Risk Insights: Senior Living & LTC

Episode 16

Avoiding the pitfalls of implicit bias

Welcome to the *Risk Insights: Senior Living & LTC* podcast, hosted by Tara Clayton with Marsh's Senior Living & Long-term Care Industry Practice. Tara, a former litigator and in-house attorney, speaks with industry experts about a variety of challenges and emerging risks facing the industry.

Tara Clayton:

Hello, and welcome to *Risk Insights: Senior Living and Long-Term Care*. I'm your host, Tara Clayton. For today's episode, I'm taking our topic from last episode, AI and the potential for bias, but I wanted to focus today with our industry guest on the concept of bias, not in the employment context, but its potential impact to residents that are living with us in our senior living communities. I'm joined by Doris Fischer-Sanchez. She's the senior vice president of clinical risk with Marsh's Senior Living and Long-Term Care industry practice. Hey, Doris, thanks for joining us today.

Doris Fischer-Sanchez:

Thanks, Tara. I'm happy to be with you all.

Tara Clayton:

Thanks. So, Doris, I know you have been a guest on the podcast before, but just in case, hopefully we do have some new listeners, do you mind taking just a couple of minutes talking about your background and what you do here at Marsh with clients?

Doris Fischer-Sanchez:

Sure. Happy to. My background is that I'm a psychiatric and family nurse practitioner by training and practice. I have my doctorate in systems. For the practice here, the Senior Living practice, it's my pleasure to work with our clients on any matter of professional and general liability risk situations, particularly focused on the clinical settings. Today's topic is of great interest because it's what we deal with every day with our residents and our care providing partners.

Tara Clayton:

Thanks, Doris. So, I mentioned last episode we got into artificial intelligence, focusing on kind of the potential impact and the benefits of how providers are using AI in the employment context. And to your point, Doris, that had me thinking, while we definitely see some of this potential bias as it concerns residents and other contacts in the day to day what happens in a community. I've read several articles as I know you've read articles, Doris. So one of those that I've read was co-authored by you around this concept of implicit bias. So as to kind of get us into that conversation, can you explain what exactly are we talking about when we talk about implicit bias?

Doris Fischer-Sanchez:

Sure. So as we know, Tara, as individuals, our beliefs influence our behavior and the decisions that we make. And frequently, these influencing beliefs are unconscious or implicit is another word. They exist kind of outside of our conscious awareness, and it makes them difficult to control because we utilize them automatically. That's kind of how we get through the day. But what those beliefs do is they lead us toward bias formation. It impacts how we behave and the decisions that we make. And we're not even really aware that they're influencing our decisions. So we can have them, they can be positive or negative. They have some various degrees of underlying stereotyping and prejudice and discrimination, but not always those words in the negative meaning.

Sometimes it's how we're able to, you know, kind of quickly make decisions, how we're approached with something and we can make a decision immediately, whether it's fight or flight, or whether it's respond appropriately or sadly, sometimes negatively. But, you

know, because it's below our conscious awareness, hopefully it benefits the group that they're working with. But it can sometimes, as I just said, involve limited or distorted perceptions of others or inaccurate perceptions of others. But the fact of the matter is that bias is everywhere and it affects all of us all the time.

Tara Clayton:

Can you, Doris, give some examples of, specifically in the senior living context, where this implicit bias that you're talking about, where that can kind of pop up?

Doris Fischer-Sanchez:

Our brain contributes to bias formation. As I say, we're continually processing and organizing a lot of information as it comes into us, and we encounter every day. And it kind of creates those abilities for us to connect and to process our information efficiently as we move along. We're hit with a lot of things, as I say, all the time. We tend to place thoughts and feelings and experiences into categories based on gender, or age, or race and ethnicity. And then that can sometimes result in inaccurate perceptions about people because of how we categorize them, maybe because of our upbringing, maybe because of what we've experienced in our lives. And again, that could lead to that implicit bias that I was talking about. In healthcare, we're not in any type of an exception from that.

And we have a lot of biases that are inherent to healthcare, like how we provide care, how we make decisions, how we order tests, how we provide referrals, and so on. And again, some of these are because of the way we were taught, some are because of the experiences that we had. But for example, some of them are, like, anchoring, which is a tendency to rely too heavily on the first piece of information that comes in. I heard someone was a big complainer, and so, I'd never met the person. I don't know anything about them, but click in my mind, anything that person says may give me the indication that that person's going to be a complainer. Or colorism, prejudices that I may or may not have based on the color of someone's skin, shade, or tone. Accurate, inaccurate; it's just the way that I am about that.

There's some things called confirmation bias, where I select focus and information that supports my initial opinion about someone. Like, for example, someone may come in with a lot of tattoos and piercings, and automatically I feel like this person is some kind of a gang member or a ruffian, or a drug addicted person or whatever. I'm probably the furthest from the truth, but that's what hits me first, based on information that's come into me from a variety of sources. Conformity bias, it's a tendency that allows other people's views to sway me. So if I'm in a group, and we all think the same, I might think the same as well, even if foundationally I know that's not correct, but kind of that group think affects me. Halo bias is a focus on a particularly positive feature of a person. “That's a doctor coming in. They couldn't be wrong; of course they're right.”

That type of a bias can also contribute to folks on the negative side, in terms of their history. Wealthy folks come into a senior living environment, the husband maybe has been not the best of partners for the spouse along the way, but the lady has always figured out a way to make sure that no one ever notices that. And so, it's beyond comprehension that they could be in a violent, a disruptive and emotionally abusive relationship just based on the presentations. And then finally, what we're going talk a lot about today is ageism within our senior living communities and practices. Other factors contribute to everything that we do, including homophobia and sexism, and as I just said, ageism as we get into this a little bit more.

Tara Clayton:

I think the examples you gave, the one I think about with the anchoring, I think we see it a lot in the litigation context, using the call light, right? A lot of times we kind of start to get that maybe implicit biasness of, "Oh, this person just always uses the call light," and maybe this is the one time I don't go and respond. And there actually was an event that the resident needed assistance with. So I think this is really important stuff to be talking about with your staff.

You mentioned ageism, and that is one that I really do want to dig in with you, Doris. I think pulling outside of the senior living context, ageism is something that I think we've heard about, we're reading articles about, we see stuff about marketing as it relates to ageism as, and I think more and more as we see the baby boomers moving into this older adult population.

It’s a big highlighted area, I think, globally. And so kind of bringing it back into the senior living context, I scratch my head a little bit when I think about the fact that there could be ageism in the senior living context, just

knowing why this industry exists. We are here to serve older adults. So how in the world would ageism be such a potentially prevalent implicit bias? So can we dig into what are maybe some of the ways that we see this in our space?

Doris Fischer-Sanchez:

For sure. Thinking a little bit about ageism, and just kind of a definition that I think about in my head, which I think that, you know, it includes the various stereotypes that I mentioned, some assumptions and preconceptions about older folks, if you will. And that can be, like you say, from the media, my experience of having maybe worked with them, my own experience maybe with my aging parents and so on. And so, from a caregiver perspective, even though we come into work and believe that, you know, we're there for all positive reasons, no one enters senior care or senior living thinking, you know, this is the place where I'm going to be a really negative person, I think you start adopting and adopting to what the culture is of the organization that you work for, the community that you're in.

And so one example I can think of that people probably think is pretty harmless, but happens pretty frequently with respect to ageism, and that's what's called elder speak. And elder speak is an example of me as a caregiver approaching an older person and maybe talking louder because just intuitively I'm thinking they don't hear me that well. I may speak more slowly for what reason, we're not exactly sure, but thinking that that'll help a person understand more. If I talk to them in a sing-song voice similar to how I might speak with a toddler, because now I'm thinking I'm infantalizing them a little bit, and we don't exactly know why we're choosing to do that either.

Also call someone honey, or sweetie, or baby without that permission having been granted to us, because we just think that's the way it's more friendly to approach someone, but we don't realize that we're being exceptionally disrespectful because we haven't sought that permission yet. On the converse side, there is ageism among residents themselves. Folks that have a walker, versus those that are more ambulatory may not want to sit with those folks in the dining section. Or people that are becoming a little bit more demented, the folks that are not, may not want to be in a dining situation or an activity situation with those particular folks. Maybe because it's too close, they don't want to be exposed to that, or maybe in their life they never really appreciated being around someone like that.

But those are two kind of oppositional ways of looking at ageism. Again, for example, the folks that are the residents and are expressing ageism amongst themselves, a person doing that could also be receiving that ageism from a caregiver and kind of bringing it down the stream. And so, we're human, and these things happen. And the question mark then becomes, what are we doing to maybe identify and make the community hopefully a better place to live?

Tara Clayton:

Hearing some of the different ways, the elder speak, I've seen it. I may have even done it with my grandparents from time to time, because to your point, we just kind of have some of these implicit things that develop over time. But to really understand, what are the consequences of this type of implicit bias? Is there an impact to the resident who is receiving this type of bias being directed at them? And if so, what is that impact? Because I think that helps build out why it's important to do something to address it.

Doris Fischer-Sanchez:

There's four ways generally of looking at ageism within a senior living community or an organization even. And the first type is that of a personal or a self-directed ageism, meaning that the person themselves is kind of looking at their environment and they're thinking that they can't, or they shouldn't do things anymore because they're just too old to be able to do that. On the flip side, a younger person could feel the same. I'm too young to do those kinds of things, or they're looked at to be too young, and so they don't get the same level of respect or a recognition for their abilities and so on. But no matter what, younger or older, this type of internalizing, this ageism damages your own self-worth. And so it kind of heightens the fears of growing older and creating doubts about the benefits of aging, in particular, when we're looking at our residents.

Another way of looking at ageism is intentional or interpersonal ageism. And that is really when two or more individuals are kind of devaluing someone. Like, for example, again, on the younger side, "That's pretty good for someone who's their age," or "You're just too old and too confused to understand, so we're just going to move along." A lot of times, for example in healthcare, we think older folks don't really understand

technology. It may be that one of our residents was a foundation IT professional in their career and got us to this point that we are today, but we automatically assume because they're older, they have no interest or no understanding. For younger people, we may say, "You're going to grow out of it," or "You're having a senior moment." So all of these kinds of things are commonplace. Again, the speaking louder, the speaking slower, speaking in simpler terms, overcompensating for an individual's presumed needs when there's not really necessary. So that's another way intentional, interpersonal ageism.

Unintentional bias is really what does our culture allow. And really, ageism now, quite frankly, is probably one of the most what we think is innocuous ways of poking fun and such. But we really don't... We don't really appreciate that we could be very hurtful to folks like saying, "You're having a senior moment," when you're forgetting something, but not realizing that maybe that person was just diagnosed with an oncoming frontal lobe dementia, and they're still fully comprehensing and, you know, they understand that pretty soon, this is not going to be going very well for them, or having over the hill parties. We think it's funny and maybe it is, but not always, right? So it's kind of unintentional. It seems to be poking fun, but maybe it really is not the best of ways of describing what we're trying to talk with someone about or how we're making them feel.

And then finally, institutional ageism, which is what we look at, obviously, when we're talking about our communities. And this may be as, you know, the laws, the rules, the social norms, the policies and practices of the institution that maybe unfairly restrict opportunities or create disadvantages just because of people and their age. And the example I have for that, the glaring example, is during COVID, while we thought we were being very protective of our elders as we didn't know what was going to be happening with the, with the viral outbreak, we isolated our older folks on purpose and maybe carried that a bit further than we had intended.

And the unintentional consequence of a lot of that was isolation and depression, and kind of possibly also creating a situation where their chronic illnesses may have taken further hold and increased their rate of demise just because of lack of access and just not focusing on what those interpersonal and social needs really were for them. And I think that was probably ageism almost at its worst.

Tara Clayton:

That's a really good point, Doris. It's a lot of just putting yourself in someone else's shoes. Is it just a jovial joke? Versus, how is that person receiving the information?

Doris Fischer-Sanchez:

Mm-hmm.

Tara Clayton:

Where is that person at in their journey of life and, and how are they receiving it? And I could see that it really would have impacts on an individual, not just an older adult, but to your point younger adults as well, that could contribute to depression, maybe even some of the signs and symptoms that we see sometimes when we're treating residents in communities. I don't know if through some of the work that you've done and other outcomes that you could be seeing in a senior living setting, if we aren't able to get some of this implicit bias under control.

Doris Fischer-Sanchez:

We talk a lot about behaviors and expressions in elder and older care and what might relate or contribute to maybe more negative ones kind of evolving. But certainly, if we're having this implicit bias, this ageism unchecked approach with folks, we could contribute to anxiety and depression, and them feeling that their thoughts and their opinions are not valued, which again, can contribute to worthlessness and increased avenues of complaint, like, "My back hurts," or "I can't move my hands," or "I can't get up today." And we may say, "Oh, they're just, you know, they're getting older, they're not feeling well." But maybe it's because we're not valuing them at all. We don't really understand that. Yeah, maybe it takes a little bit five minutes longer, but they really do want to get up. They do want to participate, they do want to be involved. They have something to say.

There's also some other secondary negative gains sometimes with folks. If that's how you feel about me, if that's what you believe, then maybe I should go to the doctor. Maybe I should get another medication. Maybe that will help me with my pain. And then we start this other strange cycle of, you know, maybe that wasn't really needed. Maybe it was just that, again, that extra five minutes to get me to physical therapy to help me feel better would've avoided me taking yet another medication. And then it can sometimes cause

aggression. There's studies that have shown that in memory care, for example, people that are being spoken to in that elder speak that we mentioned a couple of minutes ago, they can become more agitated, more restless, because intuitively, inheratibly, they realize they're not being respected.

Tara Clayton:

It makes me think of that phrase you never know, just a kind word can really brighten someone's day.

Doris Fischer-Sanchez:

Mm-hmm.

Tara Clayton:

It's kind of that same concept of the value that you're showing another individual really does impact how they feel about themselves internally, and then how they also then externally show that. Outside of the, obviously, the direct emotional, physical impact to an individual resident that they can have because of implicit bias, do you see other, from a provider standpoint, are there other financial or other type of impacts at a community level?

Doris Fischer-Sanchez:

Definitely. So if we talk about biases as a part of diversity, equity, and inclusion, and we think of that usually on the employee side. But when we think about it in a resident population, if you are not being aware or addressing the needs of folks, no matter where they're coming from, again, we said ageism isn't just an isolated bias, it comes on top of other things as well, because we carry them with us always, so homophobia, or sexism, or maybe if I'm coming in and I'm a provider and I'm not giving a complete physical because I think, "Oh, already, there's going to be deficiencies there." So maybe I'm missing something. Maybe I'm delaying a treatment, maybe I'm not ordering something, maybe I'm ordering too much.

But again, that diversity, equity, and inclusion is going to be impacted. And as a result, organizations are being looked at. They're being looked at as far as what is their response to that? How do they manage? What are they doing organizationally, individually, so that hopefully, these things aren't happening. And if they're not addressing it, they're going to get fines, losses of certification, potential difficulty with re-licensure, allegations of discrimination, reputational damage, particularly in social media. I think it starts with that one-to-one communication, whether it's with the provider and the resident, or the resident and their families, their observers coming in from the outside, they can see what's going on.

Again, claims potentially as a result of ineffective or a lack of care based on kind of what I said, our interactions, my lack of care, lack of paying attention, potentially, because I'm dismissive. Not intentionally always, just because I think that's kind of the population that I'm working with. And that's what's happening here.

Tara Clayton:

When I first started looking at what is implicit bias, I don't know that it quite registered to me, because to your point, I think a lot of the implicit bias, it's not intentional. Someone's not being malicious, or trying to be mean to someone, or make someone feel inadequate. Talking through this with you, understanding there's really truly impactful consequences, not just to the resident themselves, to the company as well. What can and should a provider look at to get their arms around how to better train and empower their staff to work around these issues related to implicit bias? Because to your point, everyone shows it to some extent, right?

Doris Fischer-Sanchez:

We need to look from the top down, and we need to, first of all, acknowledge that we have these biases and open ourselves up to them. Again, I think a lot of people have been negatively affected by the notion that we're not appropriate with one another, and we're biased, and we're racist, and we're just not acknowledging that we have differences and so on. And that's not really the spirit of this. So for example, different organizations, the American Medical Association has come out with their position, the American Nurses Association. I think organizations need to take a look at and acknowledge that these biases exist and how can we address them.

Harvard has had for quite a while called Project Implicit. It's open to the public, and you go on their website and you can, as an organization or as an individual, take a bias-related questionnaire. And there's plenty of resources there as to what you can do organizationally to help your staff become more aware, more empathetic, understand more about effective communication. And then that can also flows into what

we need from the healthcare side in terms of documentation, workflows, policies, and procedures. It really changes nothing about how we do things or what the appropriate ways of approaching something. It's really more about, are we also aware of how we come to it, and how we feel, how we exhibit what we're doing, and how that message is received.

Tara Clayton:

So it sounds like kind of starting with the educational component, understanding and acknowledging it exists, and just having staff trained and understand these are the different ways it can be shown. And kind of starting with that baseline.

Doris Fischer-Sanchez:

Definitely. Being willing to have those conversations, being... creating a safe space to have those conversations, allowing people to verbalize where they're coming from. Many times, particularly in some of our higher end senior living communities, where those folks came from, versus the care providers that come in to provide the care are two disparate worlds. (laughs) One maybe doesn't understand the other. And so, how do we better bring people to some sort of consensus of understanding of, this is who I am, this is who I think you are.

The other piece of this that's extremely important, and you had mentioned that your last episode was about bias and artificial intelligence. Well, where does that research come from? Where does that data jump from into these algorithms and programs and such that we're creating to provide care to, in this case, senior living? And so if those elements already have implicit and inherent bias in them for whatever reason, and an example I'll utilize for you is there's a large CMS study of Black veterans who were, end-stage renal disease transplant-ready folks who never made the cut for a kidney because of the bias and the data that was driven on laboratory values and never having included Blak, African American males.

We don't know the extent, necessarily, of the bias that's inherent in everything, but now that it's emerging, once again, we can't turn our back and believe that it doesn't exist. But most important is that we turn ourselves around and start to face these things.

Tara Clayton:

Yeah, almost that, we have to have a lens on in every interaction that we have. Understanding, to your point, acknowledging that it's there, and just really understanding what is that impact so we can move forward in the right direction.

Doris Fischer-Sanchez:

Yeah, I think that's a start. The training, cultural competence, versus cultural humility. Cultural competence, meaning we understand the culture. It may be different from ours, but we know that there's nuances. And mine may not be yours, but it doesn't mean it's wrong. And then cultural humility, where you've got that awareness of the competency, but you also have that respect for that other culture or that religion or that way of dress or that way of acknowledging so that you really have that appreciation for who we are as people.

Tara Clayton:

Mm-hmm.

Doris Fischer-Sanchez:

And then organizational policies, ideally, we're reflecting, that type, that level of respect, that level of how we all need to work together, partnership building skills. And then again, as I mentioned, diversity and inclusion. I mean, some larger organizations are obviously creating committees toward that, similar to how we create risk committees and, policy and procedure committees. I mean, this is no less important.

Tara Clayton:

Yeah, absolutely, Doris. Really appreciate bringing more attention to this topic because, you know, I didn't appreciate the very serious consequences, right, that can come from this type of implicit bias. Knowing that it can cause residents to have their quality of life worsen as a result of it. So, Doris, thank you, thank you, thank you for joining us and, and sharing this information with us today.

Doris Fischer-Sanchez:

Thank you, Tara, for letting me talk about a topic that's extremely important to me.

Tara Clayton:

And it shows, Doris. Thank you.

For our listeners, again, you can learn about the risk associated with implicit bias, as well as navigating other risks on our website linked in the show notes. Be sure you subscribe so you don't miss any future episodes. You can find us on your favorite podcast platforms, including Apple and Spotify. And I'd love to hear from you. Any topics you'd like to hear on future episodes, please reach out at the email address in the show notes and let me know what questions and topics you have. And again, thank you so much for tuning in, and I hope you join us for our next *Risk Insight*.

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