Mitigating Bias in Reproductive Health Conversations

Michelle Quiogue, MD, FAAFP

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Dr. Quiogue is an AAFP Health Equity Fellow and former president of the California Academy of Family Physicians. She earned both her bachelor's degree in medical anthropology and her medical degree from Brown University in Providence, Rhode Island. Upon fulfillment of her service obligation as a National Health Service Corps (NHSC) Scholar, she joined Kaiser Permanente Kern County Medical Center, Bakersfield, California, where she has championed culturally responsive care programs and physician wellness. In addition to being on faculty at Kaiser Permanente School of Medicine, she serves on the Equity, Inclusion and Diversity Advisory Committee.

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Learning Objectives

1. Describe the effects of implicit bias in conversations about reproductive health, contraception and family planning
2. Identify situations where personal implicit biases may influence patient-doctor relationships, diagnostic differentials, and preventive health services.
3. Apply specific bias mitigation techniques that can be used to create an inclusive clinical environment
4. Practice self-awareness strategies to mitigate bias in clinical practice.

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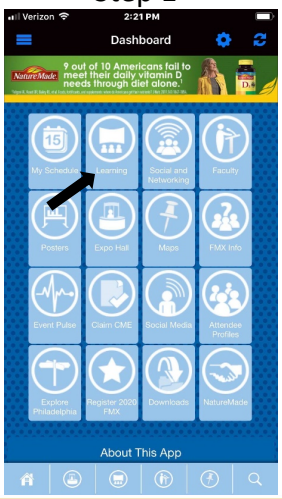
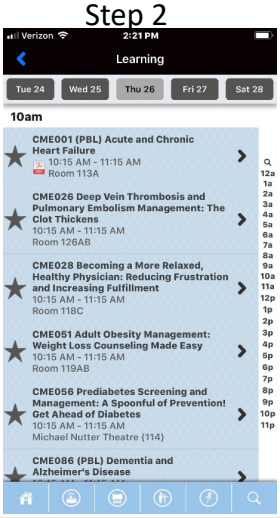
Audience Engagement System

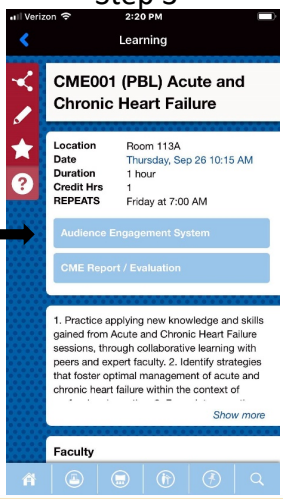
Step 1



Step 2



Step 3



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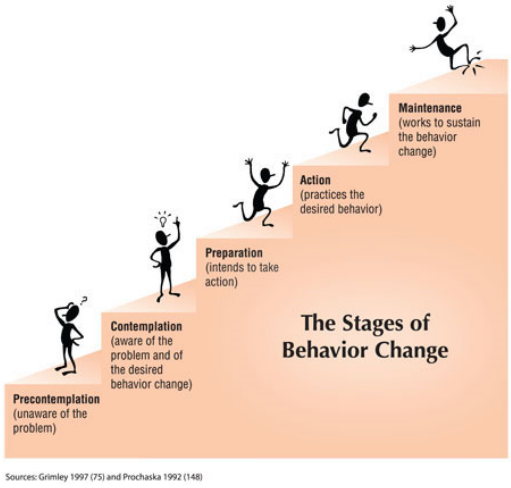
Self Awareness



Sources: Grimley 1997 (75) and Prochaska 1992 (148)

- Understand
- Decide
- Take Action

Definitions

- Reproductive justice
- Nonbinary, cisgender and transgender
- Transmasculine, transgender man, assigned female at birth (AFAB)
- Mistrust vs distrust
- Implicit bias vs explicit bias

Who's symptoms are psychosomatic?

The Pill in Puerto Rico story

https://www.pbs.org/wgbh/americanexperience/features/pill-puerto-rico-pill-trials

Hindawi

International Journal of Family Medicine

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International Journal of Family Medicine
Volume 2013, Article ID 642472, 8 pages
http://dx.doi.org/10.1155/2013/642472

Review Article

Sexual and Reproductive Health Care for Women wi Intellectual Disabilities: A Primary Care Perspective

Nechama W. Greenwood[1] and Joanne Wilkinson[1,2]

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Academic Editor: Samuel Y. S. Wong

Supplementary Material

Supplementary Table 1. Summary of Evidence and Clinical Recommendations

1. Supplementary Table

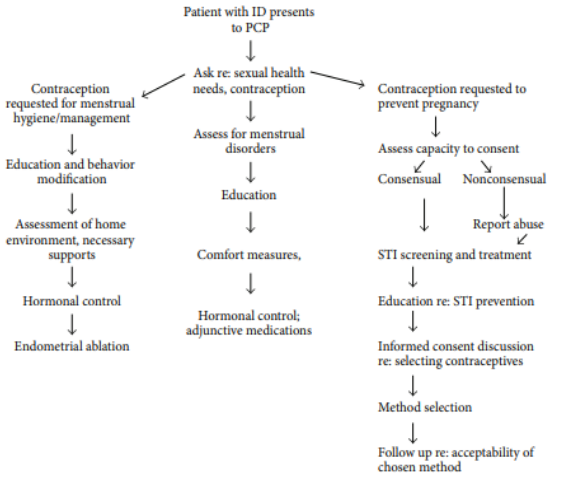


FIGURE 1: Algorithm for contraceptive decision making, updated from Paransky and Zurawin [40]

PNA

Home

NEW RESEARC

Racial bi treatmen beliefs a blacks a

Kelly M. Hoffman

PNAS April 19, 2016

Edited by Susan T. Fi 18, 2015)

Article

Significance

The present w critical health care domain with well-documented racial disparities. Specifically, this work reveals that a substantial number of white laypeople and medical students and residents hold false beliefs about biological differences between blacks and whites and demonstrates that these beliefs predict racial bias in pain perception and treatment recommendation accuracy. It also provides the first evidence that racial bias in pain perception is associated with racial bias in pain treatment recommendations. Taken together, this work provides evidence that false beliefs about biological differences between blacks and whites continue to shape the way we perceive and treat black people—they are associated with racial disparities in pain assessment and treatment recommendations.

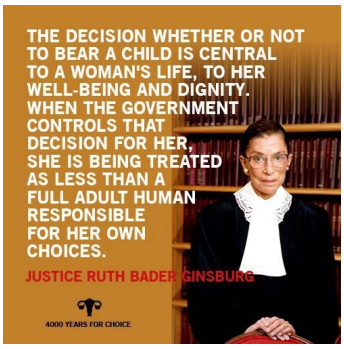
Abstract

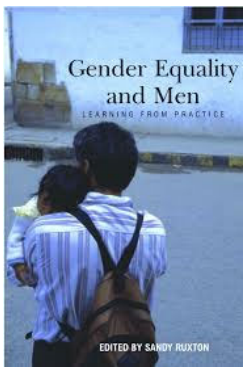
Abstract

Black Americans are systematically undertreated for pain relative to white Americans. We examine whether this racial bias is related to false beliefs about biological differences between blacks and whites (e.g., "black people's skin is thicker than white people's skin"). Study 1 documented these beliefs among white laypersons and revealed that participants who more strongly endorsed false beliefs about biological differences reported lower pain ratings for a black (vs. white) target. Study 2 extended these findings to the medical context and found that half of a sample of white medical students and residents endorsed these beliefs. Moreover, participants who endorsed these beliefs rated the black (vs. white) patient's pain as lower and made less accurate treatment recommendations. Participants who did not endorse these beliefs rated the black (vs. white) patient's pain as higher, but showed no bias in treatment recommendations. These findings suggest that individuals with at least some medical training hold and may use false beliefs about biological differences between blacks and whites to inform medical judgments, which may contribute to racial disparities in pain assessment and treatment.

Reproductive Justice

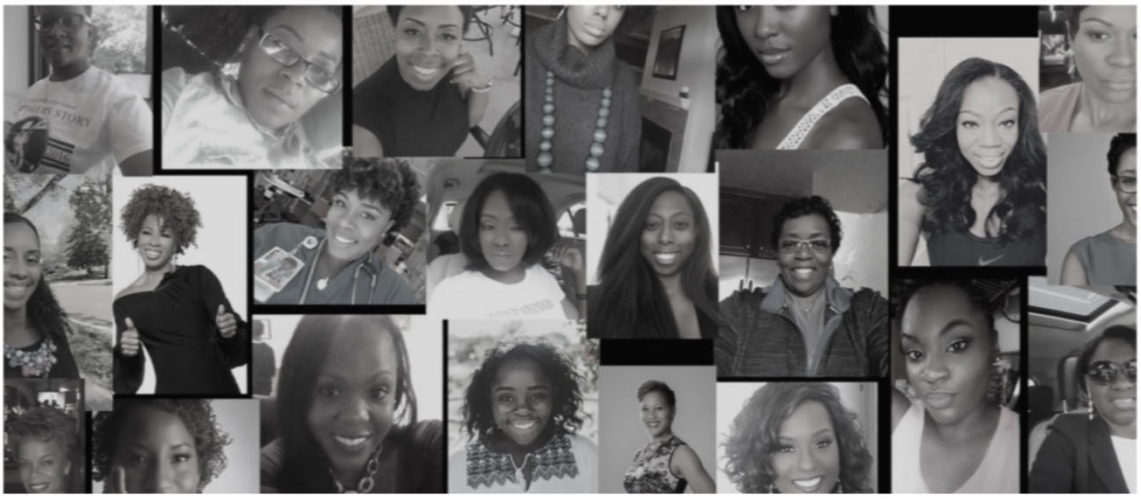
- Who's children become available for adoption?
- How does infertility impact men's lives?
- Who's fertility is worth preserving?
- Who decides when a person has enough children?





BLACK WOMEN'S HEALTH IMPERATIVE

https://www.bwhi.org/



NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

[FACT SHEET]
June 2015

Including People with Disabilities in Reproductive Health Programs and Services

COMMUNITY HEALTH

TABLE 1. REPRODUCTIVE HEALTH PROGRAMS OFFERED BY LHDS[1]

	Program offered by health department	Program inclusive of people with disabilities
Family planning services	48%	26%
Violence prevention	28%	25%
Education about mammograms	51%	21%
HIV/STI screening services	64%	20%
Education about pap smears	54%	20%
Teen pregnancy prevention	57%	18%
N=159		

Resources

The following resources contain more information on how to include people with disabilities in public health programming:

- *Strategies for Successfully Including People with Disabilities in Health Department Programs, Plans, and Services* (http://eweb.naccho.org/prd/?na598pdf)
- *Directory of Community-Based Organizations Serving People with Disabilities* (http://eweb.naccho.org/prd/?na597pdf)
- *National Assessment of Knowledge, Awareness, and Inclusion of People with Disabilities in Local Health Departments' Public Health Practices* (http://eweb.naccho.org/prd/?na631pdf)

https://www.naccho.org/uploads/downloadable-resources/Fact-Sheet_Reproductive-Health.pdf

http://www.nativeshop.org/programs/reproductive-justice.html

https://www.napawf.org/reproductivejustice.html

Poll Question #1

Birth control is contraindicated in transmasculine people while on testosterone

A. True

B. False

Medical Eligibility for Initiating Contraception: Absolute and Relative Contraindications

Risk Level	
1	Method can be used without restriction
2	Advantages generally outweigh theoretical or proven risks
3	Method not usually recommended unless other, more appropriate methods are not available or not acceptable
4	Method not to be used

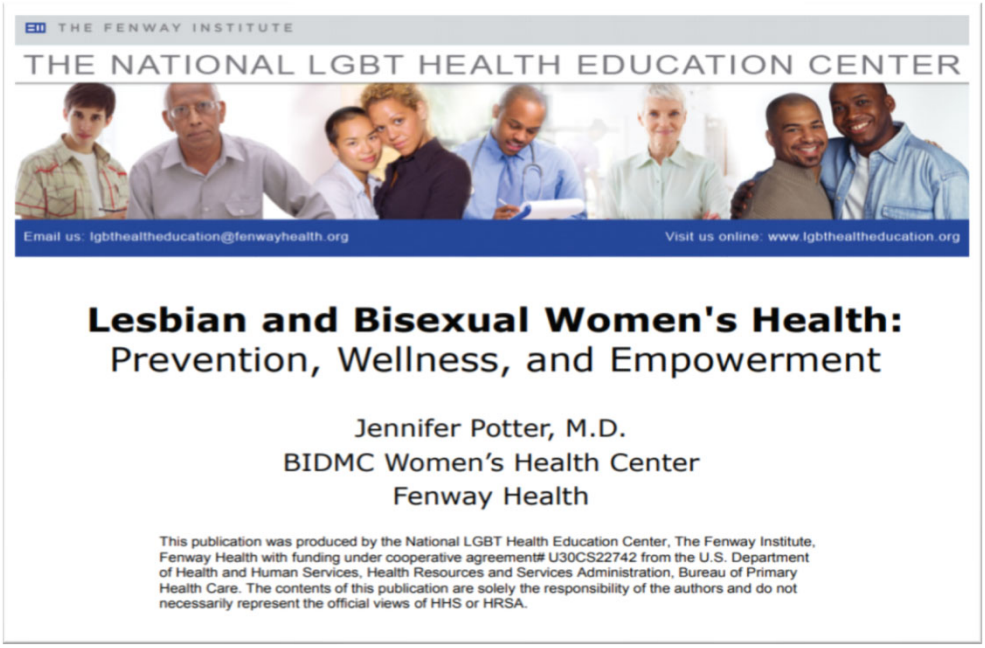
These contraceptive methods do not protect against sexually transmitted infections (STIs). Condoms should be used to protect against STIs. For more information, see

who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html
cdc.gov/mmwr/preview/mmwrhtml/rr559e0528a1.htm?s_cid=rr559e0528a1_e
cdc.gov/mmwr/preview/mmwrhtml/mm6026a3.htm?s_cid=mm6026a3_w
cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm?s_cid=rr6205a1_w
http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception
http://pediatrics.aappublications.org/content/early/2014/09/24/peds.2014-2299.full.pdf

Condition	Qualifier for condition	Estrogen/ progestin: pill, patch, ring	Progestin-only: pill	Progestin-only: injection	Progestin-only: implant	Progestin IUD	Copper IUD

Current ACOG recommendations for transmasculine persons

- All forms of contraception should be offered same as cisfemale persons
- Fertility preservation prior to starting transgender hormone therapy should be offered
- Transmasculine persons have achieved pregnancy while on testosterone
- There are no contraindications to concomitant use of estrogen or progesterone with testosterone
- Testosterone is not a form of birth control



An LGB Baby Boom?

- 41% of lesbians wish to have children (Gates, 2007)
- Random sample of households in 15 major US cities (Kaiser Family Foundation, 2001):
  - 8% of LGB were parents or legal guardians of a child under age 18
  - Among those who were not yet parents, half (49%) expressed desire to parent in the future

NATIONAL LGBT HEALTH EDUCATION CENTER

Parenting Options

- Children from previous heterosexual relationships
- Conceived through alternative insemination or surrogacy
- Adoption or foster parenting
- Blended families- step-parenting
- Extended networks of family/friends

NATIONAL LGBT HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

Resources for Patients/Families Organizations and Web Sites

- Gay, Lesbian & Straight Education Network (GLSEN): http://www.glsen.org
- Human Rights Campaign- Coming Out Pages: http://www.hrc.org/Template.cfm?Section=Coming_Out
- Parents, Family and Friends of Lesbians and Gays (PFLAG): http://www.pflag.org
- Family Acceptance Project: http://familyproject.sfsu.edu/

NATIONAL LGBT HEALTH EDUCATION CENTER
PROGRAM OF THE FENWAY INSTITUTE

Parenting Resources

- Alternative Families: http://www.alternativefamilies.org/
- The Organization of Parents though Surrogacy: http://www.alternativefamilies.org/
- Rainbow Families: http://www.familyequality.org/rainbowfamilies/
- Fenway Community Health Alternative Insemination Program: http://fenwayhealth.org

NATIONAL LGBT HEALTH EDUCATION CENTER

Poll Question #2

What percent of pregnancies in the U.S. are unintended?

A. 11%
B. 22%
C. 34%
D. 45%

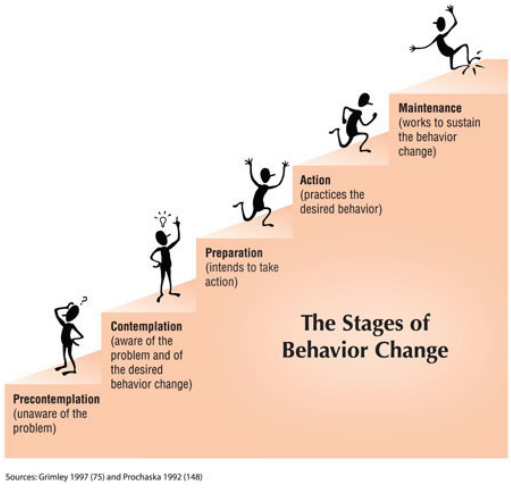
References: https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/index.htm

NARGES FARAHI, MD, and ADAM ZOLOTOR, MD, DrPH, *Am Fam Physician.* 2013 Oct 15;88(8):499-506

Truly Shared Decision Making

- Many patients currently feel they can't participate in shared decision making
- Power imbalances in the clinical encounter are a key barrier even when patients have the required knowledge
- Patients need to know that disagreement won't damage your relationship or impact their care
- The implicit attitudes of both patients and clinicians need to change to enable shared decision making

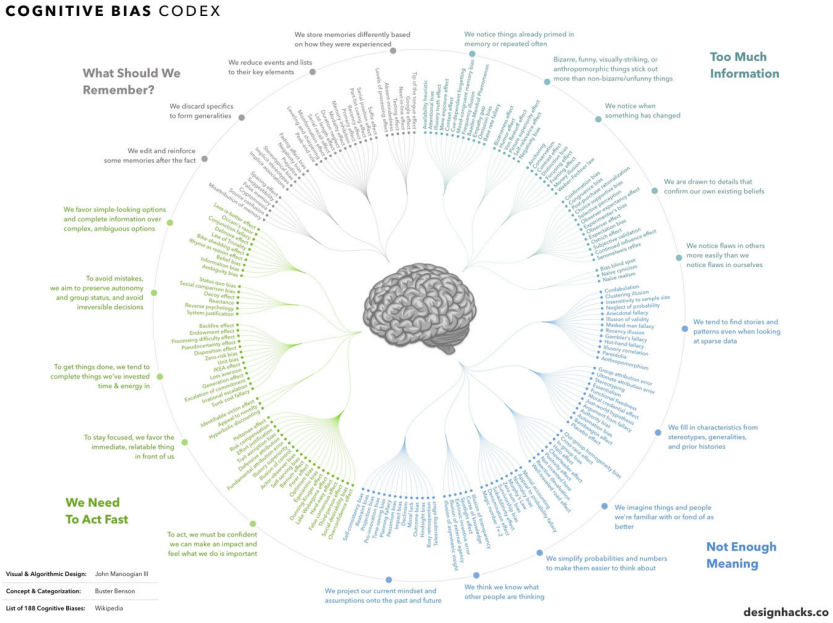
Self Awareness

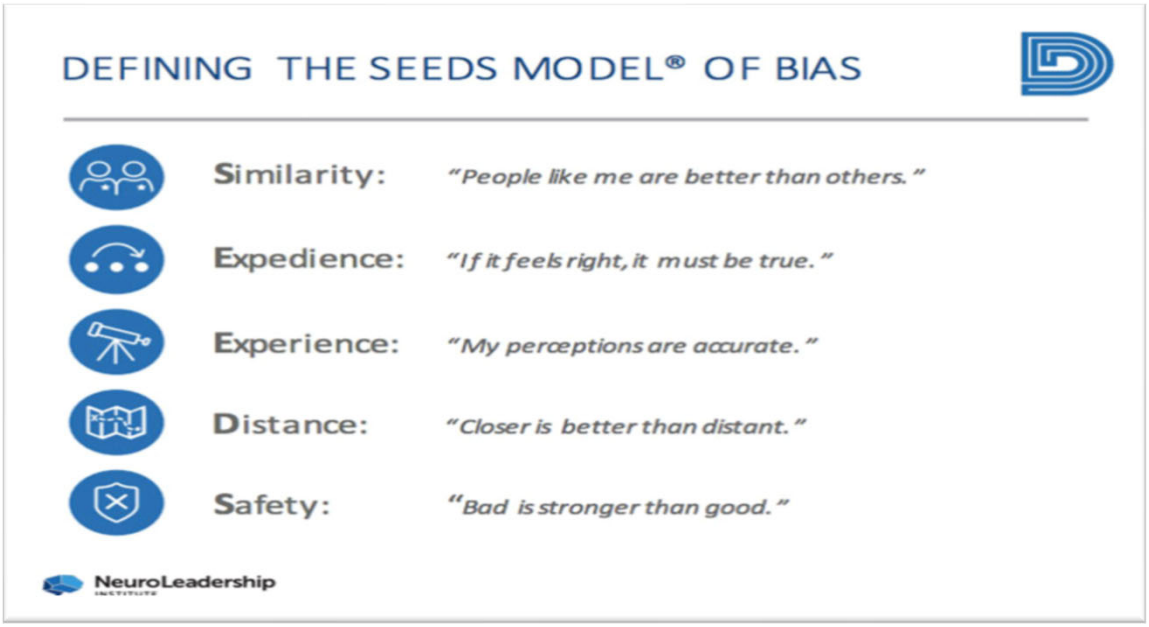


- Understand
- Decide
- Take Action

Check for blind spots

- Watch the AAMC Unconscious Bias module
- Take a few of the Harvard Implicit Association Tests
- Read Neuroleadership Institute SEEDS article


COGNITIVE BIAS CODEX
What Should We Remember?
We store memories differently based on how they were experienced
We reduce events and lists to their key elements
We discard specifics to form generalities
We edit and reinforce some memories after the fact
We favor simple-looking options and complete information over complex, ambiguous options
To avoid mistakes, we aim to preserve autonomy and group status, and avoid irreversible decisions
To get things done, we tend to complete things we've invested time & energy in
To stay focused, we favor the immediate, relatable thing in front of us
We Need To Act Fast
To act, we must be confident we can make an impact and feel what we do is important
We project our current mindset and assumptions onto the past and future
We think we know what other people are thinking
We simplify probabilities and numbers to make them easier to think about
Not Enough Meaning
We imagine things and people we're familiar with or fond of as better
We fill in characteristics from stereotypes, generalities, and prior histories
We tend to find stories and patterns even when looking at sparse data
We notice flaws in others more easily than we notice flaws in ourselves
We are drawn to details that confirm our own existing beliefs
We notice when something has changed
Bizarre, funny, visually-striking, or anthropomorphic things stick out more than non-bizarre/unfunny things
We notice things already primed in memory or repeated often
Too Much Information
Visual & Algorithmic Design: John Manoogian III
Concept & Categorization: Buster Benson
List of 188 Cognitive Biases: Wikipedia
designhacks.co


DEFINING THE SEEDS MODEL® OF BIAS
Similarity: "People like me are better than others."
Expedience: "If it feels right, it must be true."
Experience: "My perceptions are accurate."
Distance: "Closer is better than distant."
Safety: "Bad is stronger than good."
NeuroLeadership INSTITUTE

Poll Question #3

Patient requests birth control pills during her post partum visit. You grant her request even though she had an unintended pregnancy while on BCPs last year.

This is an example of which type of implicit bias?

A. Similarity
B. Expedience
C. Experience
D. Distance
E. Safety

Similarity Bias = Inaccurate

- People like me make better life choices
- People like me know how many kids we can handle
- They have different family values than me
- They probably don't need any more pregnancies/kids

Expedience Bias = Missed opportunity

- There is never enough time
- It takes too long to explain the risks, benefits and instructions for fertility preservation
- They want what they want
- Reviewing all of the options is a waste of time

Experience Bias = Not patient centered

- I don't counsel patients about some options because I haven't been trained
- Efficacy is the most important feature for all
- I don't offer same day start for LARC options because I haven't been trained
- You are not having side effects because I have not seen

Distance Bias = Disparities

- We haven't gotten pregnant so we don't need birth control
- Institutional barriers to switching methods when a patient is dissatisfied
- Only give information about methods that patients explicitly mention
- Neglect to give anticipatory guidance about teratogenic medications, fertility, missed doses, irregular menses, etc.

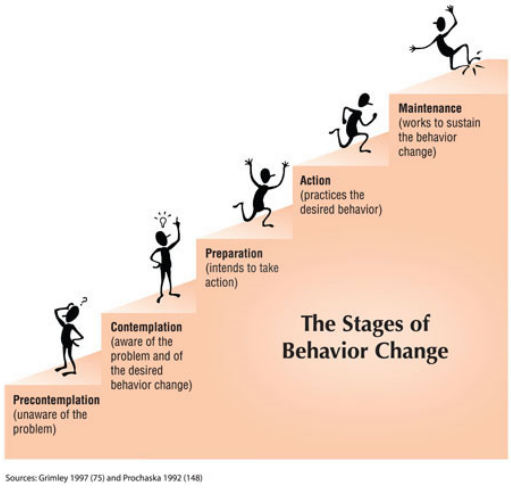
Safety Bias = Uninformed choices

- Less controversy to avoid mention of all available options for unintended pregnancy
- Safer not to screen for intimate partner violence or coercion
- Higher discontinuation rates when patients report feeling pressured
- Disproportionate level of concern for side effects & risks over potential benefits

The Triggers of Bias:

Similarity trigger:	Differences between evaluator and employee
Expedience trigger:	Deciding quickly
Experience trigger:	An absence of other points of view
Distance trigger:	Remote people, projects, and outcomes
Safety trigger:	Threat of potential loss

Self Awareness



- Understand
- Decide
- Take Action

SCARF Neuroleadership Model

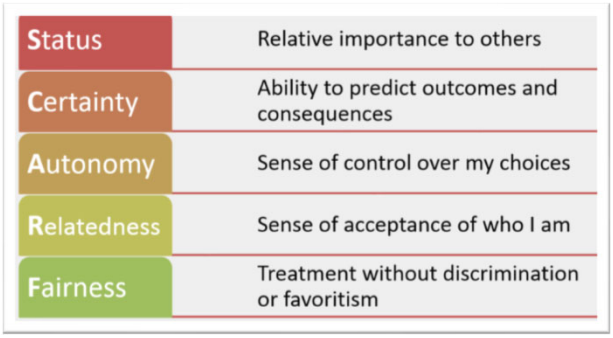
Status	Relative importance to others
Certainty	Ability to predict outcomes and consequences
Autonomy	Sense of control over my choices
Relatedness	Sense of acceptance of who I am
Fairness	Treatment without discrimination or favoritism

Communicate Respect

- Thank patients for waiting; acknowledge respect for their time
- Address new patients more formally at first
- Listen to concerns without interruption
- Regard patient as expert about their experiences, values and preferences

Partner Discussion

Which of the following SCARF model strategies is demonstrated?



Communicate Safety

- Warn patients prior to asking invasive or potentially upsetting questions
- Ask permission before initiating touch
- Explain what you are doing
- Use caring, sensitive language
- Assure patients that any information they share will be kept confidential

Partner Discussion

Which SCARF model strategy does this demonstrate?

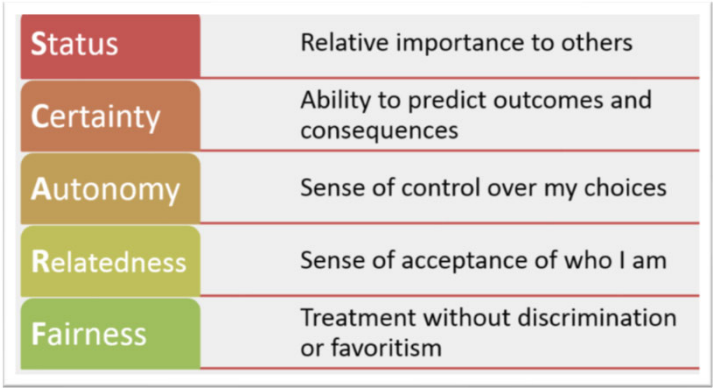
Status	Relative importance to others
Certainty	Ability to predict outcomes and consequences
Autonomy	Sense of control over my choices
Relatedness	Sense of acceptance of who I am
Fairness	Treatment without discrimination or favoritism

Communicate Kinship

- Make note of unique stories or reminders
- Discover common experiences, membership, community or interests
- Fill in knowledge gaps with facts instead of inferences and assumptions
- Establish shared treatment goals

Partner Discussion

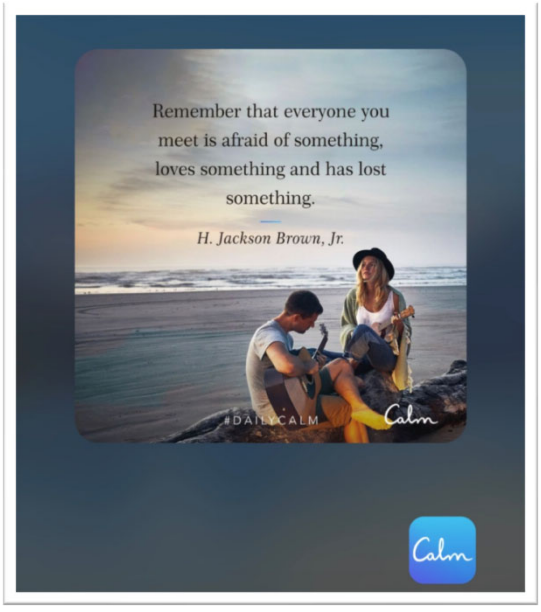
Which SCARF model strategy does this demonstrate?



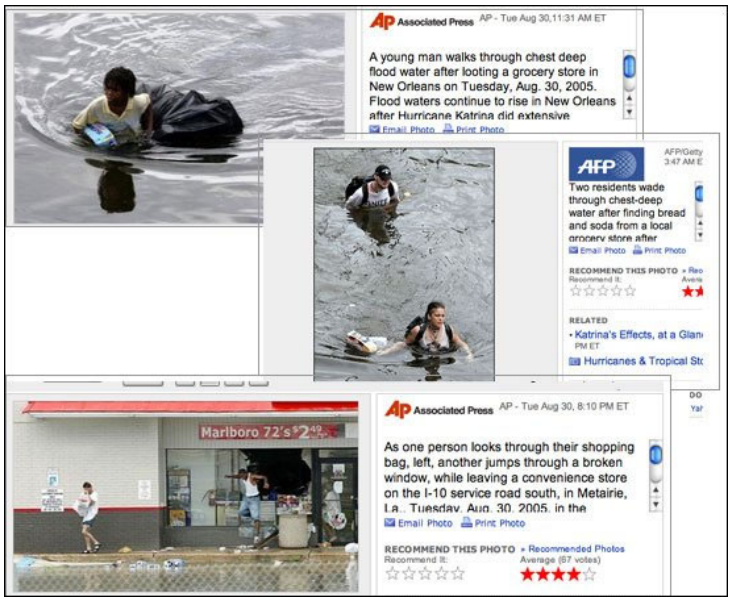
Breaking the habit

- Sentinel work by P. Devine, et al. in Madison, WI
- Premise that cognitive biases are habits that can be reduced through a combination of awareness of implicit bias, concern about the effects of that bias, and teaching of strategies to reduce bias
- Multi-faceted bias mitigation curriculum will produce behavior change by promoting the use of strategies to inhibit automatic responses

Strategy	Mindfulness
Background	Cognitive shortcuts are used inappropriately more often when we feel pressured. By engaging in mindful, deliberate processing our implicit biases are prevented from kicking in and influencing our behaviors. (A. Harris, et al, 2007) (Y. Kang et al., 2004)
Activity	1. Before an interaction with a member of a stigmatized group, take a few moments to a practice mindfulness technique 2. Intentionally and deliberately process your observations 3. Rely less on instinct

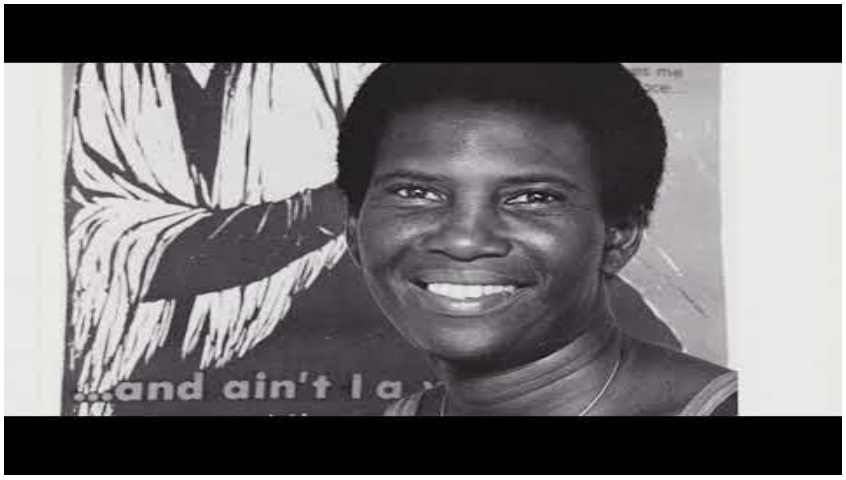


Strategy	Stereotype response & replacement
Background	This strategy involves replacing stereotypical interpretations for non-stereotypical ones. Practice this exercise before or after an interaction with someone from a stereotyped group or when observing media stereotypes (Monteith, 1993).
Activity	1. Familiarize yourself with prevalent stereotypes 2. Label an attribute as based on a stereotype 3. Reflect on why the characteristics of a group were attributed to an individual 4. Consider how the stereotype could be avoided in the future



Strategy	Positive Exemplar
Background	One way to learn more about building an inclusive and equitable climate is to talk with role models and seek experiences outside your comfort zone.
Activity	1. Plan to attend AAFP NCCL 2. Develop meaningful connections with leaders who seem to come from different world views 3. Seek opportunities to engage in positive face-to-face interactions with people in real life 4. Read novels, watch documentaries, and listen to podcasts created by artists of marginalized groups

Black Women's Health Imperative



Strategy	Counterstereotype imaging
Background	This strategy makes positive exemplars cognitively salient and accessible when challenging a stereotype's validity (Blair et al., 2001)
Activity	1. Find images of members a stereotyped group which counter negative attributes and reflect complex authentic diversity 2. Imagine vividly detailed images: can be abstract (e.g., friendly Black people), celebrity (e.g., Oprah Winfrey), or non-famous (e.g., your child's teacher) 3. View AAFP videos of us family doctors on the Facebook page

Strategy	Perspective taking
Background	This strategy involves taking the perspective **in the first person** of a member of a stereotyped group. Perspective taking increases psychological closeness to the stigmatized group, which ameliorates automatic group-based evaluations (Galinsky & Moskowitz, 2000).
Activity	1. Ask questions to show you're listening "What are some examples?" "Can you be a little more specific?" 2. If you sense a there is a lack of engagement, pause and ask, "What are you thinking or feeling right now?" 3. Elicit the patient's goals 4. Aim to accept each other as we really are

Make necessary accommodations

- Hold programs in **accessible** facilities provide educational materials in Braille, large print, audio, etc.
- **Educate staff** about providing reproductive health programs to people with disabilities
- Engage people with disabilities in **program planning.**

Strategy	Individualization
Background	This strategy relies on obtaining specific information about group members (Brewer, 1988; Fiske & Neuberg, 1990). Using this strategy helps people evaluate members of the target group based on unique personal attributes, rather than group-based.
Activity	1. Document unique stories or reminders in each patient's chart 2. Find shared experiences, membership, community and interests 3. Fill in knowledge gaps with facts instead of inferences and assumptions 4. Relate individual's uniqueness as additive to the diversity of the group (rather than as an exception that proves the rule)

Our patients

ONE KEY QUESTION® A PROGRAM OF POWER TO DECIDE

- "Would you like to have a child in the next year?"
- Yes, no, ok either way, not sure
- Non-judgmental
- Frames perspective from what they desire
- Feasible within a 15-minute primary care visit
- Improves patient communication
- Increases appropriate care (e.g. Rx for PNV, Emergency Contraception or Birth Control method)

OHSU Family Medicine Richmond Clinic

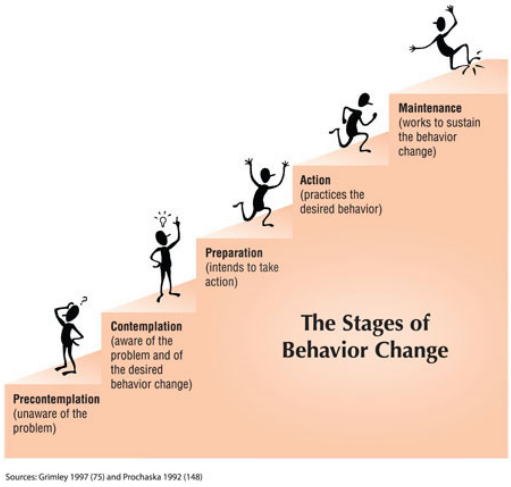
- 6-week pilot conducted in 2011 (N=154).
- None of the providers thought the clinic slowed or patient flow was significantly disrupted.
- The majority (77%) of providers thought communication with their patients improved because of this initiative
- 95% of providers reported they would recommend One Key Question®
- Women screened using One Key Question® compared to those that were not screened.
  - 3.5 times more likely to receive a prenatal vitamin prescription (p=.011),
  - 4.8 times more likely to receive an emergency contraception prescription (p=.003)
  - 2.07 times more likely to receive any reproductive health prescription (p=.003)

Poll Question #4

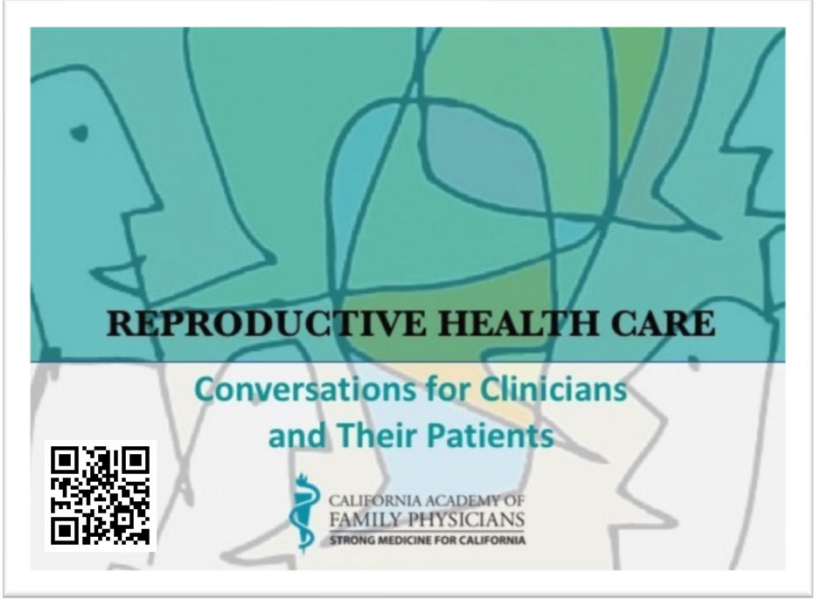
How likely are you to ask One Key Question within the next week?

A. I never need to ask this question in my practice
B. I need more information before I will start asking this question
C. I will definitely ask this question in the next week
D. I have already been asking this question in my practice

Self Awareness



- Understand
- Decide
- Take Action



MAINTENANCE OF CERTIFICATION

CAFP, in partnership with Interstate Postgraduate Medical Association, has developed an ABFM Part IV Improving Performance in Practice module. This module is designed to increase the use of One Key Question® for reproductive health planning, enhance physician-patient communication, and improve team approaches to care. The module is approved for ABFM Part IV credit, includes 30 AAFP Prescribed credits upon completion and is based on a team-approach [AMA PRA Category 1™ credit also is available]. The Part IV module is appropriate for any family physician, family medicine resident or other primary care physician plus your teammates.

Questions? Contact Shelly Rodrigues at srodrigues@familydocs.org.

8 Bias Mitigation Strategies

SEEDS/SCARF Model

- Communicate Respect
- Communicate Safety
- Communicate Kinship

Break the stereotype habit

- Mindfulness
- Response & replace
- Counterstereotype imaging
- Perspective taking
- Individualization

Practice Recommendation

ONE KEY QUESTION® A PROGRAM OF POWER TO DECIDE

- Ask all people of reproductive age:
  "Would you like to have a child this year?
- Check your blind spots
- Break the habit with practice

Practice Recommendation

- A proactive perspective towards mitigating implicit bias will lead to
  - informed, accurate decisions
  - productive, healing relationships
  - more equitable health outcomes

Thank you!

Vwdu#z khuh#| rx#duh1

Xvh#z kdw#| rx#kdyh1

Gr#wkh#ehvw#| rx#nqrz #krz #
wr#gr1#Z khq#| rx#nqrz #
ehwwhu/#khq#gr#ehwwhu#

00Gu#P d|d#Dqjhorx

CGuP lfkhT

Questions

FMX