3 ways to mitigate implicit bias in the exam room

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Bias can be explicit and intentional, or implicit and unintentional. But when a physician senses that bias may be affecting patient care, there are some concrete actions that can be taken to make patients feel more comfortable in the exam room.

One aspect of Medscape's "Lifestyle Report 2017," is the effect that bias toward several patient factors can have on a patient's comfort or care. The physicians surveyed picked four patient factors that have elicited bias: heavier weight, emotional problems, low intelligence and language differences.

When asked whether that bias affected patient care, the same four patient factors took the top of that list as well, but in an adjusted order: language differences, emotional problems, heavier weight and low intelligence.

"We deal with a lot of patients who are from different countries; English is not their native language," Fatima Cody Stanford, MD, MPH, MPA, told *AMA Wire*® after seeing language differences on the list. "I should not be discriminating or treating them adversely because of that. Yes, it does take a bit more time to care for a person who speaks a language that is different from my native English, but that person still deserves the same respect and attention as my English speaking patients."

Dr. Stanford is an obesity medicine physician at the Massachusetts General Hospital (MGH) Weight Center and an instructor of medicine and pediatrics at Harvard Medical School, where she conducts research on obesity, health policy and health disparities.

"Race, socioeconomic status, weight status; I would say those three … are the things that are most likely to portend to disparities in care," Dr. Stanford said.

From her experience treating patients with obesity at the MGH Weight Center, Dr. Stanford offered some advice to help physicians avoid bias, whether explicit or implicit, in patient care.

Use people-first language. “We don’t say, ‘a depressed patient’ or ‘a diabetic patient,’” Dr. Stanford said. “When we change the language to people-first, meaning a ‘person with obesity,’ we remove some bias that we have. Avoid labeling a patient with a disease, she said.

Instead, say that they “have” the disease. For example, “they have diabetes, they have obesity, [or] they have Parkinson’s,” she said.

More robust education. For physicians to discriminate for any reason, “let alone some of the reasons here that really are specifically targeting disenfranchised groups, speaks poorly,” Dr. Stanford said. “To make sure that we are aware of our biases … we need to do more training at the medical school and residency levels.”

“All of us will have those explicit and implicit biases,” she said. But physicians need to not only determine whether or not they have biases, but also what strategies can be taken to address those biases so they don’t negatively impact care.

Specifically, when it comes to patients with obesity, “In all disciplines throughout the country, obesity education is minimal at best, despite the fact that ... no matter what specialty we’ve chosen to embark upon, we will be affected by patients that struggle with obesity.”

Don’t assume the cause. “The likelihood that someone would have obesity just related to diet or exercise is relatively minimal,” Dr. Stanford said. Obesity is most often related to genetic factors, but stress, sleep, circadian rhythms and medications are just a few of the other possibilities that can contribute to issues with weight regulation.

“My challenge to physicians would be to not assume that the person has made poor choices that have led to their current weight status,” she said. “Before we assume that the patient is entirely responsible for their obesity, we need to dig a bit below the surface to determine what factors likely contribute to their obesity, and how we as clinicians can intervene to help them achieve a happier, healthier weight.”

Refer patients to a specialist. “My heart is broken when a patient comes through the door … and the physician tells them to just eat less and exercise more, and they’ve been trying that for the last 25 years,” Dr. Stanford said. “They come to me frustrated saying, ‘Look, I’ve done these 26 diets, these 30 different exercise programs. I’ve tried everything that I could potentially think of from a behavioral standpoint.’”

“It shouldn’t be 26 years later that they’re seeing someone like myself,” she said. “If it’s out of the training, expertise or comfort of a physician, there are persons like myself who are board certified in obesity medicine who can help when things appear to be outside of the control of what either the primary care physician or another subspecialist can treat, and utilize that.”

“Make sure that the patient is getting the best care,” Dr. Stanford said, “because if they reduce their obesity, the likelihood that that will impact all of their other disease processes is quite high in a very positive way.”