WEBVTT

1
00:00:05.430 --> 00:00:07.340
Matt Amundson (he/him/his): Alright. Good morning, everyone.

2
00:00:08.440 --> 00:00:28.550
Matt Amundson (he/him/his): Welcome to another installment of the Dean's lecture series. I'm Matt Amundsen. I'm 1 of the learning and development managers for the office of diversity, equity, and inclusion. This session will be recorded and shared out within 2 days to all who registered for the event. Otherwise the recording can be found under the education and training tab of the Ode website.

3
00:00:28.620 --> 00:00:47.700
Matt Amundson (he/him/his): Live transcription has been enabled. And please note that live transcript is not perfect as it is an auto transcript. We invite you to take care of yourself as necessary during today's session as we will not be taking a break. Any feedback or issues with accessibility. Please email us at Dls dash Odei at Umn Edu.

4
00:00:47.810 --> 00:01:09.859
Matt Amundson (he/him/his): And we asked the participants, please use the QA. Function instead of the chat. In order to ask questions of our presenter, Dr. Boucher. We will do our best to respond. But please understand that we are working within a set window of time. Should we not get to your question during the lecture today we will work with the presenter to get unanswered questions posted on our Dean's lecture series web page at a later time.

5
00:01:10.190 --> 00:01:14.059
Matt Amundson (he/him/his): So so I'm gonna paste a few items in the chat for your reference.

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00:01:15.440 --> 00:01:28.570
Matt Amundson (he/him/his): So you will find in there a link to the Dean's lecture series website, the slides to our presenters lecture and the Dean's lecture Series email address. And with that I will now turn over to Dr. Nunez, introduce today's guest lecture.

7
00:01:29.490 --> 00:01:30.320
Ana Núñez MD: You, Matt.

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00:01:30.510 --> 00:01:32.063
Ana Núñez MD: Hello, everybody!

9
00:01:33.200 --> 00:01:56.039
Ana Núñez MD: I don't know what to even say about our interesting weather. We sort of see a Laker in a temperate rainforest, or something which is good for not having to water your

garden but a little odd, so we'll keep riding the storm in terms of sort of the scattered thunder showers with, you know, blue skies and that kind of stuff. So it's it's been an interesting time. I hope all of you are able to take some time off

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00:01:56.050 --> 00:02:18.769
Ana Núñez MD: over the lovely season here, and sort of get rest and replenishment, and for those of you that are here, or might watch this archived welcome welcome. We have a wonderful sort of presentation today, and I am delighted to introduce Doctor Alex Bouchard, who's a adult and pediatric hematologist. He's our associate professor in University of Minnesota.

11
00:02:18.770 --> 00:02:42.049
Ana Núñez MD: He got his medical school training at the University of Tennessee, then got his medicine and Peed's Residency. Here at Minnesota. He did Peed's Hemog Fellowship at Cincinnati Children's Hospital Medical Center and currently leads the Sickle Cell Disease program across the lifespan, working to transform and Health Fairview's approach to sickle cell disease to be person-centered, not disease centered and focused on health equity.

12
00:02:42.050 --> 00:03:02.520
Ana Núñez MD: His research is focused on identifying and addressing hidden sources of inequities in medicine and educating trainees on these topics. Sort of how do we see what we can't see? Right? And so we have the opportunity to hear from him about the undercurrent of implicit bias in the age of emr efficiency, Doctor Bashar, welcome.

13
00:03:03.970 --> 00:03:06.250
Alex Boucher, MD: Thank you very much and get us

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00:03:07.230 --> 00:03:11.049
Alex Boucher, MD: share screen. So can you see the screen? Now? The Powerpoint.

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00:03:11.050 --> 00:03:11.700
Ana Núñez MD: Yes.

16
00:03:12.040 --> 00:03:12.870
Alex Boucher, MD: Perfect.

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00:03:13.820 --> 00:03:31.560
Alex Boucher, MD: Well, welcome, everybody. Thank you so much to Doctor Nunez and the Ode team for allowing me to give this talk today on the research that my team has done my research team as well as literature. That's out there. It's a relatively nascent field in terms of

18
00:03:31.570 --> 00:03:32.900

Alex Boucher, MD: looking at

19
00:03:33.420 --> 00:03:49.230
Alex Boucher, MD: these undercurrents or these hidden sources of systemic bias. But I think it's a really powerful message, hopefully for you to be thinking about whether or not you agree with it. Certainly not. Everybody does, and that's what we're here for. So let me get.

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00:03:49.230 --> 00:03:52.719
Ana Núñez MD: It's in a yeah, not yet. Full presentation mode. It's it should.

21
00:03:52.720 --> 00:03:56.065
Alex Boucher, MD: Yeah, there we go. Now we go. There we go perfect

22
00:03:57.136 --> 00:04:02.649
Alex Boucher, MD: so, as the engineer said that Alex Boucher and I am an associate professor here in both departments.

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00:04:03.340 --> 00:04:14.669
Alex Boucher, MD: So from a just from a disclosure standpoint, these are my research funding companies. Of course, these are not really applicable to this

24
00:04:15.380 --> 00:04:16.890
Alex Boucher, MD: topic today.

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00:04:17.329 --> 00:04:23.710
Alex Boucher, MD: But as we step our toes into this water, let's also be clear that implicit bias discussions are not easy.

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00:04:24.116 --> 00:04:31.729
Alex Boucher, MD: As I alluded to a lot of times. This can rattle people or you get defensive. And I think that's a natural

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00:04:31.910 --> 00:04:40.649
Alex Boucher, MD: response to this, because it this is, there's no easy button here. It's a hard button. But I think the more that we can tackle these topics and think about them

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00:04:41.137 --> 00:04:46.139
Alex Boucher, MD: particularly in an era where we're starting to get a bit of pushback. I think that this

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00:04:46.200 --> 00:04:47.710
Alex Boucher, MD: really

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00:04:47.800 --> 00:04:54.909
Alex Boucher, MD: I I feel like can transform medical care. And the way that we interact with the individuals who seek our care.

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00:04:55.700 --> 00:05:04.999
Alex Boucher, MD: So then, the 1st question is, we're talking about bias. Why is this guy qualified? Why is this white male who certainly in the demographic pool, has a lot of things going for him.

32
00:05:05.567 --> 00:05:10.380
Alex Boucher, MD: Have that, you know. Why is he giving this talk? Why isn't it somebody else who maybe is

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00:05:10.770 --> 00:05:17.009
Alex Boucher, MD: on the surface, more affected by this. And and I go back to these disclosures. But here's the pertinent one which is to say

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00:05:17.050 --> 00:05:29.869
Alex Boucher, MD: I'm guilty of this I've done this myself. I've perpetuated these biases. I've read too much into other notes, added my own context. I am not standing on a soapbox here, saying

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00:05:29.890 --> 00:05:32.440
Alex Boucher, MD: that I've never done these things, and and

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00:05:32.795 --> 00:05:40.060
Alex Boucher, MD: as you'll see even in this, in in our studies I found my own documents to echo that. So

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00:05:40.150 --> 00:05:46.569
Alex Boucher, MD: I am standing here amongst everybody. We're all part of this process, and we're all part of you know this issue.

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00:05:46.630 --> 00:05:58.239
Alex Boucher, MD: And so that's where I come from is is a bit of a. As I worked on this a bit of a mea culpa moment to kind of recognize how I was perpetuating these things myself.

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00:05:59.640 --> 00:06:14.849

Alex Boucher, MD: So by the end of this presentation, here's what I hope that we can cover. One is recognize that the Emr itself is really not just data points or pixels on the computer screen, but they really convey messages that have downstream effects.

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00:06:15.010 --> 00:06:19.199
Alex Boucher, MD: And this is one of these sources for implicit bias that

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00:06:19.610 --> 00:06:23.070
Alex Boucher, MD: we don't necessarily notice, especially because we're so.

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00:06:23.100 --> 00:06:26.370
Alex Boucher, MD: It's it's so much of our norm whether it's

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00:06:26.470 --> 00:06:36.919
Alex Boucher, MD: during the clinical day whether it's note writing after hours, whatever it may be. We're always taking in this information, and it can be easy to think of this as objective.

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00:06:37.317 --> 00:06:49.460
Alex Boucher, MD: Kind of clinical medical information. But in reality there's a lot of subjectivity to it. And then, rather than just calling out problems, I wanted to try to propose a few solutions as well.

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00:06:49.930 --> 00:07:08.809
Alex Boucher, MD: and you'll see here at the bottom in a couple of slides that I'll remind you. But just to sort of prep for efficiency here. As that's part of our topic. You can. If you're online, you can do pull everywhere.com. And do, Alex. Boucher. 2, 7, or you can text it on your phone.

46
00:07:08.840 --> 00:07:20.299
Alex Boucher, MD: 3, 7, 6 0. 7. We'll have a word Cloud, and a few a couple of slides here word clouds. Just so we can get your perspectives as well. And again, these are anonymous. These are not gonna be tracked in any way.

47
00:07:21.520 --> 00:07:30.459
Alex Boucher, MD: So let's think about documentation. The the notes here and this is. And to start out here, I'm gonna ask your perspective on this note, but I'll read it out to you.

48
00:07:32.350 --> 00:07:37.340
Alex Boucher, MD: these are real notes within our empath, Fairview system.

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00:07:37.700 --> 00:07:41.500
Alex Boucher, MD: So the 1st line or the 1st note.

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00:07:41.900 --> 00:07:50.700
Alex Boucher, MD: and this is from the emergency department. We went over all of our options, including coming into the observation for Iv antibiotics and careful monitoring versus a plan to go home

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00:07:50.960 --> 00:07:53.630
Alex Boucher, MD: after receiving one dose of Iv antibiotics here

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00:07:54.110 --> 00:08:08.480
Alex Boucher, MD: she's opted for the latter and given her experience in the healthcare system. This is prudent. She tells me she lives close enough to the hospital. If anything were to get worse. She feels comfortable with this plan, and politely refused to come in, which is, of course, very reasonable within her rights.

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00:08:09.030 --> 00:08:19.760
Alex Boucher, MD: And so this is a woman with in her sixties. She's undergoing chemotherapy, and it's a complicated UTI, not only because of immunosuppression, but also recurrent home catheterizations.

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00:08:19.910 --> 00:08:22.940
Alex Boucher, MD: But I want you just sort of if you were to read this note

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00:08:22.970 --> 00:08:29.454
Alex Boucher, MD: as clinician, of whatever type, training, or faculty or or staff, whatever it may be.

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00:08:30.300 --> 00:08:39.130
Alex Boucher, MD: What are your 1st impressions when you get to that? And there is a QR code in the in the top. But you can also text it and pull everywhere. Com slash, Alex Boucher 2, 7,

57
00:08:40.050 --> 00:08:43.979
Alex Boucher, MD: and hopefully this will work, and we'll start to see some things pop up.

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00:09:00.820 --> 00:09:02.200
Alex Boucher, MD: There we go perfect.

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00:09:11.470 --> 00:09:13.270
Alex Boucher, MD: I like the eyeballs

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00:09:14.170 --> 00:09:15.740
Alex Boucher, MD: so respectful.

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00:09:16.120 --> 00:09:17.389
Alex Boucher, MD: Yeah, they're busy

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00:09:17.540 --> 00:09:19.429
Alex Boucher, MD: is a complex case.

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00:09:21.870 --> 00:09:22.710
Alex Boucher, MD: perfect.

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00:09:23.490 --> 00:09:25.990
Alex Boucher, MD: So some of the words polite, realistic.

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00:09:28.410 --> 00:09:35.349
Alex Boucher, MD: alright, alright. So hold that in mind. And now we're gonna move to the next note. And I'm gonna ask you to do the same thing in a bit.

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00:09:35.580 --> 00:09:46.529
Alex Boucher, MD: This is another note, different, patient. This is typically her pattern. When she becomes frustrated she will lash out at the nursing staff with verbal abuse. This is not uncommon for her in the Ed, usually towards the nursing staff.

67
00:09:46.780 --> 00:09:56.469
Alex Boucher, MD: would recommend that eventually, after this acute episode of illness is resolved the patient's primary hematology clinic write into her care. Plan that verbal abuse of the staff will not be tolerated.

68
00:09:57.090 --> 00:10:06.930
Alex Boucher, MD: And now this is a woman in her twenties, and she's seeking care for acute pain, and I've noted here the underlining was not mine. The underlining was in there from the E physician.

69
00:10:08.770 --> 00:10:14.149
Alex Boucher, MD: So thinking about that now, or what are the responses after you read that note.

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00:10:19.960 --> 00:10:25.869

Alex Boucher, MD: These patients have as documented here lots of experience in the in the hospital.

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00:10:31.850 --> 00:10:36.720
Alex Boucher, MD: So judgmental assumptions. Yikes, I would agree.

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00:10:38.970 --> 00:10:48.530
Alex Boucher, MD: As you can see, we're reading each of these somewhat out of context. But that's how we're oftentimes reading these notes, particularly as we're thinking about acute care visits.

73
00:10:48.650 --> 00:10:55.529
Alex Boucher, MD: We are not knowing the full picture. And that's especially true on the front lines.

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00:10:55.630 --> 00:10:56.670
Alex Boucher, MD: So

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00:10:56.700 --> 00:11:02.829
Alex Boucher, MD: what I'm seeing here big Picture, is that we're seeing very different responses to somebody else who's also been in the hospital.

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00:11:03.206 --> 00:11:06.800
Alex Boucher, MD: And I think some of the things that I'm picking up here. And

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00:11:06.860 --> 00:11:25.579
Alex Boucher, MD: the reason these notes are is the 1st person was polite, was realistic, was given options to make decisions, and in this case the Ed physician is is a little bit more judgmental and and recommending specifics, even as somebody who's not ultimately doing the the long term care.

78
00:11:25.650 --> 00:11:41.199
Alex Boucher, MD: And so this is an Ed. Evaluation of a young adult with sickle cell disease. Again I left that out at the beginning, but in reality and this is my patient, and I'll come back to this case in a bit. She's been in the Ed several dozen times, so not just several times, but several dozen in the last 12 months.

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00:11:41.330 --> 00:11:55.909
Alex Boucher, MD: and as I reviewed back and looked to try to figure out how much is this experience of this? Is her? Norm echoed, and it was present only 2 other times, and then and then I should say the next. Ed note also sort of suggested this, but then it faded away.

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00:11:56.630 --> 00:12:05.039
Alex Boucher, MD: But for somebody who's been in the ed all the time. This paints a different picture than actually if you if you review through the chart itself.

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00:12:06.660 --> 00:12:11.110
Alex Boucher, MD: So then let's move towards definitions. So these are definitions from Miriam Webster.

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00:12:11.548 --> 00:12:21.129
Alex Boucher, MD: Stereotype is basically the standard mental picture. And and it's an oversimplified opinion. So I have that sort of person. That picture faded out in the

83
00:12:21.170 --> 00:12:45.600
Alex Boucher, MD: the top right to represent basically a stereotype has some potentially some semblance of truth at some point. But it's very simplified. You can't really tell the details, but in and of itself it is just that it is. It is a mental picture, whereas Bias starts to add in judgment and potentially prejudice, and we generally used to think it bias is negative. But

84
00:12:45.730 --> 00:12:52.189
Alex Boucher, MD: I would argue that we certainly have characterizations in in academia and medicine that are positive biases.

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00:12:52.430 --> 00:13:05.839
Alex Boucher, MD: And then culture is, what is that foundation that these beliefs are are happening in? And so these in and of themselves are a bunch of words, but I tend to think of it. I sort of in this metaphor of stereotype is a ball.

86
00:13:05.950 --> 00:13:08.020
Alex Boucher, MD: Bias is pushing that ball

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00:13:08.130 --> 00:13:21.739
Alex Boucher, MD: and culture is the ground and the the hill that this is going on. And and the reason it's a hill is because it's status quo will maintain. You know, just in the same way that the law of physics maintained with gravity, unless we

88
00:13:21.970 --> 00:13:36.889
Alex Boucher, MD: add in some sort of wall or speed bump, or some other way of disrupting that passage. But if we don't, if we just assume it's going to happen, and it's going to stop. I think we're going to be misled and have.

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00:13:37.010 --> 00:13:39.970

Alex Boucher, MD: or expectations.

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00:13:40.680 --> 00:13:46.460
Alex Boucher, MD: Another way to think of this are these are not independent gears. That these are

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00:13:46.480 --> 00:13:53.109
Alex Boucher, MD: that stereotype drives bias that drives culture in our community. But we are not separate from that. We are.

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00:13:53.700 --> 00:14:13.779
Alex Boucher, MD: The medical culture is, we are not living independently of our general culture. Right? We go home we leave the hospital. We try and take a break from our work, etc, as much as possible, but we are still within that, and it certainly doesn't stop at the hospital door. And so I think when we think about these things.

93
00:14:14.161 --> 00:14:16.730
Alex Boucher, MD: we have to think about where our judgments

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00:14:16.870 --> 00:14:21.150
Alex Boucher, MD: potentially from out in the community and the culture being brought into

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00:14:21.190 --> 00:14:22.700
Alex Boucher, MD: our medical culture.

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00:14:23.270 --> 00:14:27.710
Alex Boucher, MD: Because I think this is a ripple effect. Sometimes I'll talk about the medical record

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00:14:27.790 --> 00:14:34.780
Alex Boucher, MD: as social media. It's essentially medical social media. Right? You put some message out there it is there forever

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00:14:35.165 --> 00:14:46.159
Alex Boucher, MD: patients can see it, and families can see it. And it's oftentimes the next reader who you don't know who it's going to be when it's going to be, what context it's going to be

99
00:14:46.370 --> 00:14:47.899
Alex Boucher, MD: is going to take

100
00:14:48.140 --> 00:15:08.210
Alex Boucher, MD: what was said at face value, even though it's it's often lacking context. And so you you can start to get this ripple effect, in my opinion, that you start to get an expansion of an idea of a patient or a disease, or whatever it may be, based on your exposure to it which may be myopic or limited in some way.

101
00:15:09.850 --> 00:15:12.010
Alex Boucher, MD: So let's think about do words matter.

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00:15:12.654 --> 00:15:17.970
Alex Boucher, MD: So this is as as Dr. Nunez mentioned, I I lead our sickle cell program

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00:15:18.270 --> 00:15:26.950
Alex Boucher, MD: and sickle cell is certainly an a disease that has had a lot of barriers up against it, and part of the reason for that is that it has been

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00:15:27.850 --> 00:15:33.890
Alex Boucher, MD: in the medical, in certainly in the American Medical Institution, and I think this is certainly true within Europe as well.

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00:15:34.360 --> 00:15:37.730
Alex Boucher, MD: it has been characterized as a

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00:15:38.080 --> 00:15:52.319
Alex Boucher, MD: almost singular disease in the in the sense that it's thought to only affect ethnic minorities. And so this was not. This quote is this from the editor of Jama in early 1947,

107
00:15:52.420 --> 00:16:02.390
Alex Boucher, MD: not a rogue author, or something else, or an opinion piece per se. But it was the editors who said, the most significant feature of sickle cell anemia is not its characteristic

108
00:16:02.440 --> 00:16:08.609
Alex Boucher, MD: bizarre deformation of erythrocytes, but the fact that it's apparently the only known disease completely confined to a single race.

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00:16:08.820 --> 00:16:20.450
Alex Boucher, MD: and then, later on in that piece, they say, the author says, nevertheless, it appears that the sine qua non for the occurrence of sickle cell anemia is the presence of a strain even remote, of negro blood.

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00:16:20.790 --> 00:16:25.499
Alex Boucher, MD: So this is in text from essentially the leading voices in medicine in 1947.

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00:16:26.150 --> 00:16:36.630
Alex Boucher, MD: And I should also essentially make this the one drop rule in a way that sickle cell disease is associated with being from Africa

112
00:16:36.880 --> 00:16:43.069
Alex Boucher, MD: and somewhere in in your ethnicity, somewhere in your 23 Andme. And

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00:16:43.260 --> 00:16:55.049
Alex Boucher, MD: even to that point in the couple in earlier in the 19 forties. They actually had case reports which, for those of you who may not be clinical case reports are oftentimes published as unique, and novel

114
00:16:55.070 --> 00:17:13.330
Alex Boucher, MD: experiences or clinical findings. They had multiple case reports of quote, unquote white individuals with sickle cell disease that was noteworthy enough to publish. So it shouldn't be surprising then that 1947 comes around. It takes 25 more years for the National, for there to be National funding, which was

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00:17:13.599 --> 00:17:23.129
Alex Boucher, MD: called the Sickle Cell Anemia Control act, and in 1972, signed by Nixon, but even then was not really evidence based. It's laughable in terms of its assumptions. One of the

116
00:17:23.339 --> 00:17:29.610
Alex Boucher, MD: bill's statements is that there are 2 million people in the Us. With sickle cell disease estimated, which

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00:17:29.740 --> 00:17:38.090
Alex Boucher, MD: is, is certainly not that at all. Based on data from 2,010, and even with raw estimates there from 2 different papers.

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00:17:38.120 --> 00:17:48.280
Alex Boucher, MD: we think there's maybe 100,000. So not 2,100,000. But again, it's not surprising that when the healthcare system says, this is a quote unquote black disease.

119
00:17:48.480 --> 00:18:13.590
Alex Boucher, MD: and we're talking about, certainly in the free civil rights era that lingers, that ripple effect is still there, and the other reality is, if you look at the birth rates, the second

highest birth rate in the world is actually in India. But it's not the community that we often see in the Us. Because oftentimes those patients are struggling with the same social determinants of health that individuals in the Us. Are so they're not the ones who have immigrated

120
00:18:13.660 --> 00:18:17.240
Alex Boucher, MD: or emigrated out of out of India to the Us. But again.

121
00:18:17.320 --> 00:18:22.899
Alex Boucher, MD: perception becomes reality when you don't pay attention to the context.

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00:18:24.070 --> 00:18:33.669
Alex Boucher, MD: And this is not just true in sickle cell disease. If we look at other data that's out there in terms of access to care. And how might that change your treatment again? Do words matter?

123
00:18:34.131 --> 00:18:44.540
Alex Boucher, MD: I think they do. I I think that they're one data point we're looking at. Could somebody get that low dose screening cat scan for lung cancer?

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00:18:45.630 --> 00:18:52.631
Alex Boucher, MD: What you need to do to be able to to bill for it. And and not have it follow the patients.

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00:18:53.100 --> 00:19:01.049
Alex Boucher, MD: on the patient's responsibilities. You have to document. What are their risk factors? Did they smoke in some point, or did they have other some other high risk factors?

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00:19:01.431 --> 00:19:09.009
Alex Boucher, MD: Individuals who are black, non English speaking? And or had Medicaid were less likely to get that. Have that screening. If you looked at their documentation

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00:19:09.390 --> 00:19:15.299
Alex Boucher, MD: on the Flip side in a large national study, 651 community health centers in 21 States

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00:19:15.570 --> 00:19:22.760
Alex Boucher, MD: they looked at who was screened for social risk factors, and in this case they found that the underrepresented minority groups were screened, more likely

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00:19:22.850 --> 00:19:49.519

Alex Boucher, MD: as if those who were say non-hispanic white wouldn't have these issues if we take that locally. That would be like if you're more likely to screen somebody for these risk factors if they're from North Minneapolis than they are from Medina. As if there are social risk factors there, too, and if you don't screen for those you don't know how to actually help. And again, it can have downstream effects on how you categorize their risk

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00:19:49.520 --> 00:20:00.869
Alex Boucher, MD: kind of adherence to a treatment plan or how you're making decisions and finally, goals of care. We really want to have patient autonomy and the voice in their voice at the end of life.

131
00:20:01.100 --> 00:20:18.940
Alex Boucher, MD: But documentation is less. Whether or not they've had the discussion or not. We're always taught. If you didn't document it, it didn't happen, although I would argue here that sometimes you can document things that didn't happen. But you're less likely to find the goals of care discussions in elderly, racial, and ethnic minorities. So we aren't necessarily

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00:20:19.533 --> 00:20:22.440
Alex Boucher, MD: offering equitable care at the end of life, either.

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00:20:23.770 --> 00:20:31.059
Alex Boucher, MD: So then I'll move to our system. So this is our study that has been submitted for publication.

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00:20:31.340 --> 00:20:37.290
Alex Boucher, MD: And in this case, we basically, you know, we're looking at

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00:20:38.360 --> 00:20:41.290
Alex Boucher, MD: are there words that have

136
00:20:41.540 --> 00:20:44.849
Alex Boucher, MD: in there are 2 sort of categories of words. One is

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00:20:44.960 --> 00:20:54.414
Alex Boucher, MD: words that are ostensibly objective, but actually are more subjective, and we give them credit for and and medical, so that would be like compliant or non compliant.

138
00:20:54.870 --> 00:21:01.340
Alex Boucher, MD: or maybe, like respectful, disrespectful. Again, more in the eyes of the beholder than we want to give it credit for.

139

00:21:01.400 --> 00:21:24.819
Alex Boucher, MD: And then the second group were curse words as well as swearing profanity and cursing in their derivatives, because we recognize that they actually show up quite a bit in quotes, almost always quoting patients or family members. And in those cases they carry a shock value. There's neuropsychological literature showing that you're

140
00:21:25.169 --> 00:21:33.200
Alex Boucher, MD: certain areas of the brain especially related to memory and and in in kind of anchoring down on on long term perceptions

141
00:21:33.620 --> 00:21:40.020
Alex Boucher, MD: are triggered by negative words, and are triggered by these types of words differently than say a positive word would be

142
00:21:40.110 --> 00:21:47.310
Alex Boucher, MD: so. What we did was, we had 2 and a half years here, ultimately, as you can see here, about 9,000 patients, 12,000 encounters.

143
00:21:47.320 --> 00:22:01.279
Alex Boucher, MD: and these were done in acute care, settings in the Ed and inpatient with the idea that the providers writing those notes, whether they're clinical clinic staff, or I mean a hospital staff, social workers, etc, or or the

144
00:22:01.400 --> 00:22:14.209
Alex Boucher, MD: physicians, for example, or the apps. They're less likely to have a long-term relationship with these patients. Of course, that's not always the case. They may have known them from some other point. But most of those people are not following them long term.

145
00:22:15.470 --> 00:22:25.239
Alex Boucher, MD: Again, we had negative and positive, because we didn't want to just anchor down and say these were their only trends were negative, and we looked at the essentially the metro

146
00:22:25.430 --> 00:22:49.830
Alex Boucher, MD: legacy, Fairview sites. So we looked at Riverside, East Bank, Masonic Children's Ridges in Southdale, and when we looked at them and we really tried to nail down, when was the 1st time the words showed up in the encounter, and we didn't repeat them over time because of copy forwarding. We know that things can get copy forwarded 1820 times, and we didn't want to escalate, or sort of add more weight to those.

147
00:22:49.910 --> 00:23:13.369
Alex Boucher, MD: but if the patient showed up for a separate encounter later on, and that word showed up again, it would be counted again. But again, just once, and we have here.

You can kind of see there's white and black or African American categories here, and our study population was about 74% to 15% not totally different than the Fairview demographics are in that same time period, which is what we requested.

148
00:23:13.560 --> 00:23:23.240
Alex Boucher, MD: I will say. Obviously, you don't see that other than mixed race. 3 are more reported people who have 2 mixed race ethnicities based on their own report.

149
00:23:23.743 --> 00:23:32.796
Alex Boucher, MD: We categorize those. And you. You could argue that it was rightly, wrongly, we categorize those as the minority, because oftentimes in clinical care. We often we will.

150
00:23:33.665 --> 00:23:52.199
Alex Boucher, MD: Naturally based on social societal pressures, cluster them as the minority. And that that is true, based on data that's out there as well. So we categorize them as as that way. Right, Leon, because we want to be able to do the studies. But ultimately our analyses were just white versus black or African American.

151
00:23:52.570 --> 00:23:54.830
Alex Boucher, MD: because the other numbers were too small

152
00:23:55.397 --> 00:23:58.139
Alex Boucher, MD: to really get good information.

153
00:23:58.590 --> 00:24:04.239
Alex Boucher, MD: And so these are that this is one of our key findings. And so what you're looking at here? You're looking at the words on the left.

154
00:24:04.410 --> 00:24:17.270
Alex Boucher, MD: Admittedly there were a couple of words that we did not end up finding very much. And we were using natural language processing software here so that we could actually read the full context of the note because a few things we noticed happen. One was

155
00:24:17.580 --> 00:24:20.359
Alex Boucher, MD: The software itself might

156
00:24:20.390 --> 00:24:35.480
Alex Boucher, MD: find complaint listed as compliant because of being misspelled, it or not compliant, was listed as compliant. So the authors we all reviewed different words here, and and double checked on on many of them to figure out

157

00:24:35.600 --> 00:24:45.265
Alex Boucher, MD: what was the true context here. And we also took out words where, if there was a legal reason that it probably needs to be in there, we would leave it in there.

158
00:24:45.770 --> 00:24:50.339
Alex Boucher, MD: You can see here, Bdfs, you can see at the bottom there. Those are the curse words that we chose.

159
00:24:50.920 --> 00:24:54.729
Alex Boucher, MD: and then Spc. Would be swearing, profanity, cursing.

160
00:24:54.950 --> 00:25:04.589
Alex Boucher, MD: And so we were looking at those as the idea that were the curse words themselves used, or was it just swearing? Patients swore at me, and we'll talk about that in a bit.

161
00:25:04.830 --> 00:25:21.380
Alex Boucher, MD: What you're looking at here. And you can see this, the stars on the right. We use the p-value of 0 point 0 5, but the ones in orange were significant in the in the negative, and green were in the positive. And when we look at the odds ratio we used white as our as our kind of

162
00:25:21.730 --> 00:25:39.899
Alex Boucher, MD: the odds ratio of one. And so if it's higher than that, it's more likely to be used in somebody who's self-described as black or African-american, and if it's lower than that, it was significantly more likely to be in somebody who's white, and what you see here. If you look at those odds, ratios, those negatives, all fell into the individuals who are black African, American.

163
00:25:40.190 --> 00:25:42.069
Alex Boucher, MD: and the app. That was true.

164
00:25:42.230 --> 00:25:49.990
Alex Boucher, MD: and for white individuals as as self described, that they were more likely to be compliant or polite. Those types of things

165
00:25:50.990 --> 00:25:54.479
Alex Boucher, MD: when we looked at the curse, words themselves again.

166
00:25:54.980 --> 00:25:58.143
Alex Boucher, MD: and and I have a example of a quote here.

167
00:25:59.000 --> 00:26:05.990
Alex Boucher, MD: you know, upon entering a room to draw labs, and I I obviously put the stars in there. But I've been effing calling for help. And you guys have been effing, ignoring me.

168
00:26:06.570 --> 00:26:14.319
Alex Boucher, MD: To me that doesn't really add medical value. But it does paint a picture that if you're going into that room, be ready to be more defensive.

169
00:26:14.410 --> 00:26:36.960
Alex Boucher, MD: That's the exact type of thing that we were looking at, which was to say, that sends a message that is not just an objective piece of information, because the next person in there, if they read that, or whether or not they're the provider making medical decisions, or whether they're just the medical assistant or the nurse or the Pca. Coming in.

170
00:26:37.200 --> 00:26:53.070
Alex Boucher, MD: You're going to be back on your haunches a little bit. You're going to be a little bit less likely to have an open discussion because you're going to say, what am I going to? Am I going to tip this person over in terms of anger or something else? Whereas, if you said the patient swore at me

171
00:26:53.500 --> 00:26:57.879
Alex Boucher, MD: that could still have an effect. But it's not gonna have that same shock value.

172
00:26:58.190 --> 00:27:02.629
Alex Boucher, MD: We also did a post talk analysis, because it happened to be that George Floyd was killed

173
00:27:03.101 --> 00:27:14.480
Alex Boucher, MD: or was murdered about halfway between. The start and finish here? Not quite. But we did as a we did it as a pre- and post, because one of the things that I think we're all aware of

174
00:27:14.540 --> 00:27:34.790
Alex Boucher, MD: is that in the aftermath of George Floyd's murder there was a lot of push towards more understanding, more tolerance, more awareness of health, equity, and diversity issues. And so one might suspect that there'd be a normalization of these that maybe people would tone down documentation. But actually the opposite

175
00:27:34.810 --> 00:27:45.340

Alex Boucher, MD: tended to be true, although the values did not reach significance. But there was, if if we looked at that in interaction of of time and and race, there's actually an increase in those terms.

176
00:27:45.370 --> 00:27:55.181
Alex Boucher, MD: at least in terms of raw numbers just for black individuals. It wasn't true for white and and not clear why, where people were frustrated, maybe where people the

177
00:27:55.560 --> 00:28:01.550
Alex Boucher, MD: try to cover themselves with defensive documentation. Maybe we didn't obviously have a study to power as to why.

178
00:28:01.740 --> 00:28:16.879
Alex Boucher, MD: but it does seem to be at odds with the idea that we were, gonna be more inclusive. It actually, to me, it's the opposite is actually, people kind of went to their corners. Even if the system itself really wanted to trend things in a in a more inclusive tone.

179
00:28:17.300 --> 00:28:24.000
Alex Boucher, MD: And lastly, thinking about it, there was a negativity bias. So when encounters happen, multiple times for a patient.

180
00:28:24.160 --> 00:28:40.664
Alex Boucher, MD: and it didn't happen out every time. So there were some people that maybe switched positive to negative or negative. But if there was a trend a scarlet letter of sorts. It was twice as likely that that trend was a negative to a negative versus positive. And again, that gets back to

181
00:28:41.060 --> 00:28:48.520
Alex Boucher, MD: functional MRI testing, showing that negative terms are more likely to sink in and to anchor people back to that.

182
00:28:49.160 --> 00:29:07.570
Alex Boucher, MD: So let's go back to this case again. I said this was my patient, and this was one of my miaopa moments, and as I read this I also recognize that I know I could have done better in the immediacy of it. But even as I read this I cringe a little bit because I tried to sort of split the difference, and I don't know that that was helpful either way.

183
00:29:07.830 --> 00:29:20.720
Alex Boucher, MD: But this patient said we had the discussion today, or this is what I wrote. We had the discussion today, since she was feeling more awake about mutual respect that should be provided in the Ed and by her. And it sounds like this is not happening in either direction.

184
00:29:20.790 --> 00:29:31.289
Alex Boucher, MD: This led to some frustration, as she points out that Ed nursing and other providers only write down what she says, and may downplay their behavior towards her, whether they intend to treat her like they do or not.

185
00:29:31.440 --> 00:29:38.859
Alex Boucher, MD: And to me this was one. This was the encounter that stuck out to me that said, I need to evaluate this because I recognize that

186
00:29:39.030 --> 00:29:41.170
Alex Boucher, MD: I walked into that room.

187
00:29:41.240 --> 00:29:51.499
Alex Boucher, MD: taking the Ed's documentation as the objective truth, and my patient said, Look, you haven't heard my side of the story, and I have no way of documenting it.

188
00:29:51.931 --> 00:29:53.980
Alex Boucher, MD: And I think that's really powerful

189
00:29:54.240 --> 00:30:07.599
Alex Boucher, MD: to think about is that this is still there's a power differential with our patients and ourselves as clinical providers, in whatever role you are. And it's not just in the room. But it's actually in how you document as well.

190
00:30:07.964 --> 00:30:25.539
Alex Boucher, MD: Because downstream, you know. Again thinking about this case, the next Ed Provider is probably not reading my admittedly long note about this issue. They were gonna probably jump back to the last Ed note to to look for pattern recognition. And and that's where part of the problem lies.

191
00:30:26.440 --> 00:30:30.010
Alex Boucher, MD: So how do we disrupt the status quo? Here comes some of the ideas.

192
00:30:30.080 --> 00:30:37.390
Alex Boucher, MD: And again, these are not all inclusive. There are other ideas, but one is just increasing the awareness of it having a discussion like this.

193
00:30:37.550 --> 00:31:06.049
Alex Boucher, MD: And here's a study that shows that we can have a little bit of hubris about this, and we also are great at recognizing this in ourselves. So this was a study done in 2018, and what I don't have here is. There were about 500 patients and families who were also

surveyed, and they had said on average, about 50 of the time, and they all had sickle cell, or where the family was affected by sickle cell. They had had bad experiences or apathetic experiences in their clinical care.

194
00:31:07.580 --> 00:31:14.950
Alex Boucher, MD: but they surveyed Ed providers across the country. And again, this was 4 years after there were guidelines that came out that said.

195
00:31:15.080 --> 00:31:41.989
Alex Boucher, MD: you really need to get pain medicines within 30 min, and some other realities about how to manage sickle cell care. 75 said, oh, we didn't know those were out there, but 98 said they were really confident, and while I think that we have certainly gotten better over the past few years here, we're not perfect, but I would I to me this strikes a little bit of again hubris that we do it really well, even though we didn't actually know there were guidelines.

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00:31:41.990 --> 00:31:49.009
Alex Boucher, MD: and part of that is that admittedly, the guidelines were built by the National Heart Lung and Blood Institute, so hematologist.

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00:31:49.190 --> 00:31:54.119
Alex Boucher, MD: who only had a couple of Ed providers in board. But it it it's

198
00:31:54.380 --> 00:32:15.009
Alex Boucher, MD: it rubs me in the wrong way a little bit. And then who gets blamed? Why are there issues? So you can see. Here's the top 5 reasons and a lot of them were outward blaming. So the opioid epidemic, even though the data shows that for those with sickle cell disease, they're less likely to have overdose and less likely to die from opioids.

199
00:32:15.230 --> 00:32:25.829
Alex Boucher, MD: But again blaming the open, epidemic, patient behavior crowding. So this is a system issue. We just don't have enough space, but only a 3rd of them are a little over. A 3rd said, Yeah, maybe we're to blame as well.

200
00:32:26.970 --> 00:32:36.569
Alex Boucher, MD: and then thinking about quotation, caution we're used to in in training thinking about. We really wanna have our patients have a voice. So let's quote them. But that can go both ways.

201
00:32:36.620 --> 00:32:50.629
Alex Boucher, MD: So the idea may be benevolent, but there are certainly ways, and I think clinicians out here have seen this, that it can go the opposite way. It implies skepticism. And here's some examples, he said. He lost his oxycodone prescription.

202
00:32:50.660 --> 00:33:09.790
Alex Boucher, MD: She said. She had a reaction to the medicine. When you see those, and if I read those as somebody who wasn't taking care of that patient, I'm going to say somebody didn't trust that. That was the belief they actually sold their oxycodone or something else. Right? You go to nefarious thoughts here, they said they had a reaction, but it wasn't really a reaction

203
00:33:10.130 --> 00:33:16.239
Alex Boucher, MD: that undermines the the patient provider dynamic, not just for you, but for somebody down the line.

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00:33:16.882 --> 00:33:26.950
Alex Boucher, MD: Because when we don't have more information, we fill in our own gaps. That's just our natural response to that. And and but the note writer can say, well, I quoted them, that's what they told me.

205
00:33:27.080 --> 00:33:41.789
Alex Boucher, MD: and there's evidence to say that this happens a little bit less in terms of gender differences. But in this study, but in if you took again black or African American versus white. The quoting happened about 50% more in racial minorities.

206
00:33:43.260 --> 00:33:46.993
Alex Boucher, MD: The next thought would be thinking slow. So

207
00:33:47.580 --> 00:34:00.629
Alex Boucher, MD: I suspect that some of you are out there are familiar with this book. I think it's a great book for some background here. Daniel Kahneman and Amos Tversky are psychologists, but they actually won the Nobel Prize for economics with their work.

208
00:34:01.008 --> 00:34:13.900
Alex Boucher, MD: and and sort of building what's called behavioral economics, which is to say that people don't always respond rationally to different economic triggers, but it expands beyond economics, and I think it. It

209
00:34:14.290 --> 00:34:38.550
Alex Boucher, MD: fits very well within medicine. If we think about system one. So this is our automatic response. This is our pattern recognition. And in certain fields, whether it's Ed or Icu or other things where you really have to be able to respond quickly. These things have value. But we also have to recognize they're not objective in how they were set up and how we were taught to do them, and we think about

210

00:34:38.630 --> 00:34:50.009
Alex Boucher, MD: sickle cell or black individuals for a long time were felt that they had a higher pain, tolerance. That's the type of thing that heuristics get problematic with, because they're built on false information

211
00:34:50.219 --> 00:34:53.660
Alex Boucher, MD: versus slow thinking, where we actually have to think about, are we

212
00:34:53.770 --> 00:34:54.969
Alex Boucher, MD: am I,

213
00:34:55.360 --> 00:35:09.469
Alex Boucher, MD: you know, providing an equitable care or bias in documentation. In the way I provide it. I can say that when I'm sitting in my clinic and most of my patients are. Either they either have sickle cell disease, or maybe they have Thalassemia where they're immigrants.

214
00:35:09.910 --> 00:35:17.449
Alex Boucher, MD: I it's mentally taxing by the end of a half day, because I've been. I've tried so hard and it and it it gets easier

215
00:35:17.460 --> 00:35:28.250
Alex Boucher, MD: in some ways, or it gets more normalized, but it's not easy, but I think it's worth it. It's always making me. It's challenging myself to think about, am I?

216
00:35:28.270 --> 00:35:32.860
Alex Boucher, MD: There's a power I hierarchy that's that's built into this. And I challenged my

217
00:35:32.870 --> 00:35:49.570
Alex Boucher, MD: patients to speak up. If they feel like I've said something offensive, and they some of them do, which is great, because then I'm learning as I go. But we need to be able to do this more often and again, thinking about efficiency. This is where efficiency. Whether it's in our clinical care documentation

218
00:35:49.880 --> 00:35:59.850
Alex Boucher, MD: can be a can erode this thinking fast and slow and work more towards solidifying those implicit biases

219
00:36:01.791 --> 00:36:09.109
Alex Boucher, MD: next one is recognizing loaded terms, or sometimes I'll call stacking, especially when you see more of these. So this is a study that was done for trainees.

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00:36:09.300 --> 00:36:21.809
Alex Boucher, MD: where they gave the same note, and in this case the highlights are mine. But this was the the section they gave, and so a couple of things come into play here. One is that they've labeled the patient by their disease.

221
00:36:22.427 --> 00:36:35.262
Alex Boucher, MD: There's the quotes again, he reportedly. Takes those doses. Housing authority is a trigger, certainly a trigger word hanging out with friends outside Mcdonald's that a a. Also has

222
00:36:35.780 --> 00:36:36.870
Alex Boucher, MD: some

223
00:36:37.110 --> 00:36:44.610
Alex Boucher, MD: cultural currency about? What is the socioeconomic status of that person again quote stressful situations.

224
00:36:45.180 --> 00:37:01.750
Alex Boucher, MD: So they gave half the trainees this note, and they gave half the trainees this note, which is more neutral language. This person has sickle cell disease. They actually have pain. They use opioid pain medicines. He takes them. He doesn't reportedly take them. He was hanging out with friends.

225
00:37:01.770 --> 00:37:12.499
Alex Boucher, MD: etc. And basically, when they gave this, and there were about 400 students. This is at Hopkins. You see, the students had a different bit of a different mix.

226
00:37:12.540 --> 00:37:28.769
Alex Boucher, MD: And aside, they did 2 things. One is, they had a screening, a validated screening about what's your affect towards those with sickle cell. And they basically found that the further you had been into training the more cynical you were essentially about this background.

227
00:37:28.860 --> 00:37:35.299
Alex Boucher, MD: Although there was a bit of an in-group bias towards positive affect. The the general trend was still there.

228
00:37:35.460 --> 00:37:41.050
Alex Boucher, MD: and the second one is that there was less aggressive pain management. And so going again. This isn't a

229
00:37:41.070 --> 00:37:53.020

Alex Boucher, MD: a bubble, so to speak, a training bubble, but the idea that you may treat people differently, and this is shown both in in hypotheticals in this sort of situation, but also in regular clinical care.

230
00:37:54.950 --> 00:38:03.890
Alex Boucher, MD: Other ones so take caution with copy forwarding. This is probably one of our our biggest guilty things. So what is the value of copy? Forward?

231
00:38:04.000 --> 00:38:12.840
Alex Boucher, MD: It gets us through the day. It actually, yeah, we need. We hit our billing requirements. We have a lot of notes to write. They already take enough time even with copy forwarding.

232
00:38:13.180 --> 00:38:23.314
Alex Boucher, MD: But there's a few things that I've noticed, and I say this only somewhat adjust. But I've had patients who are at 8th grade for 4 years, or I've had patients who haven't had a birthday in 5 years. They're still 25, even though they're 30.

233
00:38:23.710 --> 00:38:40.570
Alex Boucher, MD: And that's because they just keep getting copy forwarded. And if my argument is, if you're not even paying attention to what age is listed there. You're probably not paying attention to the more impactful details down the line about their social history or updating the social history. Those types of things.

234
00:38:40.770 --> 00:38:41.900
Alex Boucher, MD: and

235
00:38:42.300 --> 00:38:54.500
Alex Boucher, MD: the longer the note becomes and the more that's copy forwarded, although I don't have evidence to back this up, I I certainly anecdotally read less of that note. Because I recognize that that that

236
00:38:54.580 --> 00:39:18.570
Alex Boucher, MD: I just don't have time to read all of that. But as someone who recognizes I'm guilty of these things. I'm probably guilty of perpetuating these biases. And again, you sort of have that ripple effect. You put that in there, or you don't update that information. And the next reader thinks that what you said was true, or what somebody said 4 or 5 visits ago that you didn't pay attention to was true, and it may not have been.

237
00:39:19.760 --> 00:39:23.650
Alex Boucher, MD: And the 5th thing is is add context here. So this is one more case.

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00:39:23.800 --> 00:39:41.230
Alex Boucher, MD: this eighty-year-old patient, 80 plus year old patient. I didn't. Just to try to minimize identification here has not been very compliant with follow-up, which is why he did not receive any treatment for his colon cancer until last month, and he did not receive formal chemo teaching prior to Cape Cytomine starting Cape Cytomine.

239
00:39:41.420 --> 00:39:56.690
Alex Boucher, MD: And so when I read this, I see a unifocal blame. Basically, the patient didn't follow the directions not been very compliant. And now they're going to basically deal with the consequences. But when you actually read through this note.

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00:39:57.350 --> 00:40:06.199
Alex Boucher, MD: this patient only spoke Russian and lived alone. So if they're not very compliant, is it because we didn't, they actually

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00:40:06.670 --> 00:40:23.669
Alex Boucher, MD: totally disagreed with our recommendations, or they didn't have a ride, or they didn't have a language or an interpreter that could speak their language, or they didn't have the formal kito teaching in Russian. These are things that really change the dynamic. And if you add those in, if you add that context about not very compliant.

242
00:40:24.630 --> 00:40:43.420
Alex Boucher, MD: I might read that differently than you might, but I think it. It adds more understanding to the picture, because compliant is thought to be this medical objective term. But it's really not. It's really in the eye of the beholder. And some people, you know. So so I, the idea that we need that context

243
00:40:43.660 --> 00:40:49.629
Alex Boucher, MD: takes the takes, the, you know, ideally, would chip away at the implicit bias of the reader

244
00:40:49.700 --> 00:40:53.150
Alex Boucher, MD: and and bring it back to painting. The fuller picture.

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00:40:54.360 --> 00:41:19.170
Alex Boucher, MD: So in summary, these are ingrained in our medical culture, I don't think we can avoid them, and we all have our implicit biases, and I don't like the term de-biasing, because I think that sort of assumes that you can wash it away, and our biases are often built within our culture, or sometimes they're protective. But we have to recognize that they're there so that we can challenge them when we need to. And documentation is one of those settings where it can become really problematic.

246
00:41:19.641 --> 00:41:33.798

Alex Boucher, MD: I've given a couple of suggestions about how to challenge this and and certainly there are other ways of doing this, but I think one of the big things is adding more context and admittedly in an era of efficiency, taking a little bit more time

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00:41:35.080 --> 00:41:45.260
Alex Boucher, MD: should chip away at that? Because I do. I think that words and documentation matter. So as I go back to why is this guy qualified? Aside from the fact that, as I said, I've had my

248
00:41:45.380 --> 00:42:13.959
Alex Boucher, MD: made a couple. It's why are we qualified? So when I did this, when we were doing this study, these were our pediatric edi champions and our adult Diversity Council. This is our research team, and other than Kathy Bendill, and second to right, none of the rest of us were on these councils. I joined later, but Doctor Zelaya Ivey was our heamed fellow for the adult Brittany Kimball was a medpieves resident Sharon Wies. Our research coordinator, Mike Evans, is a Biostatistician.

249
00:42:14.220 --> 00:42:24.170
Alex Boucher, MD: We didn't feel like we had. We don't need to rely just on a council or people with some sort of title to do this. We all have to do this because we're all

250
00:42:24.200 --> 00:42:30.049
Alex Boucher, MD: integrated into this, whether it's our clinical care, and, as shown here some of our research team.

251
00:42:30.540 --> 00:42:43.649
Alex Boucher, MD: So just as I close, there's a couple of future directions again. I haven't sought this finding just quite yet, but going a little bit further into that behavioral economics information. There's another book called Nudge. If you've read that

252
00:42:43.977 --> 00:42:49.520
Alex Boucher, MD: if you haven't, I would suggest it. But the idea that when we tell people don't do this.

253
00:42:49.890 --> 00:42:54.330
Alex Boucher, MD: the response may be a defensive tone, but if we say

254
00:42:54.350 --> 00:43:08.330
Alex Boucher, MD: rather, even if it's subtle within the Emr, there are ways to nudge to alternatives. If there's a word that's if it's compliant, you have to either spell it out or give some more context or something else, or get rid of that word altogether.

255

00:43:08.350 --> 00:43:26.599
Alex Boucher, MD: I think that's 1 way thinking about where in that communication string, is it? If we're talking about the Ed, is it the triage, nurse? Maybe, that if you can stop some information from being perpetuated there that down the line it helps not quite sure, but also just kind of looking at those clinical outcomes

256
00:43:26.940 --> 00:43:28.550
Alex Boucher, MD: when it comes down to it.

257
00:43:28.660 --> 00:43:36.160
Alex Boucher, MD: As as I finish here, sort of looking at this quote, if we wait for others to initiate, change, we automatically become a follower, or you automatically become a follower.

258
00:43:36.340 --> 00:43:47.500
Alex Boucher, MD: We can't wait for a Diversity Council or a few people within our division. To do this, we all have to do this, because if we think about our medical documentation, we're all doing it.

259
00:43:47.660 --> 00:44:04.769
Alex Boucher, MD: And so with that, thank you for engaging. I know that this is a topic that some people probably disagree with the impact of it, and I'm happy to kind of have these discussions here, whether it's in this forum or later. But I appreciate your time and

260
00:44:04.810 --> 00:44:06.490
Alex Boucher, MD: engagement on this.

261
00:44:09.400 --> 00:44:27.920
Ana Núñez MD: Thank you very much. That was awesome. I have many questions, but I'll I'll defer to the questions that are in the link there and then sort of save mine for later. So this update, said, can you share your thoughts on the use of AI tools that summarize or scribe visits, and how that

262
00:44:28.180 --> 00:44:29.660
Ana Núñez MD: will affect bias.

263
00:44:30.370 --> 00:44:47.350
Alex Boucher, MD: Yeah, it's a great question, and I certainly think it's a pathway that we're on our way to. I don't think there's a way to stop it. In fact, you would argue that we're using AI in a way with our study. I think we have to recognize again that I'm concerned about it, because it's built on

264
00:44:47.480 --> 00:45:05.199

Alex Boucher, MD: whether it's language databases or note databases that are inherently biased. I think when we do those they may have their value, but it's always worth double checking in the same way that we had to even double check our language processing software. It was great that it could compile this information, but we were recognizing that

265
00:45:05.200 --> 00:45:25.059
Alex Boucher, MD: it was fine. It was putting not come, not space compliant in the wrong bucket or hipaa compliant. We didn't need those types of things. So I think it's it. It will have its value in terms of efficiency. But with that comes this perpetuation of risk. And and it's incumbent on us as the users to recognize where those fallibilities lie.

266
00:45:25.580 --> 00:45:43.550
Ana Núñez MD: There is some stuff in terms of AI that says set algorithms, especially for underrepresented folks, amplify sort of bias. So it makes it faster, you know, think of facial recognition, and so on, and so forth. It makes it faster, but it makes it worse. So we have to sort of make sure that we don't sort of go that direction as well.

267
00:45:43.550 --> 00:45:57.370
Ana Núñez MD: So this is from Suman. Hi! How thank you, Doctor Brochure, for the excellent lecture. I joined a bit late, so I might have missed it. Could you provide some examples of just in time teaching that could be used in clinical settings? Great question.

268
00:45:57.790 --> 00:46:15.409
Alex Boucher, MD: Yeah, I think so. One of the is a great question, and I think that there's different ways of doing it. So sometimes, if you're on the rotation. Again expanding past documentation. It. It may be as simple as as when you're rounding and somebody says, sickle cell patient.

269
00:46:15.820 --> 00:46:20.689
Alex Boucher, MD: is there another way that we can think about it rather than you know in rather than being

270
00:46:20.920 --> 00:46:37.450
Alex Boucher, MD: confronting them, confronting that person right there. Think about how are we categorizing them? Are we categorizing this person as a person first? st And I even tell my patient that we're going to talk about? We're going to talk about you as an individual. You have sickle cell disease, but you're not defined by it.

271
00:46:37.450 --> 00:46:52.879
Alex Boucher, MD: Or if we're looking at documentation, figuring it, you know, sometimes it's just take a, you know. Take a couple of minutes with somebody, and with a trainee, for example, or faculty, whoever it may be, and just look at it and say, are there are there points within this note that

272
00:46:52.960 --> 00:46:58.489
Alex Boucher, MD: feel uncomfortable? Right that if we sat there and you just thought about this and say.

273
00:46:58.890 --> 00:47:13.580
Alex Boucher, MD: is there a different way to say this? I think you start to? I've noticed that I've done that a little bit more, and sometimes I'll change that if it's somebody who I'm taking over service from, for example. But I think it the more you do it the more you start to see

274
00:47:13.930 --> 00:47:29.750
Alex Boucher, MD: the cracks in the. You know the the cracks in the veneer, and it becomes more normal and and easier to do so. I I think it somewhat depends on your context, but just trying to do it more helps you find more. Right? Once you start to unpack it, it's there's more there.

275
00:47:29.990 --> 00:47:36.425
Ana Núñez MD: So sometimes saying, humanization and context is important reading this note, is there anything cringe worthy?

276
00:47:37.230 --> 00:47:40.359
Alex Boucher, MD: Yeah, exactly like if if somebody says they're non-compliant, I say, well.

277
00:47:40.370 --> 00:47:52.479
Alex Boucher, MD: I don't. Do. We know that they're not compliant? If I say, if my patient is more, has to figure out whether they're gonna buy their purchase, their hydroxyr pills or their or figure out where they're gonna eat.

278
00:47:52.660 --> 00:48:08.360
Alex Boucher, MD: I'm not going to call them noncompliant, because I'd rather them eat. We'll figure out some other way around it. Those are the types of things. If I read, non-compliant as one of those key ones. If I read that, I'm going to say, are there other context pictures here that I'm going to interpret that differently?

279
00:48:10.321 --> 00:48:16.799
Ana Núñez MD: Miguel Field says, can you comment on just labeling with diagnosis 23 year old, epileptic, etc. I think.

280
00:48:17.117 --> 00:48:33.920
Alex Boucher, MD: Yeah, it makes me cringe. I, you know, diabetic is another one that oftentimes shows up. And and it's certainly a cultural thing that historically was done more often, even when I was in medical training. And and again it it goes back to that, and Sickler is is is

281
00:48:33.920 --> 00:48:48.689
Alex Boucher, MD: horrendous. And and there's been publications on on how problematic that is. But the idea that we're distilling them. Somebody down into their disease is where the problem lies is is we're not. We've some. We've no longer

282
00:48:48.970 --> 00:48:53.990
Alex Boucher, MD: humanize them. And so I think that's where it comes. That's where the problems come in.

283
00:48:54.910 --> 00:49:06.590
Ana Núñez MD: One of the attendees say, very powerful presentation. Thank you. What kind of communications training are offered to medical students and residents regarding documentation? It seems training will be critical.

284
00:49:07.900 --> 00:49:17.710
Alex Boucher, MD: That's a good question. I don't know that I know that for the medical school there's been a shift in the curriculum, and about a year into it

285
00:49:17.830 --> 00:49:37.329
Alex Boucher, MD: has involved more about social determinants and health equity into it. I don't know. Actually, I wasn't part of those committees, so I don't know how they were built, but I do know that at least in a narrow scope. When I do our sickle cell teaching, you know, I've recorded a lecture, but when we have our session

286
00:49:37.730 --> 00:49:51.929
Alex Boucher, MD: it's not anything. It's not me talking. I invite patients in. I invite different patients each time, because I want to hear different perspectives for myself, and and I might have a quick grimmer on, on! How systemic racism affects it. And then I sit down, and I

287
00:49:52.590 --> 00:50:13.130
Alex Boucher, MD: I move away from it so that they can hear patients in their own perspectives. And I think so in some ways it's a little oblique to your question, but the more we can hear from our patients ourselves, and hear their perspectives again. This was my me a couple of moment of hearing it from my own patients, saying, I don't have a way to document my side of the story.

288
00:50:13.240 --> 00:50:19.640
Alex Boucher, MD: and you're only hearing it from one side, was both very courageous for my patient to say.

289
00:50:19.650 --> 00:50:32.230

Alex Boucher, MD: and I still, you know, I still care for 3 years later, and we still talk about it. And for her I think she'd sort of forgotten about it. But for me it was really impactful. And I say, this is how we try to teach it. We try to teach about our documentation based on

290
00:50:32.300 --> 00:50:37.750
Alex Boucher, MD: this moment. For me. So for you it might be different. But the more we can think about it, I think

291
00:50:38.071 --> 00:50:43.369
Alex Boucher, MD: and I. I have some trainees who have been in that situation, that they've gotten pushback

292
00:50:43.440 --> 00:50:48.069
Alex Boucher, MD: as medical students, and so that's the hierarchy. But I'm glad that they're thinking about it.

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00:50:49.683 --> 00:50:56.229
Ana Núñez MD: Kitty losses. I'm curious if you have thoughts about conducting a similar study with Bmi and waste statuses.

294
00:50:56.430 --> 00:51:05.290
Ana Núñez MD: Potential predictor of the introduction of implicit bias into clinical care. Assumption people living in larger bodies are less compliant. Another important thing to consider.

295
00:51:06.310 --> 00:51:22.839
Alex Boucher, MD: Yeah, I won't say I've thought about as doing a study, but as somebody who's struggled with weight my whole life, I recognize that that's a big issue, I will say, sort of thinking about this. I have a Beluth student and myself who are studying

296
00:51:22.840 --> 00:51:41.229
Alex Boucher, MD: how parents are described in terms of whether or not noncompliant or something else, and how it affects their cps or child protective services, engagement or other outcomes. And so we are trying to look at more of these outcomes, and I think your question, Katie, is a great one, is.

297
00:51:41.240 --> 00:51:56.739
Alex Boucher, MD: where are these other ones? In the same way? The other has been a move to get rid of the Gfr. For if African American, this idea that these ingrained statuses or or obese right, if you do a BMI number. It may be less.

298
00:51:56.750 --> 00:52:21.480

Alex Boucher, MD: Some people are going to read in that, but it's probably going to be skimmed over by a lot of people. But if you say obese in your general description, that is going to flag somebody differently. And you're right. I think that's going to flag them as well. This person's non-compliant with XYZ. Or this person can't handle their weight. How are they going to handle this other thing? And so maybe it's getting back to the numbers and letting people interpret it as they are.

299
00:52:21.720 --> 00:52:24.149
Alex Boucher, MD: because those categorizations are are

300
00:52:26.130 --> 00:52:33.049
Alex Boucher, MD: the the yeah. The times have changed. The the terms carry more stigma than they theoretically used to.

301
00:52:34.060 --> 00:52:54.470
Ana Núñez MD: Hopefully. I didn't mess up your name too much. How people think will reflect will be reflected in the documentation you need to the as people think it starts at medical school, we have to ask, why? Why is the patient noncompliant, which you know you sort of said in terms of just not the label, but sort of the. And then why.

302
00:52:54.470 --> 00:53:13.629
Ana Núñez MD: Cliff Weddig says, thank you for sharing your work, Doctor Bashar. Very interesting. Did your models adjust for which sites these notes were collected from. I'm curious about whether clinical sites that serve a larger portion of black African American patients write notes differently than those predominantly serving non-hispanic white patients. Thank you.

303
00:53:13.830 --> 00:53:21.627
Alex Boucher, MD: Yeah, so it's a great question, Cliff. We we actually did do it. We didn't present it here, cause it was a little bit all over the place, but we actually did categorize them as

304
00:53:21.860 --> 00:53:49.480
Alex Boucher, MD: campus or the urban environments versus ridges in Southdale. In in one of our analyses, and we found that it wasn't also just the idea that there's a little bit more complexity. And on average, if you're looking at the the on-campus sites, you might have higher volumes potentially at the the suburban sites. But more likely say, cardiac, you know, heart failure, something else in South Dale's cardiac. And we're gonna have those

305
00:53:49.550 --> 00:54:04.299
Alex Boucher, MD: patients who need 5 or 6 specialists more likely on campus we did see some trends. There wasn't anything. It wasn't as powerful as the negative and positive that we saw as a whole, but we did see we actually saw that

306

00:54:04.590 --> 00:54:09.799
Alex Boucher, MD: some of the interestingly, some of the ones that were on campus were more likely to categor

307
00:54:09.810 --> 00:54:13.379
Alex Boucher, MD: to, or, I should say, the ones that were in suburbia.

308
00:54:14.020 --> 00:54:27.096
Alex Boucher, MD: That shift of racial differentiation was a little bit more stark when it came to compliance and not compliant. And maybe that gets to again what is the other context? And people who are used to managing

309
00:54:27.822 --> 00:54:37.830
Alex Boucher, MD: physicians or or social workers who are used to to managing more complexity on campus are more attuned to it. I don't know it's all it'll be a hypothesis generating

310
00:54:38.275 --> 00:54:41.860
Alex Boucher, MD: but yeah, we did see a few differences between those category, those groupings.

311
00:54:42.300 --> 00:54:44.819
Ana Núñez MD: To Morse this fantastic presentation

312
00:54:44.880 --> 00:54:54.620
Ana Núñez MD: will we need to formally shift expectations of supervisors to achieve an appreciable difference in how much focus we spend on teaching our learners to evaluate their own language.

313
00:54:56.300 --> 00:55:01.030
Alex Boucher, MD: I I think we do. I think we are. You know the learners

314
00:55:01.240 --> 00:55:28.970
Alex Boucher, MD: learn by observation as much as anything else, the intangibles and the unsaid interactions. This you know whether it's sitting down in front of a in a patient room instead of standing up, and as somebody who's who's tall, I recognize that that happens that I need to do that, or it's true in terms of how we talk about. You know, if I talk to about a resident, say a female resident. I'm very

315
00:55:29.070 --> 00:55:31.109
Alex Boucher, MD: aware to say this is

316

00:55:31.280 --> 00:55:40.500
Alex Boucher, MD: doctor so and so, and not just say this is a nurse, even if we're talking about that, and even if I enter, I oftentimes will say I'm Alex, you know

317
00:55:40.780 --> 00:55:42.390
Alex Boucher, MD: I I wanna make sure that

318
00:55:42.760 --> 00:55:49.620
Alex Boucher, MD: the way I'm talking about this. So it's a little bit past. Different. Documentation is respecting

319
00:55:50.100 --> 00:56:14.239
Alex Boucher, MD: my colleagues. In the same way, I'm trying to respect patients, and it's so, and our trainees are should, are picking up on those things, whether or not they always appreciate it. So the more we can be vigilant about that. And and if we're co-signing a note, the more we can talk about why, something might have been changed rather than just moving on to the next note, and and forgetting to bring it up, the more we can kind of chip away at at that next level, because, as we saw in the

320
00:56:14.340 --> 00:56:21.859
Alex Boucher, MD: study of the documentation, those younger trainees are, are more malleable and and less likely to to be cynical.

321
00:56:22.170 --> 00:56:28.539
Ana Núñez MD: Sometimes people confuse few. We're all familiar, so we'll be a 1st name when it's actually decredentialing in terms.

322
00:56:28.540 --> 00:56:29.080
Alex Boucher, MD: Yeah.

323
00:56:29.080 --> 00:56:40.659
Ana Núñez MD: Diminishing folks so trying to fit that balance. One of our attendees says, What are your thoughts on requiring continuing education around trauma-informed care for doctors on a regular basis.

324
00:56:41.680 --> 00:56:48.470
Alex Boucher, MD: I. It's always more work. But I think it's really helpful. And and I think it, it's

325
00:56:48.730 --> 00:57:14.849
Alex Boucher, MD: I'm a big advocate within my training programs. And I'm the program director for the pediatric hemog division and an associate program director for training adult hemog. And we're trying to build out our infrastructure for education around what I would call

those peripheries, or the penumbra of education which those social determinants of health, those trauma-based information for those of you who are Med students. You'll probably have gotten a survey from me that says.

326
00:57:14.850 --> 00:57:35.170
Alex Boucher, MD: Do you know about social determinants of health, or what's your curriculum been? And then, if I ask you the details, what we've noticed in a couple of years is, people all say they've heard about it. But when I ask them what is structural competency, or what is trauma-informed care? A lot fewer people are comfortable addressing it, and so we do certainly have room to make this more regular, and it shouldn't just be for the trainees.

327
00:57:35.950 --> 00:57:53.499
Ana Núñez MD: And then Mary Ann Evelyn said, Thank you for presenting your research. I've noticed that many times these biases can be rooted in either not believing patients at pain or not finding appropriate, appropriate to order opioids as trainees, residents. How can we advocate for our patients who are experiencing pain.

328
00:57:54.420 --> 00:58:20.660
Alex Boucher, MD: It's always hard with the hierarchies that are built in. I think, if you're concerned about it, and I know you, Marianne, as a new intern. Bring it up to the Senior Resident. If you're uncomfortable, bringing up to the faculty which I recognize that that sometimes happens, bring it up to your senior resident and say, is there a way that we can address this, or you know, and

329
00:58:20.670 --> 00:58:47.489
Alex Boucher, MD: or as you're gaining comfort, and you're rounding, and you're having that discussion on pain management. Say, just say I would like to do this rather than saying, I don't think we're doing this well again. It's sort of that nudge theory rather than saying, I don't think we're doing this well, because that's not going to go over. Well, say, I think we could add this medicine in, or I'm worried that I'm worried that we're not managing this as well as we can.

330
00:58:48.150 --> 00:59:02.477
Alex Boucher, MD: I would suggest that we explore this pathway, or we talk to pain team or with something else. If we're thinking about that. And that way you're offering up rather than just confronting somebody with a negative. You're offering up an alternative, and it's generally going to be taken,

331
00:59:03.590 --> 00:59:17.859
Alex Boucher, MD: you know, at least addressed a little bit more objectively, I would think, by the the hierarchy than saying, we're not doing this well, because I've tried that it doesn't go. Well, I've tried that. When I was a resident it it rocks the boat in a way that

332
00:59:18.170 --> 00:59:19.580
Alex Boucher, MD: I could have done it better.

333
00:59:20.000 --> 00:59:43.939
Ana Núñez MD: I wonder if the skepticism of having quotes and stuff the Emr should actually prevent you from doing that? And then have you say, are you sure to sort of just stop you of like, what are you actually saying in the quotes as far as skepticism? Well, Doctor Bouchard, we could talk to you all day. This was wonderful, but everybody has to get on getting on. But thank you so much. This was fabulous. Everybody. Thank you so much for joining us, and I'll turn it over to Matt.

334
00:59:44.530 --> 01:00:09.389
Matt Amundson (he/him/his): Yeah, thank you so much. And thanks so much to have to push. We appreciate everyone for everyone for being here today. By one question. Survey will appear in your web browser immediately after ending the Zoom session. We'd appreciate if you take the time to complete the survey to inform us of future presentation topics, and a reminder that this session was recorded, and will be shared within 2 days. All those who registered for the event and otherwise recorded, can be found under the Education Training tab of the event.

335
01:00:09.390 --> 01:00:28.160
Matt Amundson (he/him/his): Odei website, and then please save the date. Our next Dean's lecture series session will be on Wednesday, August 14, th with Doctor Jennifer Connor, who is an Associate Professor Director of Clinical Services for the Eli Coleman Institute of Sexual and gender health, and for the Medical schools, department of family, medicine and community health. So we look forward to seeing you. Then take good care.

336
01:00:29.220 --> 01:00:30.249
Alex Boucher, MD: Thank you. Everyone.

337
01:00:30.390 --> 01:00:31.860
Ana Núñez MD: Thanks! Again! Take care!

338
01:00:32.100 --> 01:00:33.020
Matt Amundson (he/him/his): Thank you.