

CASE STUDY DISCUSSION GUIDE

Michael Thompson

Assumptions, Attitudes and Biases: What Patients and Health Care Professionals Believe can Delay Diagnosis and Effective Treatment

PURPOSE

This guide is designed to accompany the Michael Thompson case study and to provide guidance to those responsible for leading discussion groups with residents. The guide includes conceptual frameworks and definitions for culture, cultural competence, and linguistic competence; key takeaways points; content to inform dialogue on the reflection questions; references; and suggested resources. While the guide provides an array of information, the references and resource list offer additional sources to enhance learning and professional development in providing culturally and linguistically competent care to patients who have lupus.



GETTING ON THE SAME PAGE

The following provide a list of key terms and their definitions. Engage the residents in discussion about these concepts and to make sure they are “on the same page” and using terms in the same way.

What do we mean by culture? Culture is perceived of and defined in many different ways. Have group members discuss their definitions and understanding of culture and how culture impacts both health and health care.

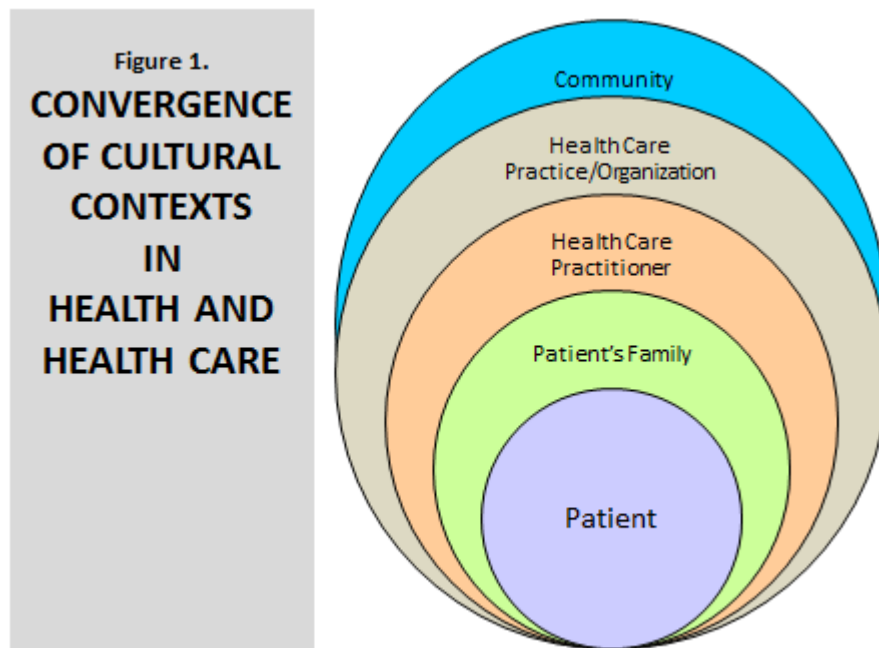
The following is a definition of culture used by the Georgetown University National Center for Cultural Competence:

Culture is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they “know” about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death.

Culture includes but is not limited to—thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of an ethnic group or social groups whose members are uniquely identifiable by that pattern of human behavior.¹

While the aforementioned definition and conceptualization present culture in terms of the group and group behavior, it is essential to note however, that aspects of culture are manifested differently in each person. A member of a cultural group may neither exhibit nor embrace all of the beliefs, values, practices, modes of communication, or behaviors attributed to a given group. This understanding of culture recognizes the individuality of human beings and the unique diversity among group members. This may include but is not limited to race, ethnicity, age, gender, gender identity, socioeconomic status, education, profession, country of origin, languages spoken, and the lived experience of chronic illness, disability, or mental illness. Importantly, accepting this understanding of culture minimizes the tendency to stereotype and reminds us that one's cultural identity is influenced by a constellation of interrelated and distinct factors. This conceptualization of culture also acknowledges professional culture, specifically *the culture of medicine* and its impact on one's values, beliefs, and world view.

Lastly, it is important within the health care context to expand our conceptualization of culture beyond individual people and groups to organizations, systems, and the socio-cultural contexts of communities in which patients and their families live. Health care practices, organizations, and systems have their own cultures – norms, rules, language, decision-making processes, approaches to communication, defined roles and responsibilities, ways of interacting with those seeking and receiving care. Figure 1 illustrates this concept by depicting the multiple dimensions of culture that converge and how they are integrally linked in health and health care. Figure 1 asks you to consider the cultures of the patient, his/her family, the health care practitioner, the health care practice/organization, and cultural contexts of the communities that impact health and well-being of patients.



Take away points

The following take away point offer insight about culture within the context of health and health care.

- Understanding another culture is a continuous and not a discreet process.
- It takes experience as well as study to understand the many subtleties of a culture other than your own.
- Culture informs attitudes, beliefs, and practices of individual patients and their families who seek and use health care.
- You are a cultural being and have multiple cultural identities, one of which is your profession – a physician or health care practitioner.
- You view and interpret the world through your own cultural lens which is comprised of both individual and group experiences over time.
- Your world view influences how you deliver health care. This world view may or may not be shared by the patients and families to whom you provide health care.
- You are influenced by the culture of the practice or organizational setting in which you provide health care.

What do we mean by cultural competence?

Encourage the group to discuss their conceptualizations and definitions of cultural competence. This will allow group members to hear how the concept of cultural competence has been taught in medical education and is understood and practiced in residency. Acknowledge that there are many definitions of cultural competence. Some definitions focus on the health care practitioner and others at the system or organizational level. Have the group to discuss the following definition and how it consistent with or different from their understanding of the concept of cultural competence at both levels.

The Georgetown University National Center for Cultural Competence embraces a definition that of cultural competence that requires organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.²

Cultural competence at the individual level requires

the capacity to:

1. *Acknowledge cultural differences* that exist between patients, their families, and health professionals and how such differences impact health care. Demonstrate valuing these differences, for example, in your manner of communication with patients and their families and partnering in medical decision-making.
2. *Understand your own culture*– willingness to reflect upon your own cultural belief systems, including the culture of medicine, and how they influence your interactions with patients and their families.
3. *Engage in self-assessment* – responding to assessment instruments/checklists and taking time for self-reflection to examine one’s own attitudes, values, and biases that may contribute to or compromise positive patient-provider relationships and your approach to health care.
4. *Acquire cultural knowledge and skills* – pursuing formal and informal opportunities to learn about the cultures of your patients, the environments in which they live including the social determinants of health, culture-specific and evidence-based practices and interventions to improve health care outcomes.
5. *View behavior within a cultural context* – even if a behavior seems illogical, seek to understand the beliefs or practices of patients (without judgement) and partner with them to overcome problems that may compromise their health and well-being. This may involve spanning the boundaries or health care to engage with social services and others in the helping professions. ³⁻⁵



Take away points

Cultural competence:

- is a developmental process and is enhanced over time, at both the individual and organizational levels.
- must be supported by organizational policy, procedures, practices, and resources.
- is an intentional, evidenced-based practice and involves gaining knowledge and skills in order to provide care that is effective and acceptable to diverse patient populations.
- involves examining one’s own beliefs and attitudes about patient behaviors including one’s biases and stereotypes about patients.

Discussion of Reflection Questions

Why do you think Mr. Thompson feels he may have made a mistake coming to the emergency room for care?

Engage participants in a discussion of this question and use the information below to inform the discussion.

1. Assumptions

The clerk made an assumption that because Mr. Thompson is African American he is poor. While intake processes are supposed to ask for insurance information, individuals conducting those procedures have been shown to make erroneous assumptions about the patients with whom they interact. A great deal of training and effort has been directed at supporting health care and other professionals to provide culturally and linguistically competent services and supports. For most patients, however, many



interactions precede the actual encounter with the health care provider. Families must make appointments, ask questions about insurance, check in and provide information at each visit, and be escorted in to see the practitioner or professional. These encounters are typically with staff in the health care provider's office or in a hospital, clinic, or agency setting. Patients' experiences in getting services are affected as much, if not more, by these interactions than by their encounters with the health care provider. Unfortunately, too many families continue to encounter the insensitivity, lack of courtesy and respect, bias, and even discrimination in their experiences with the front desk. For more examples consider sharing the following document [Cultural Competence: It all starts at the Front Desk](#).⁶

2. Lived experience of racial bias

Mr. Thompson's reaction to the clerk's assumptions about him might be seen in the context of his ongoing experience of interactions that reflect bias and stereotyping within his life. While overtly racist comments and actions may be less common, there is a phenomenon that has been described as microaggressions. "Racial microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults towards people of color."⁷ Those that inflict racial microaggressions are often unaware that they have done anything to harm another person. For Mr. Thompson, encountering bias and stereotyping at the beginning of his care has reinforced his attitudes that seeking healthcare will not be positive experience and likely reminded him of other such interactions. Often, in discussions of racial bias and stereotyping, the issue arises that "people are just too sensitive." Consider enhancing the discussion with questions that ask participants to reflect on times when someone has made an assumption about them based on factors other than race or ethnicity — such as age, gender, gender identity or expression, profession, or religion. The goal is to engender an ability to take another's perspective—a key skill for culturally competent health care professionals.

What assumptions did the nurse make about Mr. Thompson and why he didn't have a regular source of medical care?

How might her assumptions affect Mr. Thompson's health care experience?

***What should health care professionals know about the cultural beliefs of the patients they serve?
How can they learn about those beliefs?***

Using the information below, engage participants in their responses to the questions above.

3. More and more assumptions

The nurse made an assumption about why Michael did not have his own doctor and why he has not sought care earlier. She assumed that it was financial barriers that prevented him from seeking ongoing care. There were multiple assumptions wrapped together, including an assumption that because he is African American he is poor and costs were the barrier to care. Culturally competent health care providers know to ask patients about their reasons for a particular behavior—whether it is not seeking health care or not following through on recommended treatments. The patient's belief systems or personal, family, and community contexts or practical barriers impact behavior. Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.⁸ Culturally competent health care providers know that culture provides the context for all behavior—yours and your patient's. Learning about the health beliefs and practices of the communities one serves through reading, opportunities for community members to teach and share their perspectives, and engaging in activities within communities one serves are effective methods to enhance cultural competence. It is important to recognize that each individual has his or her own set of beliefs and values. Asking patients in a non-judgmental way about why they have chosen a particular behavior is a key to culturally competent and patient-centered care and can open up a discussion that can lead to mutually agreed upon recommendations for health behaviors.

How can racial bias affect health care?

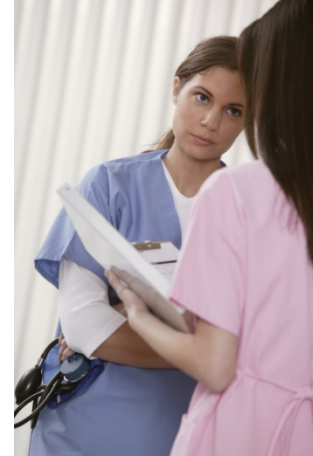
Can well-meaning and fair-minded health care providers have and act on racial biases without knowing it?

Engage participants in discussing these questions. The following information can be used to inform the discussion.

4. Multiple manifestations of bias

It is important to understand bias and its multiple manifestations in our efforts to address lupus-related disparities and inequities. The Institute of Medicine (IOM) concluded in 2003 that "bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care".⁹ Although health care practitioners, whose professions epitomize helping others, find it very difficult to accept that they may indeed harbor biases that result in differential treatment and care provided to their patients, bias is an attribute that exists in all humans as a natural sociobiological process.¹⁰ The obligation of health care practitioners is to become aware of their biases and take action to mitigate the effects.

There are two types of bias identified in the literature. In the case of explicit or conscious, the person is very clear about his or her feelings and attitudes and related behaviors are conducted with intent. This type of bias is processed neurologically at a conscious level as declarative, semantic memory, and in words. Conscious bias in its extreme is characterized by overt negative behavior that can be expressed through physical and verbal harassment or through more subtle means such as exclusion.¹¹⁻¹³



Implicit or unconscious bias operates outside of the person's awareness and can be in direct contradiction to a person's espoused beliefs and values. What is so dangerous about implicit bias is that it automatically seeps into a person's affect or behavior and is outside of the full awareness of that person. Implicit bias can interfere with clinical assessment, decision-making, and provider-patient relationships such that the health goals that the provider and patient are seeking are compromised.¹⁴

Implicit bias has been demonstrated to impact clinical decision-making. Findings have reflected differences in care or proposed care based on race and ethnicity for cardiac conditions, HIV/AIDS, end stage renal disease, psychiatric treatment, surgical safety and outcomes, and treatment of pain, among others. A complex array of factors contributes to the impact of implicit biases on decision-making.¹⁵⁻¹⁷ Fatigue, stress, and cognitive overload are closely linked to health care practitioners and the environments in which they work. In high demand, high performance situations, practitioners are vulnerable to the "hard wiring" employed by the brain to circumvent cognitive overload by simplifying information through group generalizations and stereotyping. Ultimately, such behaviors result in biased or compromised medical decision-making that cannot be fully explained by specific clinical factors of the patients involved.¹⁸⁻²³



A suggested activity

There are a number of self-assessment tools and instruments designed to help you learn about unconscious or implicit bias. One such tool is the Implicit Association Test (IAT), developed by a team of leading cognitive scientists and rigorously researched.

<https://implicit.harvard.edu/implicit/demo/background/thescientists.html>.

While the IAT was developed to research unconscious bias, it is now available to those interested in learning about themselves.

It is good to point out that taking the IAT can be a little unsettling. Remind group members that it measures unconscious bias and even those who are fair minded and detest prejudice at a conscious level, often turn out to have some unconscious biases based on race, age, gender, and other factors.

There is an in-depth, free CME activity provided by the Lupus Initiative of the American College of Rheumatology for those who want to learn more about unconscious or implicit bias in health care, how it operates, and how to address it.

Conscious and Unconscious Bias in Health Care: A Focus on Lupus

- [Epidemiology, Disparities, and Social Determinants of Lupus](#)
(0.5 credit hour)
- [Defining Bias and its Manifestations and Impact of Bias on Health and Health Care](#)
(1.0 credit hour)
- [Even Well-Meaning People have Bias](#)
(0.5 credit hour)
- [Well- What's a Well-Meaning Health Care Professional To Do?](#)
(1.0 credit hour)

Why is it important for health care providers to have knowledge about incidence of diseases, disease presentation, and appropriate treatments based on factors such as gender, race, ethnicity, and sexual orientation?

Engage participants in discussing this question. The information provided below can be used to inform the discussion.

5. Attending to cultural factors in disease incidence, presentation, and treatment

Cultural factors (i.e., gender, race, ethnicity, sexual orientation) that represent types of diversity in patient populations, are important variables in understanding the patient. In the past much of the research conducted on disease incidence, disease presentation, and effective treatments was typically done on men and mostly white men (non-Hispanic). Researchers are increasingly taking an approach that helps delineate differences based on race, ethnicity, gender, sexual orientation, and other factors. In some cases, presentation can differ. For example, Canto, et. al.,²⁴ examined research over 35 years and found that between 30-37% (depending on the study) of women did not have chest discomfort during a heart attack compared with 17-27% of men. Women were more likely to report other symptoms such as pain in the back, neck or jaw, loss of appetite, cough and others. Lack of chest pain was noted to be an impediment to accurate diagnosis. As already noted in the modules, SLE is more common in women, but does occur in men and may have a somewhat different presentation. Effectiveness of medications has been linked to factors such as gender, race and ethnicity as well. Culturally competent clinicians acquire the knowledge that allows them to develop a nuanced and differentiated approach to diagnosis and treatment based on the most recent evidence. Lack of such knowledge can impact accurate and timely diagnosis



There are both biological differences that impact these factors as well as differences in interactions with the healthcare system, approaches to health promotion and healthy behaviors, and exposure to risk factors. Culturally competent clinicians do not take a deterministic view of these factors; rather they use

the knowledge from the literature within the social and economic contexts of the patients they are treating.

What can health care providers do to better communicate complicated health information?

How can they be sure they have successfully communicated that information?

Engage participants in discussing these questions and use the information below to inform the discussion.

6. Communicating in plain language

The literature has documented that when information is not communicated in a way that patients can understand, they cannot or do not follow through with healthcare recommendations. While the physician knows that the findings of “active urinary sediments” is of great concern, Michael does not. Even individuals with a high level of education, such as Michael, may not have detailed knowledge of highly technical medical terminology and information. It is easy for healthcare professionals to become so used to their “language” that they do not realize they are not sharing information in a way that is easy for patients to understand. One simple way to be sure that a patient understands and can act on information is to use the Teach Back method²⁵ <http://www.teachbacktraining.org/> This method basically asks a patient to tell you what you have just told them. It is a good check on how effectively you have communicated important information. Effective communication is key to building a trusting relationship with patients.



From the Teach Back Training website:

[10 Elements of Competence for Using Teach-back Effectively \(PDF\)](#)²⁶

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to teach back correctly, explain again and re-check.
9. Use reader-friendly print materials to support learning.
10. Document use of and patient response to teach-back.

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About the Georgetown University National Center for Cultural Competence

The Georgetown University National Center for Cultural Competence (NCCC) provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy. The NCCC is a component of the Center for Child and Human Development and is housed within the Department of Pediatrics of the Georgetown University Medical Center. The NCCC provides training, technical assistance, and consultation, contributes to knowledge through publications and research, creates tools and resources to support health and mental health care providers and systems, supports leaders to promote and sustain cultural and linguistic competency, and collaborates with an extensive network of private and public entities to advance the implementation of these concepts. The NCCC provides services to local, state, federal and international governmental agencies, family and advocacy support organizations, local hospitals and health centers, healthcare systems, health plans, mental health systems, universities, quality improvement organizations, national professional associations, and foundations.

For additional information contact:

Georgetown University National Center for Cultural Competence
Center for Child and Human Development
3300 Whitehaven Street, N.W., Suite 3300
Washington, DC 20007
Voice: 202-687-5387
Fax: 202-687-8899
E-Mail: cultural@georgetown.edu
URL: <http://nccc.georgetown.edu>

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