A Model for Bias and Compassion:
learning from patients, learning from each other

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BACKGROUND:
In the 2016 Physician Lifestyle Report, 40% of practicing physicians self-identified as having bias or prejudice towards specific groups of patients. Younger physicians, before age 35, were the most likely group to admit that they have prejudice [2016 Lifestyle Report]. Additionally, biases among students in medical school have been documented for topics such as obesity, race, gender and sexuality [Häder, Hoffman, Persky]. Rates of unconscious bias among physicians and medical students are similarly high [Chapman, Miller, Phelan]. Both implicit and explicit bias has been linked to poor outcomes and lower patient compliance/satisfaction [Brach, Castro].

Addressing physician bias is an important career-long goal across specialties.

DESIGN:
Medical students at Dartmouth piloted a peer-implementation program designed to decrease prejudice and improve care for future patients. The model allows students with experience in areas of stigma (such as LGBTQ health, obesity, addictions, mental health, physical disability, race/SES) to identify patients who are willing to come and share their story. Student facilitators use their knowledge of the area of stigma to guide the interview but ultimately allow the patient to tell their own story. In this way, facilitators guide students to insights within the patient story, and students in turn feel safe exploring stigma – including their own discomfort and unfamiliarity.

RESULTS:
The peer-centered protocol demonstrated gains in learning in the areas of: empathy and compassion, the doctor-patient relationship, interviewing and active listening. Additionally, debriefing protocol after interviewing resulted in qualitative reports of long-term gain one year from baseline.

REFLECTIONS:
"I learned that one of the most important things a doctor can do with a patient with a disability is to treat them normally. I think we have all heard this before, but hearing it directly impressed upon me the emotional texture of that desire; a longing for normality in interactions. Hearing this directly from a patient gave me confidence to practice it in the future with other patients."

"Through these experiences I was able to discover a confident unknowing."

"Without knowledge and experience about our own implicit biases and discomforts, healthcare providers I was worried I would create interactions that feel unsafe and judgmental...The real challenge is for healthcare providers to see past any bias or preformed stereotypes to be able to engage directly with the human being for which they are caring."

RESOURCES:
Protocol for a student-run elective, or guidelines for faculty-run patient panels, allowing both students and faculty to strengthen (or create) programs capitalizing on patient participation in medical education.

RECOMMENDATIONS/FURTHER STUDY:
The five patient characteristics that most frequently trigger bias among physicians include emotional problems, weight, intelligence, language differences and insurance coverage.

SIGNIFICANCE:
Most medical schools have patient panels and/or facilitate patient encounters for students to begin to understand the patient’s experience of disease and (occasionally) stigma. But in large groups led hierarchically by faculty, there is neither the intimacy nor safety for both students and patients to demonstrate vulnerability about their discomforts or questions. This model, which is easy to adapt to an elective or series of seminars, is a more potent way of allowing medical students to become intimate with their discomfort with diverse patients and work through that so they can respond empathically as physicians. Similarly, small tweaks in how large group patient encounters are facilitated, can adapt this model to more explicitly help students identify and address their bias.
“LET A TEACHER WAVE AWAY THE FLIES AND PUT A PLASTER ON THE WOUND. DON’T TURN YOUR HEAD. KEEP LOOKING AT THE BANDAGED PLACE. THAT’S WHERE THE LIGHT ENTERS YOU.”
HAFIZ, A 13TH CENTURY SUFI POET

“SUFFERING OCCURS WHEN AN IMPENDING DESTRUCTION OF THE PERSON IS PERCEIVED; IT CONTINUES UNTIL THE THREAT OF DISINTEGRATION HAS PASSED OR UNTIL THE INTEGRITY OF THE PERSON CAN BE RESTORED IN SOME OTHER MANNER.”
CASSELL MD, NEJM 1982