Is unconscious bias Healthcare's "dirty little secret"?

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To be human is to have bias and all are likely to be part of a disadvantaged group but some groups have more disparities than others. Two orthopedic surgeons take the lid off one of medicines "dirty little secrets", discussing ways in which unconscious bias towards race, ethnicity, gender, class and condition results in better outcomes for some than others. Unless physicians can recognize and tackle their own unconscious biases, they may continue to be out of sync with their patients, and the nation will be sicker for it. With Professor Mary O'Connor and Dr. Bonnie Simpson Mason.

Dr. Mason Simpson: Hello, you are listening to the Health Disparities podcast from Movement is Life conversations about health disparities with people who are working to eliminate them. I am Dr. Bonnie Simpson Mason, Founder and Executive Director of Nth Dimensions and an orthopedic surgeon. Today, I'm discussing health disparities and bias with Dr. Mary O'Connor who's also an orthopedic surgeon. She is the Director of the Center for Musculoskeletal Care at Yale School of Medicine and Yale New Haven Health. Mary, thank you so much for joining us today. I want to talk about the difficult subject of bias and how bias is impacting, not just health disparities in our communities, but maybe even how bias is affecting the way we render care for disparate populations. So, that might be two different questions there. Nonetheless, I think you can tackle them.

Dr. Mary O'Connor: Well, Bonnie, thank you. It's great to see you, and this is such an important topic. I think of it as kind of like the dirty little secret that we have in medicine where we don't want to talk about the fact that bias impacts the recommendations that we as physicians give patients. It impacts how patients perceive those recommendations. There's bias on the part of the physician with the patient. There also can be bias on the part of the patient relative to the physician and care team. But of course, as we know in this conversation, the physician is really more of the driver of what is occurring in that healthcare space, right? The physician is the one making the diagnosis, making treatment recommendations, prescribing medication, or recommending surgery. And, of course, ideally, those decisions happen in a shared decision-making model but in my opinion, we don't do that very well.

Dr. Mason Simpson: I mean, ideally it happens in a sheer decision-making

Dr. Mary O'Connor: Ideally, and I think that one of the important points to understand is that when we're talking about shared decision-making, the difference between that and what we would say is "informed consent", is that shared decision-making takes into account the patient's values and the patient's preferences in terms of their care. Whereas the concept of informed consent is I'm going to do knee replacement surgery on you. And I've talked to you about the risks of the surgery and the potential benefits,

and you are making a decision because you have a basic understanding of the risk versus the benefit that has nothing however to do with your personal values as a person or your preferences. And where that I think impacts disparities is we have communities that have different cultural backgrounds. And so, not recognizing that there are some cultural influences and nuances in terms of how patients want to receive care matters. You know, I remember in my own practice, this was several years ago. I had a young woman from Puerto Rico and she was brilliant. She was very well-educated. Her father had died and she had a very challenging problem. And she came and her brother would always come with her to every visit. And I realized, I thought, well, isn't that nice? I mean, it's nice that she has a family member. She was single, but he was the eldest male in the family now and in their culture, right, that responsibility now fell to him exactly to do that and it was important for me to recognize the role that he played in the decision-making process. And it wasn't that I was changing my values or my beliefs, which is she, the patient is the one making the decision, but it was a recognition of the value and importance of his influence on her, right. In other words, I wanted him to be aligned with the direction that I thought was the best option for her. And I think my awareness of that cultural difference allowed me to have a better interaction and help that patient get to a great outcome with a lot more emotional comfort than I probably would have otherwise.

Dr. Mason Simpson: So, what you've just given us an example of is cultural sensitivity versus cultural competence. So, it's not just the knowingness, it's the understanding of how the patient wants to be treated and considering their cultural norms as a part of the decision-making and treatment process.

Dr. Mary O'Connor: Absolutely, but now let's take that to gender, race, and ethnicity because it's all the same. These are all the same concepts. And the central concept is if I'm the doctor and you're the patient and we're different, we have different gender, different races, and different ethnicities, we'll have different communication styles, we'll have different experiences. How effectively are we really communicating? And when you come in and you tell me as a woman that your knee pain is 8 out of 10, and a man comes in and tells me his pain is 8 out of 10, who do I think has more pain. The answer is they both have the same pain. But we are not brought up in this society to see that. We have an unconscious bias that women are more prone to exaggerate their pain. And so, then we under-appreciate the severity of symptoms and women are hurt medically. I mean, we have bad outcomes. I believe that we have avoidable deaths even because we are not really believing the patient and we're not believing the patient because we're taking our unconscious bias and overlaying it, at some level, on what they're telling us and discounting what they're telling us, in some manner.

Dr. Mason Simpson: So, Mary, now, is it your belief or your understanding that we all are bringing unconscious bias to the table?

Dr. Mary O’Connor: We all do.

Dr. Mason Simpson: Even, me, as a woman, I might bring my biased thoughts to the table or the decision-making process. So, everybody may not understand that.

Dr. Mary O’Connor: Correct. So, if we're human, we have a bias. We have conscious bias that we're aware of, and we have unconscious bias. It's part of the human condition. So, our job as physicians is to try and recognize both our conscious and unconscious bias and work to mitigate that so that we can provide more equitable care to our patients. I'll give you an example. If you look at obesity and I give a talk to a large group of orthopedic surgeons, and I say, how many of you enjoy operating on obese patients raise your hand. Nobody raises their hand. Okay. Now, obese patients may not quite understand that it's actually physically more demanding to operate on an obese patient. There's more risk, there's more stress, et cetera, and surgery is a physical profession. So, there's actually, I think overt bias, clear bias that people say, I don't prefer to operate on an obese person versus a normal weight person.

Dr. Mason Simpson: So, that's conscious.

Dr. Mary O’Connor: That's conscious. And even if it's not conscious, then I think a lot of people have it as an unconscious bias because of their experience and the fact that they know that the risk of, for example, wound healing problems, infection, blood clots are all higher in patients who are less mobile people who are obese. And so that can factor into, you know, or, is the risk of surgery too high? Should I not recommend surgery to you? Even though I know your joint is very arthritic and having the joint replacement surgery will help your knee, for example, but maybe it's just too risky for you otherwise.

Dr. Mason Simpson: Now, playing into implicit or the subconscious, unconscious bias, maybe how we're socialized to think about different groups of people, maybe the media, do those things also play into it.

Dr. Mary O’Connor: So, Bonnie, we have lots of data that tell us that we're not imagining these healthcare disparities. They're real. When I speak to this topic, which I do quite frequently, one of the things that's most important for me to tell people is that healthcare disparities are real. We're not imagining them, and you may not believe you're experiencing them, but the reality is unless you're a Caucasian male, you're in a disadvantaged

group from a healthcare standpoint. And even for Caucasian women, there are disparities. And we know that these disparities exist for example, in musculoskeletal relative to knee arthritis. Women don't have knee replacement surgery at the same "stage of the disease." as men. Women wait longer and then people would say, well, they're waiting because they're taking care of their families or they're risk-averse and other reasons. But we know that part of the reason why, that we believe women undergo joint replacement surgery, even though they need it at a lower rate and at a more severe disease state is because the surgery may not be offered to them at the same time as the man. Right? So, that is to the detriment of the woman. She improves after the knee replacement surgery, but she never ends up, this is what the data clearly shows that she doesn't end up with quite as good a result as the man.

Dr. Mason Simpson: If she had had it earlier, perhaps she would have had a better chance.

Dr. Mary O’Connor: Exactly. And we have to be careful with that message because ideally, we're preventing people from developing arthritis. That's our whole focus at Movement Is Life. You know, we understand that movement is the key to breaking the Vicious Cycle, which is joint pain, leading to decreased mobility, promoting weight gain. And that weight gain then puts more pressure on your knee joint, which produces more pain.

So, you get into this cycle, which ultimately results in knee arthritis, but then, what's associated with that obesity is hypertension, diabetes, heart disease, and what is very common, but very under-recognized is depression, especially in women. And, you know, as an orthopedic surgeon that most orthopedic surgeons don't really want to deal with or address depression that they feel, this is not my professional space.

Dr. Mason Simpson: Exactly, but what we know here with Movement is Life is that that's actually part of the natural sequella.

Dr. Mary O'Connor: Absolutely.

Dr. Mason Simpson: Of not addressing the knee pain at an early enough stage where we get into the Vicious Cycle. And I think it's just so important for us to really be as clear on that as possible, so our patients can even understand it, even if sometimes the physicians don't explain it to us, which is the point of, you know, why we're here having this conversation today, because you want to stay out of that vicious cycle, if at all possible.

Dr. Mary O'Connor: We have to improve the health of our nation and our communities, especially our communities of color and especially the health of women. That's what we absolutely have to do. The path and trajectory that we're on is unsustainable. I really find it's a moral

imperative. We can't leave. I don't want to leave this country to my children along this trajectory of, you know, the medical kind of disaster that we're headed towards. And the key to that is movement, it really is. We can become healthier. We can lower our risk of all kinds of other medical conditions that are very disabling, if we become more active and we move and we need to honestly lower this rate of joint replacement surgery. It is increasing. Its skyrocketing. It's just crazy how many surgeries we do. And I'm an orthopedic surgeon. I do these operations

Dr. Mason Simpson: Exactly. I mean, and I think one key to that is something that you alluded to was that as physicians, us having this understanding about the bias we bring to the table, which can help us, you know, start to have the conversations with our patients to impact the rate of arthritis earlier, understanding and encouraging our patients to move more earlier, from a preventive perspective, as opposed to just being reactive on the side of surgery or not being offered.

Dr. Mary O’Connor: But I'm often asked, Bonnie, what advice I would give an individual patient if they've seen a physician and they actually don't feel good about the interaction. So, I say to people, well, that's a red flag right there because you can have an interaction where the physician may not be telling you what you want to hear, but in the ideal setting, you believe

that that physician is telling you that news because they are doing it as a way of helping you. Okay. So, the patient comes to see me and she's really obese and her knees are very arthritic and there does come a point when even I say, we need to address your obesity before we can do your knee replacement surgery because your risk of a complication after the surgery is just so much higher, okay. Now, that's not what that patient wants to hear because she has struggled with her weight, her entire life but my goal is for her to at least feel that I'm not fat-shaming her, I'm not discriminating against her, I'm really trying to help her. And what we have done as a society is failed so many of our brothers and sisters, because they're in this situation where they're immobile, they're really big. You know, they're not a little overweight, they're really big, and they've developed all these other comorbidities and now we just seem to like to accept it and say, it's okay. Instead of saying, let's get out there, let's move, let's be healthier. Let's embrace healthier lifestyles.

Dr. Mason Simpson: And even, taking that same message because we're working with some of our medical students now and advocacy taking that same message to the decision-makers who are in charge of policy, but also the economics that sometimes prevents access to some of the same things that you and I enjoy, access to grocery stores, transportation, the actual healthcare facility that's there. We actually have access to it for any number of reasons but taking that message to a higher and to different

levels, so that some of these fundamental changes that the individual can't change can be addressed, but also empowering the patient him or herself to address what he or she can't change, by understanding the connection to the vicious cycle and the comorbidities.

Dr. Mary O’Connor: I'll share with you. One of my biases and that is I think the key to making our communities healthier and stronger is by engaging the women. I think, and this is again a biased and sexist comment, but I still believe that if you engage the mother in the family and you get that woman on board with how she is going to take better care of her health, because she cannot help anyone if she is sick, if she is disabled, if she is immobile. And that's an important lesson for all of us, particularly women where we are, you know, we may be working, but we're still often doing, caretaking and other roles. And how important it is for that woman to recognize that she has to take care of herself. And when she starts adopting healthier choices, it rubs off on everyone else in the family.

Dr. Mason Simpson: And everyone else is dependent on her for the modeling of their activities, their intake, their self-esteem, their self-worth. So, I think I agree with you on that point of bias because I mean, she is the linchpin for the family. And so, I think reaching more women, having them feel empowered enough to ask questions or to switch doctors as in the example you gave, if you do not feel that that person has your best

interest at heart, not that they didn't tell you something you wanted to hear, but be empowered to continue to find a surgeon you align with or a physician you align with better so that you two can partner.

Dr. Mary O’Connor: You have to partner. How can you know, and that patient needs their doctor to believe in them and boost them up and say, you know, I know you can do it. I believe you can do it. And I'm going to be right here with you. I'm not leaving you. I'm not abandoning you, but you've got to come partway here. Right. We have got to do this together.

Dr. Mason Simpson: Right. But that requires the physician to acknowledge his or her biases, so that maybe even share those in order to help build that trust bridge, address them so that they can build a greater level of cultural sensitivity that we spoke about earlier today.

Dr. Mary O’Connor: Absolutely. And we know Bonnie when we have healthcare teams that are more diverse, we make better decisions. I mean, business, big business has known this now. Look at all the studies that talk about gender diversity on boards of major companies and corporations and how they outperform competitors that have less diversity.

Dr. Mason Simpson: Absolutely.

Dr. Mary O'Connor: We see this.

Dr. Mason Simpson: Well, we know that if you are on a diverse team that is that varies by respect of gender or race and ethnicity, everyone's bringing their perspective, their life experiences, and their problem-solving skills to the table, which inherently you won't have because you haven't lived their life. So, when we build, and that helps to build more of a common respect for the people at the table, but it expands, we have a cross-learning shared learning experience, and it helps us understand how many different ways we can approach to solve a problem rather than just looking at it unidirectionally, or just from one perspective.

Dr. Mary O'Connor: You know, I'm hopeful that I see my children growing up in an environment that's more diverse than when I grew up. Their peers, they are just more diverse and that's because the demographics of our nation are changing. And as we know, the estimate is by 2044, which isn't that far away, we will no longer have a white majority and that the population increase is particularly strong in the Hispanic/Latina community. Okay. So, the face of the nation is changing. We are becoming more diverse. And when we have those populations that are having higher levels of adverse health outcomes, this means we're even at higher risk of having essentially a sick nation and that's just not the future that we want.

Dr. Mason Simpson: It's not okay.

Dr. Mary O’Connor: It's not okay. It's not okay. It's not okay.

Dr. Mason Simpson: Well, I think that continuing to have conversations that are transparent, like this that are authentic, where we can take the lid off of that little secret that we spoke about at the beginning of the podcast. I mean, this is what's going to propel us forward. First, we have to acknowledge it, so that we can address it and then continue to work to change it. So, Dr. Mary O'Connor, we thank you for your time, enthusiasm, and input today, here on the Health Disparities podcast from Movement Is Life. For everyone listening, we look forward to your feedback, your comments, and your recommendations on what other topics or subjects you would like us to speak about. Mary. Thank you so much.

Dr. Mary O’Connor: Bonnie, thank you so much. Everyone have a great day.

(End of recording)