cultural intelligence, in my opinion, has less of a stereotyping connotation than cultural competence. Because when you think of

cultural competence in my previous work in education and training, when I'VE had discussions about cultural competence. It is a term that people use to say, well, if I understand this person's culture, their background, then I will be able to relate to them and provide better care.

But unfortunately, oftentimes cultural competence you cannot learn every aspect of person who comes from a particular racial background, ethnic group, socioeconomic status. So unfortunately, oftentimes cultural competence can reinforce some of the stereotypes that we have learned about different populations. And when you think of cultural intelligence and that ability to work in culturally diverse environments without superimposing those stereotypes we may have learned in the past, that gives you a different perspective to look at improving your culturally focused care. As we go through the presentation, I created a case study and I want us to keep this person, Carol, in mind as we go through the rest of the content. So Carol is a 55 year old person with a history of substance use disorder.

Carol is a divorced parent and also cares for her aging mother who lives in the home. Carol's son is 16 and spends time with his father on occasion. Carol's company is downsizing in the months to come and concern is growing regarding the longevity of her current position. So when you think of Carol and she seems to have a few different things going on. She has a history of substance use disorder.

She's divorced or currently a single parent. She's what we call in that sandwich generation where she's caring for an aging parent and also still has a child under her care in her home. And she may or may not be getting support as far as parenting with her teenage son because of the statement saying on occasion. And she's also having now some potentially socioeconomic concerns regarding a position that may be being eliminated. So I wanted to ask, and you can put this in the Q and A, what are some thoughts, positive or negative, that come to mind regarding Carol during this entire conversation?

I would like us to think about Carol, the different situations that she's in personally, professionally, and how when we have certain thoughts, whether they're positive or negative, they may impact any

interactions we have with Carol. If she comes across our path and is seeking care.

The next thing I wanted to talk about is acknowledging it, this implicit bias and impact on care. Because whether we realize it or not, our internal thoughts and emotions do have impact on interactions with people with behavioral and or medical healthcare conditions.

And we have to be careful with the words we use when we're talking and interacting with people who seek care, because those are just as important as that, those other types of feelings that we may have.

As we talk about diagnoses and health conditions. I've been shifting towards using the word health condition because I think it gives us a different perspective of viewing people who are seeking care, Whether it's behavioral health or medical related. Using the word health condition, I believe, provides a different lens to view people. Oftentimes we may look at people as a disease state rather than a person with a health condition. And if you've worked in acute care or in particular areas where there is a strong medical presence or a physician presence, then oftentimes we shift into viewing patients or people seeking care under the medical model.

They enter into our spaces, into our healthcare settings with a particular issue. And we unfortunately, oftentimes can look at the person as their diagnosis or their symptom or their issue, rather than a person as a whole. And so we have to make sure that our efforts to treat and we should consider the whole person. And there's been efforts to improve that care, to look at people as a whole person. So, for example, I've seen in my career as a nurse, the transition to having multidisciplinary team rounds, Bedside rounding, electronic medical record, screening questions, case management, assessment, family meetings.

In my opinion, all of these things help us to shift to look at the person in the context of their disease, but also in the context of the other issues that surround our patients. When you have the entire healthcare

team come together, even though we each may have a different focus, Whether you are a nurse, a physician, a social worker, behavioral health professional, you have a different perspective based on your training. But when you come together, look at the person as a whole, then each of these different disciplines can interact and can really see that we can work together, Even when we have a different purpose for our interactions and come up with a plan that will greatly benefit the people that we're caring for.

As I was doing some digging and thinking about behavioral health, I came across something called the STOP criteria. And it's a way to recognize attitudes and actions that support negative stereotypes. And again, as we think about implicit bias, emotional intelligence and that cultural intelligence, those key terms we spoke about at the beginning, this is a tool that you may or may not want to adapt, or you may or may not have heard of, but it was rather intriguing to me. So when we think about attitudes and behaviors, we want to think of this acronym, stop. So the S is for stereotypes.

So stereotypes people with mental health conditions. That is, you may assume that everyone with a particular mental health condition is all alike rather than individuals. And that gets back to that interdisciplinary team's approach. And that coming together different disciplines to come up with a plan for that specific unique person. The T that acronym indicates trivializes or belittles people with mental health conditions and or the condition itself.

So we have to be careful that we don't do this and let our attitudes and previous experience, maybe with a similar person, impact how we're dealing with the person that's in front of us right now. O means that these types of behaviors can offend people with mental health conditions by insulting them. And the P indicates that you patronize people with mental health conditions by treating them as if they were not as good as other people. So again, we all know that some of these preconceived notions and behaviors can have a negative impact. So when you think of this acronym and the examples of what

each of those step criteria indicate, it's a very good way to kind of catch yourself and try to prevent you from unfortunately letting some of those preconceived notions that we all have impact care to people who are seeking assistance.

And again, in behavioral health, some conditions are chronic and require daily management similar to medical conditions. So patients who have long standing health conditions need to manage them similarly to diabetes, heart disease, or chronic pain. There's work that needs to be done every day. Whether it's a medication treatment, whether it's some type of behavioral therapy, cognitive behavior theory, or counseling, we have to work every day on improving how we handle these medical conditions. And so we need to help our patients and the people coming to us to receive care, help them come up with tools that will work for them, that will be effective, that will be practical for them in order to help them to be able to manage all of these different health conditions that they have.

And we also know that healthcare is getting more complex and complicated. So the more we can arm the people who come to us for care with resources based on helping them improve their current situation, regardless of their past diagnoses, their past history, or what's going on in their personal environment. We have to really look at the person as an individual and not let preconceived notions about a particular population keep us from offering certain treatments and behaviors because we think it may or not work, may or may not work for that particular person.

So I just wanted to briefly pick up or bring up the 10 top 10 medical conditions impacting our population today in the United States. And all of these should look very familiar. But I wanted to also bring up with this slide, the fact that a lot of patients struggling with or diagnosed with heart disease, cancer, all of these different top 10 medical conditions may also have a behavioral health condition condition that coexist in conjunction with these medical conditions. You may have a patient who has been diagnosed with cancer, may be struggling with depression. Someone who had an accident or an unintentional

injury may suffer from ptsd.

There may be an anxiety component for someone who has Alzheimer's disease. So all in all, we can't simply just look at medical conditions and separate them from behavioral health conditions because indeed they. And that means we need to even be more aware of how our own thoughts, feelings and attitudes about particular people may impact this even more complex care that we're faced with dealing with today.

When we get to assessing implicit bias, there is a group out of Harvard and the group is called Project Implicit. It is a nonprofit organization and international collaborative of researchers who are interested in implicit social cognition. Their mission is to educate the public about bias. They have this very popular implicit association test that measures attitudes and beliefs that people may be unwilling or unable to report. And actually there are many tests available if you go to their website to measure your implicit association or implicit bias and attitudes on several populations and that may be of interest to you if you haven't heard of that resource.

They also say that people may discriminate unintentionally, which continues to have implications for understanding disparities. So again, we have to get to the root cause and figure out where these thoughts, attitudes and behaviors come from that we are exposed to during our lifetime that may impact people seeking care. And as of note, I have seen that this group has been criticized for their work. There has been writing in professional journals saying that there's inconsistency of results, that each time they take a specific implicit association test, a different score is received. So there is some, there have been some questions raised about the validity and reliability of these tests that they have.

So I would say anytime you find any type of resource where you can have a self assessment and do a test or some use some type of tool, always keep in mind that these may or may not be very stringent and very well tested. So just always make sure to do your research before you use any type of tool.

And you can imagine that if indeed every time you take one of these tests you get different results, it may lead to some frustration and a high level of anxiety. Because if you really feel at your core that you don't necessarily have stereotypes or attitudes toward a particular subset of the population and you get this test back and it says you do indeed may have some type of these tendencies that can be very uncomfortable to deal with. So always keep in mind whatever tools you use, do your research and make sure that they are valid, valid, reliable tools.

One thing I also wanted to speak about was care seeker perceptions. So when people come to us seeking care for behavioral health and medical conditions, they're. They have a lot of perceptions based on how they're treated. Some patients feel or people seeking care feel they're treated differently because of factors beyond their control. They may feel because of their race, their gender, their heredity that leads them to having a tendency to have a certain health condition occur more often.

They may feel like they're being treated differently because of these factors they can't control. They also feel that oftentimes communication lacks empathy and people seeking care will tell you talk to me as a person, not a disease. As I spoke previously about using these new types of ways to approach patient care and management of conditions, looking at the person as an entire individual and not just disease. And then we want to make sure that plans of care are for me are different than for others. Again, tapping into that uniqueness of this particular person.

We know that social determinants of health, your insurance status, you can be underinsured, uninsured, that also can have an impact on plans of care, your socioeconomic status, being a person with substance use disorder. Make sure that you look at take all of these factors into condition and don't make assumptions about people who you may know a few things about, but that does not indicate about that entire person. And during my time as a staff nurse case manager, I've worked in the medical science. As a medical science liaison in the medical device industry, I've worked with people who cared

and expressed concerns regarding their care. And so it's very important when we're talking about improving the quality of care and decreasing risk and improving safety for our patients, it's very important that we keep all of these perceptions in mind and that when we're meeting with people to help manage their disease states that we are offering them things that can help them be successful and manage that.

As we spoke, that 80% of the time when they're out of the healthcare system and having to manage things independently in their home. So again, as we think about Carol, what are some biases Carol may encounter when seeking care? What are some concerns Carol may have when seeking care for her family? How can healthcare professionals support Carol and her family? As we go through this and continue to talk about implicit bias and some other things, think about Carol and challenges she may have, and I did see some really good insight and good questions posted in the Q and A.

So thank you for that.

So when we think of the impact of implicit bias, it can cause a lack of empathy. And all workers in healthcare who cross paths with people seeking care, not just licensed professionals. You may have someone coming to employment who says the valet who parked their car was inappropriate and did not treat them with respect. You may have someone have a negative interaction with environmental services when they go to use the restroom during an appointment. You may have someone report an unpleasant experience with a transporter who was, you know, providing the transportation to an X ray or from one building to another.

So it's not just about licensed healthcare professionals. It's everyone who's in that healthcare setting, in that physical environment that unfortunately can express a lack of empathy for people who are dealing with unfortunate healthcare conditions. We can have empathy, increased risk and safety issues in healthcare settings. And it's all people, employees, and the consumers seeking care. So that's

important to keep in mind as well.

It can be us as well as the people who are seeking care that are impacted by implicit bias. This implicit bias can impact and cause a poor quality of care because beliefs and attitudes of behavioral medical health professionals can oftentimes limit access to certain treatments and procedures. If you feel that at your core that a particular population would not accept or be successful with a particular treatment, and this again is emphasized with this decreased access to treatment plans or care recommendations, minority populations remain absent from research studies. So a lot of times people may ask, well, for someone like me, where's the research? Can you tell me how this would impact someone of my racial, ethnic group, of my gender?

And so sometimes we don't have those questions. So we really have to be mindful and thoughtful when we're looking at research and evidence based practice, look at the populations that these studies are performed on and trying to find evidence to support using certain tested and, you know, randomized clinical trials or whatever type of research it is. We want to make sure that those populations, that the samples are reflective of the people that we serve. And we want to make sure that intentional steps to increase access to diverse populations and IRB proposals is also very important. If we're working in academic setting or in a strictly research environment, it's very important sometimes that we have discussions about oversampling in certain populations so we have a diverse body of the sample so we can generalize our findings.

Then when we think about ethics in healthcare, we all were introduced to ethics on some level during our education to become a healthcare professional. And I just wanted to quickly review these four terms. Beneficence is the act for the benefit of all. To act for the benefit of all people. Non maleficence is to do no harm to people.

Autonomy indicates that people have the power to make rational decisions and moral choices. And that is regardless of their background or how how we feel about them, people have a right to make choices and then justice. We want to make sure there's fair, equitable and appropriate achievement for all people. And I wanted to note that this equitable care is a component of justice, indicating the term has been around for quite a long time. We must continue to work on improving diversity, equity, inclusion and belonging in the healthcare industry so that all of our people seeking care have the appropriate treatment and don't have limited resources when they're seeking care to manage their different medical conditions and behavioral health diagnoses.

When we think of ethical implications of implicit bias, there can be some definite implications. Biases, attitudes and behaviors of healthcare providers can negatively impact health outcomes for marginalized populations, including their care decisions. We can say that we may want to try to change recruitment and hiring practice to create a more diverse workforce, which may help to address some of the issues and concerns of implicit bias. We want to make sure we have increased training related to value and contributions from people of diverse backgrounds in the workplace. But if we don't have a diverse workplace, then how are we going to hear and accept those contributions that may be offered?

And then we need initiatives that discourage bias influenced health care that can impact treatment plans. Again, we want to make sure that we're understanding the bias where it's coming from and not letting that allow treatment decisions and plans we're making to manage care for people coming to get assistance from us.

So accepting it implicit bias. Who, me? Well, yes, you and actually me as well. We all have implicit bias. Whether we want to admit it or not.

It's not comfortable, but we all have felt uncomfortable maybe dealing with a particular person and we have to look at ourselves and say, wow, I didn't know I felt like that about a particular person, or I didn't

know I don't know where that feeling is coming from. So yes, you, me, all of us, we do have some type of bias and we have to learn to accept it, but then move on from it. We have to make sure we use accurate words when talking about people with behavioral and medical health conditions because as someone stated also that words are powerful and what we use to address people coming to seek care so why is implicit bias training needed? Well, one thing is we do not always say what's on our mind. And oftentimes because we don't say it, doesn't mean that it's not there.

So we may be unwilling and or unable to say what's in our mind. Oftentimes when we're unwilling, it can be because we're embarrassed to admit the truth. We don't want to say what's really deep inside. Also, if you're unable, you want to. You have that feeling that you truly believe this feeling is the truth.

The difference between being unwilling and unable is that one means you're purposely hiding something from someone, and the second means you're unknowingly hiding something from yourself. So it's very important that we as healthcare professionals have this training because it increases the quality and standards of our care, but it also helps us to identify some of these issues we may have that may be impacting the care we're providing for people who are coming to us to help manage these very complex healthcare issues.

One part of this is called critical conscious reflection. It's the process of generating thoughts as to where the bias originated from or getting to the root cause of that particular bias. It challenges one to own the feelings that arise when interacting with individuals who make you feel uncomfortable. And yes, we have all been in a setting in our professional capacity where we've interacted with someone who made us feel uncomfortable. And oftentimes we don't know why.

So that's the importance of participating in these types of trainings so you can get to the why and figure out what was that feeling and where did it come from. So when we're doing self reflection, we must be committed to addressing our own implicit bias. We have to be ready to explore the underlying thoughts,

behaviors and feelings of these potential biases. And we also have to realize there's some discomfort, but it's a good thing when performing self evaluation. It may be uncomfortable when we start thinking about this negative interaction we had potentially as a child or when we were in school.

And every time we interact with someone and that that memory comes back, it can be uncomfortable. But also identifying why it was uncomfortable, why it wasn't resolved, can help you figure out how to address it now and then be able to move forward and again. Self reflection increases the ability to witness and evaluate our own cognitive, emotional and behavioral pract and progress to change them as needed. So it's important to do this work. Not all states, as we are probably aware of, do require implicit bias.

Training, and some states are eliminating some of these DEI focused types of work. But if you are working in healthcare with the goal of improving care of people who are coming to you to improve their health status, it's very important that we take this upon ourselves, whether it's mandated or not, to understand what within ourselves can prevent us from providing quality care to people who need our help and how can we provide them with the appropriate resources that they need to be successful.

The next thing to talk about when we're talking about implicit bias, yes, we all have it, is accepting it. We need to accept that society is becoming more diverse every day. There's a lot of people that we interact with every day who don't necessarily look like us or come from the same background or have had the same experiences. So we have to learn to appreciate those differences. We also need to accept that public discussions on the impact of diversity can be uncomfortable.

You can be out in a public format or a public forum and these discussions and you hear dialogue and it can be very uncomfortable. But again, discomfort can be a good thing to help you to address and dig deep and figure out, why do I feel a certain way? Why did I have that type of reaction when I was exposed to this particular event or this person? And so it's very important that we increase our

acceptance. Another thing is that healthcare professionals need to address the role of implicit biases, excuse me, and how they can impact care.

Again, if you have some underlying stereotypes or attitudes or behaviors towards a particular population, it can impact the care that you provide to patients who represent those specific groups. And there's also evidence that indicates healthcare professionals exhibit the same levels of implicit bias as the wider population. So again, we are all humans. We were all born in certain circumstances, and we are human beings before we're healthcare professionals. And so we have to not make the assumption that because we work in health care that we can't, you know, have implicit bias and we're different from other people.

But in reality, we are all human beings and healthcare professionals do have the same level of implicit bias as the wider population.

I also wanted to talk a little bit about microaggressions. This is a term a lot of us have heard of and may not have seen the specific definition and incorporated this into our implicit bias training. So microaggressions are an unconscious statement or action regarded as discrimination against a marginalized community. When it's combined with implicit bias, it can be psychologically damaging. It can affect both people seeking care and providers.

Delivery of quality patient care is adversely affected and an awareness that implicit bias and microaggressions exist and recognition that these phenomena are problematic are the first steps toward fostering a more equitable and inclusive culture. And I'm seeing some of this great feedback on Carol's the case study. Our case study person, Carol. I see this about facing ageism and sexism and how that can increase her stress. There's a lot of different things about making sure she has appropriate support and resources.

We also have to keep in mind because of things she's experienced in life, some of those resources may not be offered to her. So I'm enjoying and appreciating seeing these questions and answers that you are posting here. Thank you. So I also wanted to share a couple of examples of microaggressions and you may think of Carol when we look at these examples. So one example would be of ageism.

A patient looks at someone and says, you look too young to be doing this.

Well, unless you know exactly how old someone is, you really shouldn't say this. But again, you look at someone and assume their age based on physical appearance when that may not be the case. There's people that may be more seasoned, as I like to call it, who look young and there may be a person who is younger who may look a little more mature or seasoned. And so we have to be careful with what we say. An example of sexism was when a physician says, hi, I'm Dr.

So and so and the patient responds with well Ms. Instead of referring to them with their title of doctor or physician. And then when we think of racism, a patient may say to a provider that they come across or to a healthcare professional, wow, you speak well for a. And you can put in a plethora of terms in that category. And then an example of an anti gay microaggression is patient says, oh, I see you finally got married.

How is your wife in this particular situation? This is a gay male doctor who married his partner. So again, there's underlying attitudes, behaviors and stereotypes when we come across certain individuals. And so we have to again be careful with the words we use.

And I wanted to just briefly speak about motivational interviewing considering the audience. Some of you are probably very have expertise in this area. I've done some motivational interviewing training. By far not an expert. But I wanted to bring this up because as we think about implicit bias, emotional intelligence and that cultural intelligence, those may have an impact when we're utilizing motivational

interviewing and working with people who are coming to seek care.

This is just A brief review of Motivational interviewing It's a collaborative, goal oriented style of communication with particular attention to the language of change. It's designed to strengthen personal motivation for and for a commitment to a specific goal and explore the person's own reasons for change within an atmosphere of acceptance and compassion. So when we're thinking of using MI strategies with people seeking care, we have to make sure that implicit bias and those other things don't impact when we're coming together to come up with a plan to help this person improve their condition. So again, in the spirit of mi, it's partnership dancing together, it's acceptance reference for diversity of humankind. It has a compassion component, top priority to well being of the one you're serving and empowerment helping people realize strengths.

MI spirit can be impacted by microaggressions and implicit bias. So it's very important again that we learn them, acknowledge them, and then we're going to move into addressing it. Embracing prevention strategies in the context of implicit bias. So this article Gonzalez et al. Spoke about teaching for IB recognition and management and there's some key concepts that they brought up and I didn't list all of them, but just a few that I thought would help with this presentation.

We have to create a safe learning environment. We have to normalize bias while reducing self blame. We have to integrate the science behind implicit bias and evidence for its influence on clinical care. We have to create activities that embrace discomfort because again, discomfort can be good if it means that it's bringing something to your attention that you hadn't previously thought of, but you're going to use that discomfort to move forward and change your thoughts and open your mind to some new types of information. We also make sure we want to implement implement, excuse me, critical reflection exercises and reinforce implicit bias recognition management as part of lifelong learning.

These articles spoke of transformative learning theory. Again, I'm by far not an expert in this, but I thought it was a good theory to take into consideration when we're talking about implicit bias, recognition and management. And it's an explanatory framework and a guide to inform instructional design related to implicit bias involves a process, it's triggered by disruption where you present someone with a particular situation that triggers some disruption in their current thinking and it's followed by revised interpretation of experience that guides an individual's actions. So again, it's a way to make you uncomfortable and then allow opportunities for you to move forward with some very personal skills to manage that level of discomfort or that disruption. So when we think about implicit bias, recognition and management.

We're striving for ideal, but we're accepting actual. We know that you may have some long seated biases and it's not going to change overnight. But making that intentional effort to identify your own biases and address them is very important. Different strategies include a disorienting experience, critical reflection, and acquiring and using skills to practice or role model new behavior strategies. Again, similar to when we discussed emotional intelligence, a lot of these things can be improved.

They're not stagnant, they're not set in time. As you grow and make some intentional efforts, these preconceived notions and behaviors and attitudes can change. Unfortunately, there can be some reinforcement of implicit bias when we don't address attitudes and stereotypes when we focus on one population of people. Again, implicit bias isn't just simply a black and white type of issue. It's not a racial issue.

There are many populations that have had implicit bias, types of attitudes and behaviors expressed towards them. And in certain beyond a racial concern, there's very many, many different populations that have been subjected to implicit bias. And it's not simply, as I said, just a racial or ethnic issue. And again, as we know, states are gradually acquiring training for healthcare professionals. Some are

actually rescinding and restricting training.

So it really is something that we as healthcare professionals have to be committed to, as I stated before, not because we are forced to do it or made to do it because it's the right thing to do. So when we think about implicit bias management strategies, we're going to talk about this disorienting experience. So this process involves you think critically about your experiences and then there's a process of self awareness and promotes a deeper level of understanding. So again, one example is the implicit association test. And again, as I stated, there's been some recent concern on the reliability and validity of those tests.

So again, there's other resources. There's a be equitable, that is a group that has a website that has a lot of resources as well, so. Or you can do your own work. And again, I'm not promoting any particular assessments but just providing some information. And one way to utilize this self awareness and promote deeper level of understanding is to view a video of an interaction with a patient which includes examples of implicit bias.

So that's really an active way to address that self awareness and develop a better understanding. And it's a safe space. You see a video and you can work on it individually or in a group to see where these feelings came from that you are experiencing.

And then when we think of implicit bias management strategies too, we have to have critical reflection and dialogue, written or verbal prompts to a scenario. So there's two ways to do this. We can have self reflection, document your thoughts about a culture and think peer share with people in the room. And that's in a safe space. And then we can ask learners to discuss experiences which they observed how implicit bias adversely impacted a patient care experience.

So again, this provides opportunities for people to come to training and work amongst groups and help people in a similar professional capacity understand and reflect in a safe space about these feelings that they have.

And so I do see a question what our thoughts on individuals after completing these trainings believing they're experts and no longer have to do continuous work. You know, we'll get to that a little bit later. I think that'll be a good question for us to close out with. So thank you for adding that. And we will and discuss that a little bit later.

As far as implicit bias management strategies, three, it's important to acquire or use skills to role model new behavior. So two ways to do this would be role play, where participants are channels to simulate a patient journey through a clinical environment that reflects the impact of implicit bias. And then standardized care with a virtual patient. I know in nursing, I am a nurse, as you noticed when I started this presentation, for my credentials, we're doing a lot of use with virtual patients. And so again, that creates a safe place where you can interact with a potential person that you may come across.

And it allows you to practice and acquire skills that you can use to model the appropriate behavior when you're addressed or when you're interacting with someone that you may have some preconceived notions about. And that is a safe space, again, where you can evaluate yourself and identify things you come across and be able to change how you impact in the future.

So as far as takeaway points, this presentation is simply an introduction to implicit bias training. And more education is definitely needed for behavioral health and medical healthcare professionals. And I apologize if there are issues with the microphone. For effective implicit bias training, we have to make every attempt to incorporate all marginalized groups of people. Effective training reinforces that it takes time for change to occur.

It includes impact on patient health outcomes. Because if we are limiting the types of treatment plans and modalities that we're using to manage behavioral health and medical conditions, then we may be impacting our patients health outcomes by not offering them some resources to manage their particular health conditions because of a feeling that that Particular group or person may not receive the treatment, follow through on it, and those types of things. So it's very important when we're thinking about patient outcomes that we want to make sure that our people that we're interacting with have a wide variety of options to manage their particular healthcare concerns. And effective training also provides opportunities for healthcare professionals to address attitudes and behaviors that can ultimately lead to unfair treatment.

And so we have provided links to some ethics codes that you can look at for your reference.

And then we have several pages of references and we can take some questions.

All right, thank you so much. I think we're going to move into the Q and A portion for today. So I'm just going to open up the Q and A and look at what questions we've got. It looks like the first question is, what happens when people believe that completing implicit bias training makes them experts who no longer need to do the work?

So I would say that you definitely would need to really look within yourself, because I believe as healthcare professionals, we're lifelong learners and any new content that we come across, even in nursing, when you did your professional training as an audiologist, it took years for you to feel confident in your skill set. And so I would say that one training definitely would not make someone be an expert in addressing their own implicit bias and other issues. But again, I think just having open ended, honest conversations with a colleague, you may come across someone who said, you know, I did this training and I don't think I need to make any changes. And then you could say, well, there's things you learn day one as an audiologist that may or may not apply after you've been in this profession for a while. So just

being open minded and having conversations about, well, why would you think that?

And what did you learn from that particular educational session that you think makes you an expert? And maybe you can share how you've become an expert and offer me some suggestions and advice because I still struggle with some of my own preconceived notions and thoughts about certain patient groups that happen. And so I think just having an open and frank conversation, because I'm still not an expert, I don't think in nursing, again, I still enjoy learning new things, learning new ways to communicate with patients and families and making sure they understand their treatment plans, their chronic disease, that they're managing, whatever state that they appear to receive care. It's always an opportunity to learn new information and learn how to communicate that better with new population.

That's great advice. It's always good to keep that in mind, there was a comment here, I'm trying to read and talk at the same time. Probably not a good idea. There was a comment about assumptions that women over exaggerate symptoms and how that could also play into women over exaggerating tinnitus, dizziness or pain associated with hearing or balance disorders. And do you have any thoughts about that?

That's an excellent point. And I actually have been recently working on a research study with veterans, and particularly female veterans, and I believe encouraging our female patients, patients who identify as female, to have their own voice. And I coach patients to be prepared when they go for visits, have a list of questions. Oftentimes it's intimidating to go in to seek care for what may not be a common illness. And again, if women are perceived to be as fragile or their symptoms aren't actual viable symptoms, we know the history of cardiology research, you know, women's chest pain and other cardiac type of symptoms have been kind of put to the side and it's, you know, it's depression.

She needs, you know, an antidepressant. But, but I think just coaching our patients to be confident and be advocates for themselves and if they feel that their, their symptoms aren't being addressed, then be

able to articulate that and say, you know, I'm, I've come here to get assistance. I've been dealing with this issue for X amount of time. How much more, more clearly can I articulate this to you? I'm not understanding what you're sharing with me.

What's the next step? I think those are good prompts for female patients particularly to have confidence and feel that you deserve the right and you have the right for your symptoms to be properly addressed and you have the right to question things and make sure you have an understanding. And if there's a female provider available, you can request that. Although that may or may not always work either. But I think just in promoting self confidence and self advocacy and the ability to ask questions in a non antagonistic manner to get a proper response, that is definitely a wonderful tool and tip for all women to be able to ask those questions.

And I'm always trying to teach my daughters the same thing. We've got another question, more from clinical supervisor point of view. And if you have a student clinician that you're working with and maybe they have a specific bias that you've been working with and it just doesn't seem like they can work through it or get make any headway on it, what additional strategies might that clinical supervisor use to support some change with them.

That's a good question.

I would say even having them write maybe a couple of paragraphs about this particular feeling that they have and maybe go into a deeper kind of root cause analysis. Where did this, these feelings originate from? Have there been some negative experiences in their past that haven't been resolved? Those are a few strategies I would try to have an open ended conversation. Students can be challenging.

I would definitely reach out to maybe an advisor in the program and share, you know, this feedback that this patient seems to or this, I'm sorry, this student seems to be struggling with a particular type of

patient and some beliefs that they have and you feel that that may not bode them well as they progress in the program. There's some additional learning strategies, some additional learning exercises. There were some things on a couple of the slides, some pages, some different tests, you know, the implicit bias test and maybe challenge them. You know, I see your thoughts, you know, haven't changed much. And here's some strategies because you're going to come across all types of patients from all different demographics, socioeconomic status, race, gender, etc.

And the more prepared you are to appropriately manage and address patient concerns without letting your personal opinions interfere. It's going to be a great tool to have as you progress in your career. That's excellent advice. All right, I think that's the end of our questions and at this point I think we can advance to the last slide. There we go.

And I just want to thank everybody for attending today. I know that ethics and implicit bias is always wonderful content for everybody that is so, so very much needed. And as a reminder to the audience, make sure to go back to audiology online. Once this course has end to take and pass your 5 question multiple choice test, it will only be in your account for the next seven days. So in order to earn the CEU for this live event, you're going to need to get back to do that.

And again, I want to thank Dr. Holmes-Walker for being here and we really appreciate it. Thank you for the opportunity. All right.