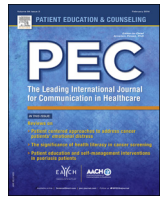




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Discussion

Mindfulness practice: A promising approach to reducing the effects of clinician implicit bias on patients

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ABSTRACT

Like the population at large, health care providers hold implicit racial and ethnic biases that may contribute to health care disparities. Little progress has been made in identifying and implementing effective strategies to address these normal but potentially harmful unconscious cognitive processes. We propose that meditation training designed to increase healthcare providers' mindfulness skills is a promising and potentially sustainable way to address this problem. Emerging evidence suggests that mindfulness practice can reduce the provider contribution to healthcare disparities through several mechanisms including: reducing the likelihood that implicit biases will be activated in the mind, increasing providers' awareness of and ability to control responses to implicit biases once activated, increasing self-compassion and compassion toward patients, and reducing internal sources of cognitive load (e.g., stress, burnout, and compassion fatigue). Mindfulness training may also have advantages over current approaches to addressing implicit bias because it focuses on the development of skills through practice, promotes a nonjudgmental approach, can circumvent resistance some providers feel when directly confronted with evidence of racism, and constitutes a holistic approach to promoting providers' well-being. We close with suggestions for how a mindfulness approach can be practically implemented and identify potential challenges and research gaps to be addressed.

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1. Introduction

There is increasing evidence that healthcare providers, like the population at large, hold *implicit stereotypes and prejudices* against members of socially stigmatized groups (racial/ethnic minorities, gay and lesbian, obese, lower social class), which can contribute to healthcare disparities [1–6]. These unconscious biases are “habits of mind,” learned over time through repeated personal experiences and cultural socialization, which can be activated unintentionally, often outside one’s own awareness, and are difficult to control. They can occur despite nonprejudiced intentions and are hard to break [6–9]. Implicit biases affect behavior through a two-phase process: biases are *activated* in the presence of a member of a social

group and then are *applied* so that they affect the individual's behavior related to that group member. In the healthcare context, for instance, implicit biases may be activated when a provider is interacting with an African American patient, particularly under conditions that tax her cognitive capacity (e.g., stress, time-pressure, fatigue, competing demands), and can then influence how she communicates with and makes decisions about her patient [10]. Most of this research has been conducted on implicit racial and ethnic biases, which have been shown to affect the quality of patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes [1,4,11], with the strongest evidence for its effect on patient-provider interactions (e.g., less patient centered communication, warmth, friendliness, collaboration) [4]. There is also ample documentation that minority patients perceive discrimination within the healthcare system [2], to which providers' implicit racial bias may contribute, as there is evidence that racial minority group members can detect implicit racial bias [12]. To date, little

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progress has been made in identifying and implementing effective strategies to reduce the negative impact of clinician implicit bias on patients [1,4]. We propose that meditation training designed to increase clinicians' mindfulness skills is a promising and potentially sustainable way to address this problem.

In this article, we conceptualize mindfulness as a metacognitive skill involving attentional control (including paying attention to one's experience in the present moment), emotional regulation, self-awareness and a nonjudgmental and curious orientation toward one's experiences [13,14]. In this way mindfulness is a "mode of awareness" that can be enacted in different situations, including those which are emotionally challenging [14]. Although mindfulness can be conceptualized as a trait, or disposition, we focus primarily on mindfulness as a set of skills acquired through meditative practice [13] (e.g., Mindfulness-Based Stress Reduction (MBSR), programs specifically designed for providers such as the Mindfulness-Based Medical Practice program) [15–17]. In our review, we also include studies examining the effects of lovingkindness meditation, a Buddhist meditation often practiced in the context of mindfulness, aimed at cultivating compassion and warm feelings toward the self and others [18].

1.1. How mindfulness and lovingkindness meditation practice can reduce the effects of implicit bias on patients from stigmatized groups

1.1.1. Meditation reduces the likelihood that implicit bias will be activated in the mind

In recent laboratory experiments conducted with non-clinicians, meditation was shown to reduce implicit bias, assessed by Implicit Association Test (IAT), a widely-used computer-based measure of unconscious bias [19]. In one study, non-black community-dwelling adults randomly assigned to participate in a lovingkindness meditation training program (6 h-long weekly sessions with home practice) showed significant decreases in implicit bias toward blacks and the homeless, compared to control group participants [20]. In another study, white college students randomly assigned to participate in a 7-min lovingkindness intervention, which included 3 min of lovingkindness meditation directed towards a black person depicted in a photograph, showed lower levels of implicit bias against blacks compared to an active control [21]. In another experiment, students who were assigned to 8 min of lovingkindness meditation with either a stranger or a homeless person showed lower levels of intergroup anxiety toward and greater intentions of future contact with homeless people than control participants did [22]. Additionally, white college students randomly assigned to practice mindfulness using a 10-min guided recording showed lower levels of implicit age and race bias relative to attention controls [23], and showed less racial discrimination in a simulation trust game [24]. While promising, these studies have important limitations including the use of non-clinicians as participants; an intermediate outcome measure, IAT scores (although IAT scores are associated with discriminatory behaviors) [19]; and the fact that outcomes were assessed closely after study completion, so it is unknown whether these effects persist.

Converging evidence comes from neuroimaging studies, which have identified neural structures underlying the activation of prejudice [25] that mindfulness meditation has been shown to modulate [13]. The *prejudice network*, which underlies activation of implicit prejudicial responses, involves the activation of the amygdala, which is integral to activating threat responses, including in the presence of racial cues (e.g., white subjects viewing images of black faces) [26] and reduced activity in the ventromedial prefrontal cortex (involved in empathy and "humanizing") in the presence of members of low-status groups [25]. A recent review of functional and structural MRI studies of changes in core brain regions after mindfulness meditation shows changes

conducive to prejudice reduction in the prejudice network (decreased amygdala activation in response to emotional images and increased activation of ventromedial PFC) [13]. These results should be interpreted cautiously, however, as this research is in its early stages and the quality of these studies is uneven [13].

1.1.2. Once implicit biases are activated, meditation can increase providers' ability to become aware of those biases and to engage in self-regulatory processes, so they can act in a manner congruent with their egalitarian values

Becoming aware of and being able to regulate one's stereotypic and prejudicial biases once they are activated is a key part of reducing the impact of implicit biases on behavior [5]. Negative emotion is a common part of the activation of implicit bias [5]. Mindfulness meditation promotes early awareness of emotions, so one is better able to engage in regulation before the emotional responses become intense [27]. A systematic review of 29 studies (including 14 RCTs) of MBSR or MBSR-based interventions in health care providers found that MBSR improved providers' self-rated skills on their ability to identify and accept their emotions, as well as to identify others' emotions [16]. In a focus group study of clinicians who completed an MBSR program adapted for health care professionals, participants reported that the course increased their ability to be non-judgmentally aware of their thoughts, sensations and emotions and their ability to regulate their attention and emotions in clinical encounters [28]. Functional and structural MRI studies show consistent changes, following mindfulness meditation training, in core regions associated with self-regulation of awareness, attention, and emotion [13], including neural structures implicated in the control of prejudiced responses (the anterior cingulate cortex; the lateral prefrontal cortex and the medial prefrontal cortex) [25,13].

1.1.3. Meditation can reduce stress and internal sources of cognitive load that contribute to the activation and application of implicit biases

Implicit biases are more likely to be activated and applied when individuals experience greater *cognitive load*—the amount of mental activity imposed on working memory [29,30]. Although most of this evidence comes from laboratory experiments, a recent study of resident physicians in a pediatric emergency department found increases in implicit racial bias from pre-shift to post-shift, when the emergency department was more overcrowded and when patient load was greater [31]. Unfortunately, many sources of cognitive load (time pressure, competing task demands, lack of resources) are endemic to the clinical environment and are more likely to be present in facilities in which racial minority patients receive care [30,32]. An increasing number of studies have found, however, that internal sources of cognitive load, such as burnout, compassion fatigue, stress, anxiety, and depression, among clinicians and trainees, can be reduced through mindfulness meditation [15,16,23,33–36]. There is evidence that these effects persist post-intervention at 9 [37] and 15 months [15]. A pilot RCT (N=32) with surgical intensive care unit personnel found that an 8-week group mindfulness based intervention reduced participants reactivity to stress, with levels of salivary amylase reduced by 40% in the intervention group [38]. Mindfulness and loving-kindness meditation have also been found to increase self-compassion [16,18,35,39], which may protect against burnout and compassion fatigue.

1.1.4. Meditation can engender empathy and compassion, which reduce the activation and application of implicit bias [40–45] and promote willingness to engage with members of stigmatized groups [46]

Empathy has a cognitive dimension (the ability to take others' perspectives) and an affective dimension (one's emotional

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