Hidden Curriculum: Implicit Bias and Ageism in Medical Education

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Disclosures

• I am a clinician-educator in the field of geriatric psychiatry
• No other conflicts of interest to disclose

Objectives

• Define the hidden curriculum
• Describe implicit bias and ageism
• Identify examples of ageism in clinical settings
• Discuss strategies to reduce ageism bias in clinical education

Hidden Curriculum and Bias: What’s in a Name?

• SOCIALIZATION PROCESS (grounded in social learning theories)
• Defined in context of medical education by Hafferty and Franks as the transmission of attitudes, implicit beliefs, norms, and values
• Overall concepts not included in the OVERT/explicit educational format
• Learning experiences, positive and negative, that are not part of the explicit (spoken, formal) curriculum, but that result in changes in attitudes, beliefs and values of learners.
• "Unintended curriculum"
• Educators must be aware of the hidden curriculum that may be communicated or modeled in interactions.

Curricula in Medical Education


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<th>Types of Curriculum</th>
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<td>Classification</td>
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<tr>
<td>Formal</td>
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<td>Assisted</td>
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Hidden Curriculum and **Bias**

*What’s in a Name?*

- **Bias** – noun
  - A particular tendency trend, inclination, feeling, or opinion, especially one that is preconceived or unreasoned

- Explicit/direct bias: Aware of evaluation, believes it to be correct, has the time/motivation to act on it in the current situation

- Implicit/unconscious bias: unintentional, may even be unconscious. Can be activated quickly and unknowingly but still exerts an influence on perception, memory, behavior

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**Ageism**

- Prejudice by one age group against another.
- Coined in 1969 by Robert Butler, MD (1927-2010):
  - “Ageism describes the subjective experience implied in the popular notion of the generation gap.”
  - Can be positive, but mostly applied to negative, stereotyped opinions and beliefs about older people.

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**Ageism: Explicit Bias**

- Older patients are too complicated/ beyond help
- Older patients (their conditions) are not exciting, fun, interesting/ futile
- Old people don’t think about sex/intimacy
- Frailty is a natural occurrence in older people
- Debility is inevitable in older people
- Exposure to older adults interspersed in general clinical rotations is sufficient for expertise

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**Ageism: Implicit Bias**

- Using non-standard questions when screening for cognition (serial 3s instead of serial 7s)
- Bias: Cognitive decline is inevitable with aging
- Avoiding sexual history taking
- Bias: Older adults are asexual
- Not considering psychotherapy as an option when treating an older adult
- Bias: He/she is too old to for it

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**Implicit Ageism Bias in Healthcare**

- We are not immune

- Repeated reinforcement of social stereotypes occur in clinical settings:
  - Reliance on stereotypes for efficient decision-making
  - Group level information (e.g. population risk factors) may reinforce stereotypes

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**Impact**

- **Professionalism**
  - Burnout/cynicism

- **Empathy Erosion**
  - Vicarious
  - Imaginative

- **Healthcare disparities**
  - (differences in access to care AND treatment)

- **Institutional-organizational**
- **Interpersonal-social**
- **Day-to-day interaction with peers, residents, faculty, staff**
- **Contextual-cultural**
  - Occurs in the "broader cultural milieu of medical education"
- **Motivational-psychological**:
  - Unintended teaching through informal dialogue, transmission of implicit beliefs
Measuring Implicit Bias in Medical Education

- Implicit Association Test (IAT)
  - Tests strength of association between concepts (e.g., aging, obesity, race, gender)
  - Computerized assessment of latencies in response to categorization tasks
  - Initially developed for social bias research
  - Other tests are mostly quantitative (testing knowledge/attitudes)

Promoting Ageism in Medical Education

- Varying exposure to geriatrics/geriatric mental health training in UME curriculum
  - Few offer a standalone rotation experience
  - Geriatric mental health exposure is even more limited
  - Content expert availability
  - Despite 2012 Institute of Medicine Report
    - Urgent need for development of national competencies and curricula in geriatric mental health for all clinicians

Geriatrics Exposure in UME

- Geriatric Medicine:
  - Bragg et al., 2012:
    - American Geriatrics Society/ ADGAP Geriatrics Workforce Policy Study Center Surveys of U.S. Medical School academic programs
    - 2005 and 2010 surveys
  - Results:
    - 27% of US UME schools required geriatrics clerkship (M3)
    - 89% (n=88) offered elective geriatric experience (mostly M4)
    - In 2005, 4.5% of respondents to the AAMC graduation questionnaire believed time devoted to geriatrics was inadequate
    - AAMC minimum geriatrics competencies for graduating medical students requires ~15 dedicated lecture hours, 4 week block rotation (AGS estimate)
    - In contrast, all US medical schools require ~7.2 weeks of core clerkship training in pediatrics

Geriatric Psychiatry in UME

- Lehmann et al., 2015:
  - Survey of psychiatry clerkship directors at 110 US medical schools (56% response rate)
  - 21% of respondents lacked geriatric psychiatry incorporation into the teaching curriculum
  - No correlation between clerkship length and clinical or didactic exposure to geriatrics

Reducing Impact of Implicit Bias on Healthcare Disparities

- Conceptualize bias as “habit of mind”
  - Facilitates intentional behavior change
  1. Promote awareness:
    - “Individuals need to become aware of their habitual engagement in undesirable behavior and be provided with strategies to increase self-efficacy to engage in new behavior”
  2. Individuating
    - Conscious effort to focus on specific information about an individual vs. social category information (age, race, gender etc.)
  3. Perspective-taking
    - Conscious attempt to envision another person’s viewpoint

How to Address?

- S: Seek- Seek out and understand all aspects of the curriculum- formal and hidden
- O: Observe- Observe what people are doing and not doing
- L: Listen- Listen to what people are saying and not saying
- V: Vocalize- Vocalize.. Ask questions, check for understanding (reflection)
- E: Educate- teach and LEARN.
What Helps?

- Promote diverse interaction through formal/informal clinical experiences:
  - Promoting interaction with “outgroup members” to promote bias reduction through exposure to counter-stereotypical examples to revise the automatic associations held.
  - Negative stereotypes about older adults that are communicated at young age become deeply ingrained and persistent. With more life experience, counter-stereotypical information violates/disrupt these initial thoughts.
  - Counter-stereotypical information originating from interactions with older family members and friends may contradict societal messages about “typical” aging.
  - “This information might also originate within us. As people experience the aging process, they reflect on their place in society and their everyday behavior, and they revise their beliefs about themselves.”

References

- Liaison Committee on Medical Education Accreditation standards. Available at: http://www.acme.org/publications/standards.
- AAMC. CG Medical School Graduation Questionnaire, All Schools Summary Report [on-line]. Available at: https://www.aamc.org/data-reports/curriculum-reports/interactive-

Competencies for UME

- Proposed by AAGP Teaching and Training Committee workgroup in response to 2012 IOM report “The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?”
- 1. Normal aging
  - Physiologic changes in memory
  - Resilience with aging
- 2. Mental health assessment
  - Functional assessment (not just dys-function assessment)
- 3. Psychopharmacology
- 4. Depression
- 5. Dementia
- 6. Delirium

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