Recognizing and Managing Bias

IN THE INPATIENT HEALTH CARE SETTING

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INTRODUCTION

An individual's beliefs influence their behavior and decision-making. Often, these beliefs are unconscious or implicit, existing outside of our conscious awareness. What many fail to realize is that our unconscious or implicit biases are difficult to control and are automatically activated, leading to bias formation that impacts our behavior and decision-making without us even being aware of their influence.[1] More specifically, implicit bias can be defined as having "varying degrees of stereotyping, prejudice and/or discrimination below conscious awareness in a manner that benefits oneself or one's group; it involves limited or distorted perceptions of others. It is everywhere and affects everyone."[2] Studies continue to demonstrate that implicit bias is a factor contributing to health inequities and poorer-quality health care and outcomes.[3]

The human brain plays a role in bias formation as it continually processes and organizes the vast amount of information we encounter every day and creates an outline of connections helping us process the information more efficiently.

Unconsciously, and sometimes consciously, we place others into categories based on gender, age, race and ethnicity, which may then result in having inaccurate perceptions about the people we categorize, leading to bias and the potential for making clinical and organizational decisions influenced by those biases.[4]

Categories of implicit biases that commonly occur in health care, either individually or in any combination, include the following[5]:

- **Affinity bias –** Preference for people who share qualities with you or with someone you like (e.g., someone who looks like you)
- **Ageism –** Discrimination and prejudice against people based on their age
- **Anchoring –** Tendency to rely too heavily on the first piece of information offered when you are making decisions (e.g., considering the appearance of the individual as the most critical element when listening to a patient's chief complaint)
- **Attribution bias –** Tendency to attribute other people's successes to luck or help from others and attribute their failures to lack of skill or personal shortcomings; or attributing clinical data to incorrect assumptions (e.g., attributing shortness of breath to body mass index [BMI] and not to other evidence present in clinical data)
- **Beauty bias –** Assumptions about people's skills or personality based on their physical appearance and tendency to favor people who are more attractive
- **Cisnormativity –** The assumption that all individuals are cisgender (a person whose gender identity corresponds with the sex the person had or was identified as having at birth) and that anything else is abnormal
- **Colorism –** Prejudice/preference on the basis of skin shade or tone, which also can happen between and within racial and ethnic minority groups
- **Confirmation bias –** Selective focus on information that supports your initial opinion(s) (e.g., all patients with multiple body tattoos are drug seekers)
- **Conformity bias –** Tendency to allow the views of other people to easily sway you from your own opinion, which differs perhaps from others' opinions

- **Contrast bias –** Assessment of two or more similar things by comparing them with one another rather than looking at their individual merits (e.g., minimizing a patient's complaint of pain when it does not correlate to their physical presentation)
- **Halo bias –** Focus on particularly positive features about a person that clouds clinical or professional judgment (e.g., focusing on a person's prominence in the community and ignoring their potential of being a victim of domestic violence/intimate partner violence)
- **Heteronormativity –** The assumption that all individuals are heterosexual (and that anything else is abnormal)
- **Horn effect –** Focus on a negative feature of a person that clouds professional judgment (e.g., focus on the socioeconomic status versus the physical complaints of a patient)

Whether we are health care professionals, patients, family members, or visitors, we all have implicit biases and unconscious beliefs, and the extent to which these biases and beliefs manifest themselves, including their impact on others, depends on the roles we play. Specifically, implicit biases and unconscious beliefs in health care occur within many types of patient-provider interactions (e.g., obtaining medical history, conducting a physical examination, ordering diagnostic tests), treatment decisions (e.g., diagnostic interpretation, treatment recommendations, referral decisions), treatment adherence, patient satisfaction and overall patient health outcomes.

Negative implicit biases — unconscious beliefs regarding religion, race, gender, gender identity, ethnicity, sexual orientation, physical limitations, age, mental health, and other characteristics — can contribute to disparities in health and health care delivery. These disparities can manifest as adverse patient outcomes, resulting in personal and financial losses, patient/family dissatisfaction, patient harm and/or professional liability. In particular, patient/family dissatisfaction is an important consideration for risk professionals and health care providers; the data show that patients who are satisfied with their care are more likely to adhere to treatment and follow-up with their clinician, have better health outcomes overall, and are less likely to engage in litigation against a provider or health care organization. Minimizing the impact of implicit bias increases the opportunity for greater patient satisfaction and less organizational risk, not to mention better patient outcomes. Health care organizations, and specifically health care risk professionals, play a unique and vital role in reducing the impact that negative implicit biases have on patient safety and preventing adverse patient outcomes. Specifically, risk professionals are well-positioned to contribute through education and implementation of proactive identification, assessment, mitigation and monitoring of the implicit biases present in the various health care delivery systems and processes encountered by patients.

This is Part II of a three-part white paper series. The series is designed to assist health care organizations and health care risk professionals with exploring the definition and impact of unconscious and implicit biases on health care delivery and patient safety, including but not limited to biases related to religion, race, gender/gender identity, ethnicity, sexual orientation, physical limitations, age and mental health, and their impact on the pediatric/adolescent, adult and geriatric populations across various care settings, including ambulatory, inpatient and telehealth/digital service lines.

This white paper series serves as a primer for risk professionals and others to identify and begin to address implicit biases. Further, it provides health care organizations and health care risk professionals with appropriate intervention strategies and resources applicable to both current and forward-thinking strategic care models.

As in Part I of this white paper series, "Recognizing and Managing Bias in the Ambulatory Health Care Setting," subject-matter experts offer their personal and professional experiences in areas such as ageism, religion, race, mental health, and lesbian, gay, bisexual, transgender, queer, intersex, asexual/aromantic and more (LGBTQIA+) identities, and they utilize scenarios to illustrate the presence of implicit bias and the role it plays in health care delivery and patient safety. Some of these scenarios may be shocking or upsetting, and you may feel strong emotional reactions. For risk professionals, these issues are present and pervasive. The intention of this white paper series is to promote awareness, address the need for authentic conversations and insights, and ideally encourage sustainable changes regarding implicit bias within health care organizations.

When reviewing this white paper series, keep in mind that each organization is unique and varies in how services are offered, creating differences in potential liability exposures. Therefore, it is best to seek risk management expertise or legal advice specific to your organization when developing and implementing the measures discussed as part of this white paper series.

Finally, the scenarios in this series reflect the language used by those sharing their stories. The terms used may be inconsistent with personal preference or other guidelines. In order to respect the shared and lived experience of the subject-matter experts the terminology has not been changed. For resources on current terminology and best practices, please see Appendix B.

PEDIATRIC/ADOLESCENT

Pediatric Patient in the Post-Anesthesia Care Unit

SCENARIO

Luis is a **10-year-old Hispanic male** receiving treatment for a high-grade, rare malignant soft tissue tumor with a generally poor prognosis. Luis's parents are divorced, and he lives with his mother and older brother. His mother speaks limited English and is very distraught and inconsolable when speaking of Luis's diagnosis and prognosis. She tearfully and continually speaks about her sister's death due to "stomach cancer."

The most effective treatment for Luis's type of malignancy is surgical resection.

The surgical resection was completed as planned. When Luis awoke in the recovery room he was crying and complaining of pain. A nurse administered pain medication, but Luis continued to cry out in pain, and attempted to get out of bed. Luis's mother also began to cry and scream for help whenever she heard him moan. Luis's vital signs were stable, and his dressing was free of unusual amounts of bloody drainage. The Post-Anesthesia Care Unit (PACU) nurse attributed Luis's complaints of pain to his "Hispanic heritage" in the documentation and made note of Luis's mom's "highly emotional state" in the medical record. During the next shift, Luis continued to cry in pain. His nurse contacted the surgeon and relayed the information and asked if there could be an increase in the prescribed pain medication. The surgeon explained that while there was room to increase the pain medication dosage safely, he was not inclined to do so with Luis at this point, without providing the rationale for his clinical decision making. During rounds the next morning, the attending, after reading the progress notes and listening to Luis cry, adjusted his pain medication plan.

Luis's mother frequently expressed concern about whether enough was being done to "get Luis better." For the most part, Luis's recovery was unremarkable for the remainder of his stay.

How were the explicit or implicit biases manifested in the interaction?

Ethnic/racial minority children experience the same biased treatment as minority adults. As such, in the scenario described above, two potential implicit and explicit biases were present in Luis's interactions with the health care delivery system:

- **Confirmation bias –** Luis did not receive adequate pain management based on failure to objectively assess his level of pain and mistaken assumptions regarding the use of pain medications in minority children, or the provider's own biases regarding the perception of other's pain
- **Horn effect –** clinical documentation was not always objective or descriptive and reflected the providers' implicit biases

How did the biases affect the course of hospitalization and the patient outcome?

Pain Management

It appears from Luis's scenario that his pain management was inadequate and that there was a reluctance by some of his providers to address his pain with measures such as increasing medication dosage, due to perhaps erroneous beliefs regarding pain tolerance of racial and ethnic minority patients.

Research shows that racial and ethnic minority patients often experience inadequate pain management due to medical judgments based on false beliefs among health care professionals regarding biological differences between racial or ethnic minority patients and non-Hispanic White patients. Ongoing research reveals this occurs with pain management in pediatric patients as well. For example, a 2015 study published in *JAMA Pediatrics* found that Black children with appendicitis were 20% less likely than White children to receive painkillers in the emergency department (ED).[6] Further, a 2016 study by the University of Virginia ascribed the contrasting treatment to erroneous beliefs about biological differences among these two races.[7] There are several theories as to why this occurs: (1) medical providers, although they recognize the patient's pain, don't treat it due to concerns about noncompliance or access to health care; or (2) medical providers may not recognize the patient's pain due to the provider's own biases in perception of other's pain, assuming, for example, that racial and ethnic minority patients feel less pain than White patients, or that Black people have thicker skin than do White people, or that Black people's blood coagulates more quickly than White people's blood.[8] In addition to being aware of their own implicit biases and how they affect treatment decisions made, health care providers need to develop cultural awareness and an understanding of how other factors contribute to disparity in pain management among races and ethnicities. For example, racial and ethnic minority patients may underreport pain because they are intimidated by the health care setting, or their culture may pressure them to appear stoic. Or they may have a disease process that stigmatizes them, such as sickle cell disease.

Documentation

Social science research shows that an individual's attitudes and biases can be reflected through the language they use. Here, Luis's medical record reflected that the PACU nurse attributed Luis's complaints of pain to his "Hispanic heritage" and made note of Luis's mom's "highly emotional state." The documentation was not objective or descriptive and likely ran the risk of conveying and reinforcing negative attitudes and stereotypes.

When the language used is negative (as opposed to objective and descriptive), it may potentially transmit bias and affect the quality of care that patients experience by influencing the decision-making of clinicians reading the record.[9] A recent study examined history and physical notes looking for documentation containing a negative descriptor and found that Black patients had 2.54 times the adjusted odds of having one or more negative descriptors in the electronic health record compared with White patients. Examples of commonly used negative language include using the words, "refused," "(not) compliant," "difficult" and "agitated."[10]

Research has consistently demonstrated that use of negative language also affects the patient's perception of that care due to its contribution to patients having difficult interactions with their health care providers.[11] Patients who have difficult interactions with a clinician may perceive that they are not receiving high-quality, patient-centered care, and may be at risk of distrusting or disengaging from care.[12] Moreover, these patients may be prone to instituting litigation or regulatory proceedings on the belief that the care delivered was negligent.

Examples of negative language include descriptions that[13]:

- Question patient credibility
- Express disapproval of the patient
- Stereotype according to race or social class
- Portray the patient as difficult or challenging
- Convey a paternalistic tone

Conversely, positive language includes descriptions that[14]:

- Express approval of the patient
- Disclose the provider's positive emotions related to the patient
- Minimize blame/convey understanding
- Incorporate details about the patient as an individual
- Reference the patient's expressed preferences into the treatment plan

What are some suggestions to improve the interactions and eliminate demonstrated biases?

As has been discussed previously, awareness and acknowledgment that such biases exist is a first step to undercutting unconscious bias in medical judgments. Risk professionals can work to develop and support education and training to decrease the impact of implicit biases in their organization's health care delivery system. Training and education to address the issues Luis experienced may include developing health care provider skills related to[15]:

- **Stereotype replacement –** Involves training health care providers to recognize that their response toward a patient may be based on stereotypes and implicit biases, and not reality. Subsequently, the individual learns to label their response as such and think about why they may be experiencing the response, in order to replace their unconscious assumptions with those more based on the specific circumstances involved in the situation.
- **Counterstereotype imaging –** Involves thinking about/imagining examples of people who do not conform to stereotypes, and can be a powerful tool in combating racial/ethnic stereotypes.
- **Individuation –** Involves learning to see people as individuals with unique traits and characteristics, as opposed to viewing them according to a group membership.
- **Perspective taking –** Involves imagining ourselves to be a member of a stereotyped group. The resulting effect is to develop a psychological closeness and reduce the impact of automatic responses based on stereotypes and implicit biases.

Documentation Considerations

The risk professional can conduct unit or departmental-based reviews of clinical documentation to identify negative patient descriptors and address the findings with staff through patient stories and best practices. Additionally, the risk professional can promote incorporating quality improvement methods (e.g., clinical audits, process mapping, communication tools, and decision trees) to regularly focus on clinical decision points that are particularly vulnerable to implicit bias. Consider implementing a case review format, similar to a Morbidity and Mortality Conference, to discuss in a peer review or a quality forum those patient cases where implicit bias may have impacted patient care. Risk management resources can be utilized to provide the data and documentation education for clinical providers to raise awareness of the importance of using objective and descriptive language to document a patient's condition and care delivered.

Using objective, descriptive and culturally/racially aware language can help remove negative and stereotypical labels and improve patient-provider encounters.[16] Finally, health care institutions, medical schools, and accrediting organizations can work to incorporate implicit bias training into education and certification and also work to adopt goals and implement policies that diversify the health care workforce.[17]

Patient Selection for Treatment

Implicit bias may be embedded in many areas of health care systems and processes. In addition to provider-specific bias, implicit biases can impact patient selection for treatment and even admissions to health care facilities.

For example, the Centers for Medicare & Medicaid Services (CMS) recently examined three CMS Innovation Center models: the Kidney Care Choices Model, the Comprehensive Care for Joint Replacement Model, and the Million Hearts® Cardiovascular Risk Reduction Model. The evaluation found that use of certain risk assessment and screening tools, provider tools, and payment design and risk adjustment algorithms has led to the exclusion of some beneficiaries from these models.

The health care risk professional plays a pivotal role in addressing the ever-evolving discoveries of implicit biases embedded in data and assessment tools such as those mentioned previously. By bringing awareness of these issues when designing policies and by determining what quality data to examine, the risk professional can help minimize the unintended consequences of using "race-adjusted" tools and data.

Adolescent in the Emergency Department

SCENARIO

Early one morning in the emergency department (ED), a **58-year-old Black female** brings her **17-year-old grandson** to be seen for acute abdominal pain. Her grandson is well known to the ED as a "sickler" who frequently asks for pain medication "every" visit. The patient is assigned to Dr. Kelly, who recognizes the patient and comments: "He usually comes in alone during the day. I know what he wants." Dr. Kelly is working an extra shift due to overcrowding and reduced workforce. Dr. Kelly is tired, feels impatient and recalls that during his last visit the patient was rude, uncooperative and verbally threatening. After the last visit, Dr. Kelly recommended that this patient be dismissed from the system so that no other provider would have to experience the same disrespect.

In his extreme discomfort, the patient does not recognize Dr. Kelly and says very little. Dr. Kelly decides not to do a work-up, orders a nonsteroidal anti-inflammatory drug and discharges the patient. The patient's grandmother notes that Dr. Kelly was sarcastic, dismissive and judgmental. Dr. Kelly feels the grandmother is not objective because she is not aware of the patient's "frequent flyer" status in the ED.

Twelve hours later, the patient is brought back to the ED by his grandmother, his abdominal pain having escalated. After an abdominal work-up it is noted that the patient has cholecystitis requiring emergent surgery. The patient's grandmother calls patient relations and risk management to complain about the lack of care her grandson experienced with Dr. Kelly.

What explicit or implicit biases were present in this interaction?

- **Attribution bias –** Dr. Kelly determined the patient's ED visit was inappropriate without consideration of broader contextual factors. This is an example of attribution bias, the tendency for people to overemphasize individual and personality-based explanations for behaviors while underemphasizing situational explanations.[18]
- **Confirmation bias –** In 2011, Kahneman described "yin-yang out," which illustrates cognitive shortcuts as part of an innate mode of cognitive processing in the ED that leads to the belief that everything that can be done has been done. In the case of acute or chronic conditions, a patient may be discharged with subsequent missed diagnosis or misdiagnosis.[19] Patients with a history of high ED utilization may have their medical concerns minimized, making them susceptible to limited clinical assessment and the potential to miss acute pathology.[20]
- **Horn effect –** Dr. Kelly made a snap judgment based on one negative interaction with (or trait of) the patient. This bias made Dr. Kelly feel angry and disrespected just to see the patient again.[21]

Implicit biases during ED evaluation can negatively impact not only the evaluation in the ED but also the entire hospitalization. Heavy workloads and time constraints mean that unconscious bias may play an even greater role in the rapid decision-making and disposition planning by ED providers than in other areas of health care.[22]

How did the biases affect the course of hospitalization and the patient outcome?

If the patient had had the abdominal work-up during the first visit with Dr. Kelly, the cholecystitis might have been discovered hours earlier, the patient would have had urgent as opposed to emergent surgery, and Dr. Kelly might have received a compliment from the patient and family instead of the complaint of lack of caring and delayed diagnosis.

Overcrowding, an overwhelmed primary care system, the gaps ED providers face in knowledge of patients' medical histories, the lack of long-standing patient-provider relationships, and numerous distractions: all of these can translate into medical decisions based on stereotypes or gut feelings instead of best medical practice.[23]

In a study published in *Academic Emergency Medicine Education and Training* in September 2021, two dozen medical residents at three different emergency medicine residency programs were asked to describe times that their personal identity differed from patients' identities. The recurring themes were that respondents often felt more uncomfortable engaging with patients who were from backgrounds different from their own, who had difficulty communicating their needs in ways the residents were used to hearing them described, who had mental health issues, and who interacted with the health care system in ways that didn't match medical residents' own sense of ideal use. The study also found instances when providers seemed to blame patients for their problems, in part because they did not understand their patients' life circumstances.[24]

What are some suggestions to improve the interaction and eliminate demonstrated bias?

In 2018, a study of implicit bias awareness education in emergency medicine training provided the insight that resident participants were largely unaware of their implicit biases.[25] The interventions included taking the Implicit Association Test (IAT) on race from Project Implicit (see Appendix A) to introduce the concept of implicit bias. This was followed by open discussion to understand participants' perceptions on whether their implicit biases would lead to variations in care. After analyzing data from the discussion before and after the IAT, the researchers noted that participants' awareness of their individual biases increased by 33.3%.[26]

Awareness is a good first step. In 2019, the University of Minnesota Family Medicine Program developed a curriculum on implicit bias that produced lasting effects. The curriculum included the IAT, a safe forum for sharing concerns, implementation of new ways to address and manage bias, and institutional capacity building, recognizing that implicit bias training is iterative and requires continued vigilance. In a six-month follow-up after the original training, findings indicated lasting effects.[27]

Residents need role models; emergency medicine is one specialty where ethnic and racial minorities are underrepresented.[28]

Lastly, related to Dr. Kelly's suggestion that the patient be dismissed from the system, the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 states that any hospital that receives Medicare dollars must (1) screen all patients who come to the ED to determine whether a medical emergency exists, (2) stabilize patients who have emergent conditions, and (3) restrict transfer of nonstabilized patients to cases in which a physician certifies that the benefits of the transfer outweigh the risks or the patient (or surrogate) requests a transfer in writing after knowing the risks involved. Since EMTALA's inception, many controversial opinions regarding this act have surfaced, but it exists to protect the patient with a medical emergency.[29] Neither this patient nor any other can be denied emergent care.

ADULT

Patient on a Medical Unit

SCENARIO

In Canada, a **37-year-old Indigenous Native American mother** of seven was being seen in the hospital for breathing problems and stomach pain. The patient had a history of heart problems, but the medical staff assumed without evidence that she was suffering withdrawal from narcotics. In crisis, she started recording live on Facebook, screaming for help, and saying she was being overmedicated.

Near the end of the seven-minute video, hospital staff are recorded talking in her room. Two women are heard calling the patient "stupid," questioning her life choices, saying she's "only good for sex" and that she "would be better off dead." "And who do you think is paying for this?" one of them was heard saying.

The patient died soon after. According to her family, she had long suffered from heart issues and is believed to have had an adverse reaction to morphine.

According to a relative, the patient was often hospitalized because of her severe cardiomyopathy and had experienced similar discrimination in the prior month.

Another video, one that the patient's daughter captured the morning of her death, showed the patient barely breathing, very pale and probably in a coma. A resident gastroenterologist who, according to records, took her vital signs midmorning documented that the patient was "calm." The coroner noted that "there is a difference between calm and a coma."

The coroner found the cause of the patient's death to be pulmonary edema and went on to state that her death could have been prevented if she was monitored after she was given a powerful sedative that morning and, furthermore, that racism played a role in her treatment.[30]

What explicit or implicit biases were present in the interaction?

- **Microagressions –** statements, actions, or incidents regarded as instances of indirect, subtle, or unintentional discrimination against members of a marginalized group such as a racial or ethnic minority, evidenced by the nurses' remarks that the patient "is only good for sex" based on the number of children the patient has, negatively judges the patient's life choices and demeans her intrinsic value as a mother.
- **Explicit bias –** the nurses' overt expression of bias and demonstration of unprofessional care and treatment based on the patient's ethnicity as an Indigenous Native American.
- **Attribution bias –** the assumption that the patient was not worthy of the same standard of care because of the type of insurance paying for her care.

How did the biases affect the course of hospitalization and the patient outcome?

This example shows how explicit bias can affect a patient's care and treatment and how health care providers' biases can contribute to a patient's death:

- The patient's complaints of breathing problems and pain were ignored, with inadequate medical evaluation resulting in a missed or incorrect diagnosis.
- The patient was disparaged for her ethnicity and life circumstances with grossly inappropriate comments made to and about her.
- The resident failed to accurately assess the patient because of the assumption that she was addicted to opioids.

A commission created to study the way public services treat Indigenous Peoples in this Canadian province found, after a three-year study, that racism and prejudice against Indigenous Peoples by hospital staff "remain prevalent." One professor told the commission the situation is so dire many Indigenous People will avoid going to the hospital over fears of discrimination. For those who must go, they mentally prepare themselves first for the treatment they'll be subjected to.[31]

What are some suggestions to improve the interactions and eliminate demonstrated bias?

A chapter in the book *Necessary Conversations: Understanding Racism as a Barrier to Health Equity* notes that nearly 87% of schools in America do not teach about Native Americans after 1900. Furthermore,

> 95% of the images that turn up in a search of the term "Native American" on the Google images database have 19th-century origins. Native Americans are hidden by the media as well, representing less than 0.04% of television and film characters. When they do appear, characters are variously depicted as savage, mystical, alcoholic, or oversexualized and the storylines in which they are featured are again well over a century old.
>
> All of that contributes to stunning ignorance—78% of Americans say they know little to nothing about Native people. The reality that tribal nations have the political status of sovereign nations recognized within the Constitution of the United States is overlooked. The values of spirituality, commitment to family, connection to art and culture, and the sense of environmental responsibility that are at the heart of Native Americans life are unacknowledged. "We're really relegated to being like ancient civilizations," said Echo

> Hawk, who is often asked whether she lives in a teepee. "Generation after generation of American children are coming through our institutions and being conditioned to think we no longer exist."[32]

In addition to the recommendations provided with the previous scenarios, hospital policy should require immediate reporting of expression or demonstration of explicit bias. Any colleague who hears or observes such overt bias should be mandated to report it to the appropriate authority immediately.

This scenario illustrates that in times of stress, biases may emerge and limit the potential treatment options offered, either due to providers' evaluations or in response to the information/ communication received from other caregivers.[33]

Patient on an Oncology Unit

SCENARIO

A **56-year-old Asian American and Pacific Islander (AAPI) male** was being treated for cancer in the hospital and was questioned on the day of admission by his roommate, who asked in a threatening manner, "Where are you from?" The patient hesitated to respond to the roommate, who continued, "It's because of you and your people that we have 'the COVID' in the United States and why my family cannot come in to see me while I am sick in here. You better sleep with one eye open."

The AAPI patient immediately requested a room change but was told that due to the number of patients awaiting admission, it was not possible to change rooms.

The AAPI patient later spoke with his physician to ask if treatment could be provided at home or on an outpatient basis, but due to the type of chemotherapy he was receiving, he was told the treatment had to be given on an inpatient basis.

The AAPI patient called his family, his voice shaking, near tears, and shared his fears of his roommate. He was unable to eat and was afraid to sleep without a family member there. The family called the risk professional to plead for their father's safety and well-being.

How were the explicit or implicit biases manifested in the interaction?

- **Microaggression –** the roommate's question "Where are you from?" is too often asked of AAPI people whose families have been in this country for generations, revealing that the United States remains a society that still considers "white skin" the norm
- **Overt racism –** evidenced by the roommate blaming the patient for the coronavirus pandemic and threatening physical harm based on the AAPI patient's ethnicity

Racism against AAPI people persists, most recently in the alarming increase of hate crimes against Asian Americans and inappropriate references to COVID-19 as the "China virus" and "Kung Flu." By creating false perceptions and fomenting anger, these and similar comments have helped to fuel a rising tide of discrimination against AAPI people.[34]

How did the biases affect the course of hospitalization and the patient outcome?

- The AAPI patient's verbalized concerns were not heard.
- The AAPI patient contemplated disrupting his intended life-saving chemotherapy treatment due to the threats from his roommate.
- The AAPI patient was in a state of severe anxiety and fear throughout the time he and the threatening roommate shared the room, which affected his mental state and physical response.
- The AAPI patient and family questioned whether the staff understood the fear of the AAPI patient and/or shared the bias given their refusal to switch the AAPI patient's room.

What are some suggestions to improve the interactions and eliminate demonstrated bias?

For this patient, the risk professional needed to:

- Listen to the AAPI patient's concerns for their safety and not diminish their anxiety and fear.
- Facilitate changing the patient's room so that a newly admitted patient could be with the first roommate.
- Discuss with staff whether the inaction on the part of the staff to transfer the AAPI patient to a new room gave the impression and implied indication on the part of the patient and family of their condoning of the roommate's remarks.

It is important for the risk professional to understand the mental health risks posed by such incidents of bias: "For the AAPI communities in this country, COVID-19 has further ushered in a secondary epidemic of hate incidents. While national interest in anti-Asian hate crimes has been centered on a handful of highly publicized tragedies, 1 in 5 AAPIs have reported experiences with hate incidents, which included discrimination, harassment, and assault. These adverse experiences have led to suicidal ideation and depressive symptoms, as well as susceptibility to substance use disorder and traumatic symptoms. With the ongoing COVID-19 pandemic and continued reports of anti-AAPI activities, the long-term impact on the victims of these hate activities cannot be understated."[35]

Surgical Patient

SCENARIO

A **30-year-old, White, transgender male** (Aiden) made the decision to pursue gender affirmation surgery from a large academic medical center in a metropolitan area that has a specific program for transgender and nonbinary patients. The surgical team is diverse, representing various specialties, and is committed to assisting transgender and nonbinary people achieve their individual goals. Aiden entered this step in his journey with hesitation and nervousness, having had negative experiences with health care providers in the past. At the encouragement of his primary care physician, Aiden made the call to the surgeon's office.

The surgical scheduler was friendly and personable and immediately asked Aiden for his name and pronouns. The scheduler then let him know her name and pronouns and informed him that it is built into their policy to ask each patient their pronouns to avoid over-the-phone assumptions. When scheduling his in-person appointment the scheduler let Aiden know what to expect when arriving on campus. She explained which documents he would need to provide the team and mentioned that if any documents provided listed Aiden's prior name or gender marker, the team would continue to respect his identity.

Aiden arrived for his appointment three weeks later to learn more about the surgical process. Due to the initial conversation with the scheduler, Aiden felt relaxed upon arriving. While in the waiting room Aiden completed the required paperwork, including information on his preferred name, pronouns, gender identity and sexual orientation.

Aiden met with a nurse and his surgeon in an exam room, and together they mapped out what Aiden could expect related to his surgery. Aiden left feeling confident with his surgery scheduled six months out.

The day of his surgery Aiden reported to the hospital, where his positive experience continued. Along with the questions related to his name and pronouns, the nurse working with Aiden let him know that the next provider would ask some questions that may make Aiden uncomfortable. She asked Aiden if she could share these questions; after he consented, she pulled up a chair to walk through the next steps. The nurse told Aiden that he would be asked about sexual health and that he would be tested for pregnancy. Although these questions were unavoidable and could have thrown Aiden off guard, the provider took time in a sensitive way to let him know what to expect. Further, the nurse was sure to engage with the patient face to face while having this discussion rather than standing, turning her back or multitasking. The next provider did speak to Aiden about sexual health and pregnancy. As with the nurse, the surgeon was sure to state the reason for his questions and ensured that Aiden was comfortable every step of the way.

As Aiden was wheeled out for his surgery, he felt cared for and comforted by the team. Aiden noted how quickly the "small" moments add up to provide a stellar patient experience.

What are some suggestions to improve communication in this health care scenario so that bias would be less of a factor?

The scenario presented demonstrates how explanation, body language, tone and inclusivity can drastically change a patient's experience. From prior health care experiences, Aiden was concerned that he would be dismissed, misgendered or worse. Instead, he met front-line staff who had received training and a team of providers dedicated to providing respectful and gender-affirming care.

Organizations should consider streamlining their forms and training to include questions related to the patient's name and pronouns, avoiding using phrases such as "preferred" pronouns or "preferred" name, as these suggest an element of flexibility or that someone's identity is less than valid. Someone's name and pronouns are not suggestions and are not preferred over something else. They are inherent to who they are.

The forms presented and Aiden's comfort level in answering the questions are important aspects to highlight. Frequently, providers are often concerned that their patients may not be comfortable answering such personal questions, despite this data adding to the quality of care. In research conducted at three Mayo Clinic sites in Minnesota, nearly 97% of patients in their study were comfortable answering questions regarding orientation and gender identity when asked in a respectful manner with clarity as to why they are being asked.[36]

How did the avoidance of bias affect the interaction and the patient outcome?

Aiden received compassionate and culturally sensitive care, resulting in a positive experience from beginning to end. This positive experience increases the likelihood that he will be more likely to show up to his post-surgery appointments. As many people in marginalized communities express distrust about the medical system, this type of positive experience can assist in improving overall community health.

What are the probable feelings elicited in the interaction for the patient, the family and the provider?

Patient: The patient felt cared for and was encouraged by the respectful response from his care team. Additionally, from a wider lens, he is hopeful that his experience is representative of growing awareness across the organization of transgender and nonbinary individuals and their care needs.

Provider: In this scenario, multiple providers made a positive impact on Aiden's experience. As each step was explained to Aiden in detail, the providers ensured that Aiden was fully aware of the process and was seen as a respected individual, thus garnering respect and trust from the patient and his family.

What are some suggestions to improve documentation in the transgender patient's medical record?

According to The Joint Commission, "accurately documenting both current gender identity and assigned sex at birth is critical to the support of clinical processes and understanding of a

patient's unique health needs."[37]

Additionally, considerations for transgender patients' documentation can include providing nonbinary options on admission/registration forms and within the electronic health record. The patient's name and pronoun should be easily accessible and visible to the health care team and be used with all communication with patients, such as emails, texts and voicemails with appointment reminders.

Upon inpatient registration, all patients should be asked their name, what pronouns they use, their gender identity and their sex assigned at birth. (Keep in mind that some electronic health record systems may require modifications to appropriately capture this data.) All staff should be encouraged to practice asking patients their pronouns, using they/them pronouns when interacting with patients, and apologizing if misgendering — all of which should be practiced outside the presence of the patient.

In the absence of an organizational Transgender Care Policy,[38] questions may arise about the care of transgender patients in the hospital or long-term care settings. Recommendations include:

- **Placing the patient in the room of the patient's self-identified gender.** It is helpful to ensure that providers and staff are not disclosing protected health information in a way that violates the Health Insurance Portability and Accountability Act (HIPAA) or other privacy and confidentiality laws. Lambda Legal has published a resource on HIPAA, gender identity, and sexual orientation, but organizations should consult legal counsel in developing policies and training in regard to privacy and confidentiality.[39]

  In the guide *Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies* developed by the Human Rights Campaign and Lamba Legal, a model policy states: "Complaints from another patient related to a roommate's gender identity or expression do not constitute grounds for an exception to [the] room assignment policy." If the roommate continues to complain, room dividers (e.g., curtains) may be used for privacy. If the roommate still complains, the roommate should be relocated to another room if doing so would be safe and medically appropriate.[40] If a transgender patient reports being harassed by a roommate, the policy indicates that a staff member who is trained in transgender cultural competency and has experience with patient relations and complaint management should relocate the roommate if doing so would be safe and medically appropriate. "If the roommate cannot be relocated, the transgender patient should be moved," the model policy states. "The transgender patient's health is not to be compromised by an unsafe room assignment."[41]

- **Explaining that they are asked questions** and tested for pregnancy and other gender-specific preventive care in order to provide medically appropriate care and meet the standard of care.

- **Permitting equal visitation** of LGBTQIA+ spouses, domestic partners, families and support persons.

- **Providing gender-affirming personal care items.**

Health care teams should continue to provide training on best practices related to transgender and nonbinary patients to ensure that the ancillary and clinical staff are up to date on current terminology in order to provide patient-centered care.

Patient on a Maternity Unit

SCENARIO

"I almost died after giving birth to my daughter, Olympia. Yet I consider myself fortunate."[42]

These are the initial comments in a CNN Opinion article written by Serena Williams, tennis star and entrepreneur, after the birth of her daughter.

Serena described her relatively easy pregnancy, the birth of her daughter after an emergency C-section when the baby's heart rate dropped dramatically during contractions, and the elation when she held her daughter Olympia for the first time.

But 24 hours after Olympia's birth, Serena experienced almost a week of what she termed "uncertainty."

As Serena wrote: "it began with a pulmonary embolism, which is a condition in which one or more arteries in the lungs becomes blocked by a blood clot. Because of my medical history with this problem, I live in fear of this situation. So, when I fell short of breath, I didn't wait a second to alert the nurses.

This sparked a slew of health complications that I am lucky to have survived. First my C-section wound popped open due to the intense coughing I endured as a result of the embolism. I returned to surgery, where the doctors found a large hematoma, a swelling of clotted blood, in my abdomen. And then I returned to the operating room for a procedure that prevents clots from traveling to my lungs. When I finally made it home to my family, I had to spend the first six weeks of motherhood in bed."[43]

Serena expressed her gratefulness for both access to and the expertise of the medical team of doctors and nurses at a hospital with state-of-the-art equipment. She noted that if not for their professional care, she "wouldn't be here today."[44] Serena experienced a pulmonary embolism a day after giving birth to her daughter via cesarean section. Serena was gasping for breath and recognized that blood clots were blocking one or more of the arteries in her lungs as she had experienced this condition previously. Medical staff initially dismissed her concerns, wasting crucial time before her diagnosis and the treatment she specifically requested. When she self-diagnosed her condition, a nurse dismissed her concerns, thinking Serena was "confused."[45]

What explicit or implicit biases were present in this interaction?

- **Racial bias –** failure of the staff to respond immediately to Williams's breathing problems, disregard of her history of pulmonary emboli and her knowledge of the symptoms, and failure to intervene. As noted by other Black mothers: "If Serena Williams with all her money, power, access and reach had her voice IGNORED, what do you think happens to poor, immigrant Black women?"[46] The National Advocates for Pregnant Women expressed their opinion that "Serena Williams wasn't taken seriously after she gave birth and knew

she had a pulmonary embolism. This speaks volumes about how little our society values and supports pregnant women & how significantly racism and sexism influence our health care system."[47]

- **"VIP syndrome" –** When very important people (VIPs), often those who hold celebrity status, power or perceived connections, become patients, they may engender awe, fear, and intimidation in those who care for them, leading to a negative impact on care. With the goal of discretion and privacy for these patients, they may not be monitored as frequently as other patients.

How did the biases affect the course of hospitalization and the patient outcome?

Williams could have died. When health care providers did not listen to her and respect her knowledge of her condition, interventions were not timely, and the delay could have resulted in death.

Racism affects so many things before the patient even gets to the clinical encounter. Both implicit bias and structural racism affect how women (and specifically Black women) are cared for in the health care system.

For example, throughout pregnancy and the postpartum period, Black women are often not monitored as carefully as White women are. When they do present with symptoms, they are often dismissed. Williams' story illustrates the biggest problem facing Black women, even when they are successful and affluent, said Dr. Allison Bryant Mantha, vice chair of quality, equity and safety in the obstetrics and gynecology department of Massachusetts General Hospital in Boston.[48]

Providers need to do a better job of listening to and trusting the patient. For example, Ms. Williams obviously knew her body and was aware of what was going on with her. The nurses and medical staff should have respected and heard her when she first notified them of her breathing problems rather than dismissing her as "confused."

The evidence of racism in maternity care is clear in mortality and morbidity data:

- Among 11 industrialized countries, the United States ranks last in maternal mortality. For Black women, the statistics are particularly startling. In 2021, the maternal mortality rate in the United States for non-Hispanic Black (subsequently, Black) women was 69.9 deaths per 100,000 live births, 2.6 times the rate for non-Hispanic White (subsequently, White) women, according to the Centers for Disease Control and Prevention.[49] Causes of death most often include cardiac conditions, preeclampsia, eclampsia, hemorrhage and embolism. Although cardiomyopathy is the leading cause of maternal mortality in the postpartum period, Black women are more likely to be diagnosed later.

- Black infants are significantly more likely to die than White infants. The Black infant mortality rate is 2.3 times that of White infants.[50] Health care professionals failed to recognize serious medical conditions such as jaundice in Black babies because "White bodies" were considered the norm.

- Black women are more likely to give birth to low-birth-weight infants.[51]

- The myth that blood pressure "runs high" in Black people, can affect timely assessment and treatment of high blood pressure during and after pregnancy and childbirth. The results are potentially dire, as high blood pressure can be a sign of preeclampsia and eclampsia, potentially lethal pregnancy and postpartum conditions.[52]

- Too often Black women are just given formula to feed their babies in the hospital, with no discussion of breastfeeding and its value.[53] Breastfeeding support and options are often limited for Black women because maternity care practices and resources that support breastfeeding are less likely to be available in Black communities.
- Education, income and access to health care do not protect Black women from the risk of maternal death. The publicly discussed birth experience of tennis icon Serena Williams and those of many other educated Black women with good health insurance and access to quality health care underscore this fact. Black women with college degrees have a higher risk of experiencing a preterm birth than White women who did not graduate from high school.[54]
- The Association of Women's Health, Obstetric and Neonatal Nurses' position statement on racism and bias in maternity care addresses the misconception that Black people have higher pain tolerance scores than White people following surgery.[55] This reflexive resistance to giving Black patients less pain medication than White patients dovetails neatly with stereotypes of Black people who request pain medication as drug seekers or sellers.[56]

What are some suggestions to improve the interaction and eliminate demonstrated bias?

Eradicating bias in medical education and subsequent medical practice through textbook revision and practitioner training are key steps to transforming the system. The National Birth Equity Collaborative (NBEC) and the American College of Obstetrics and Gynecology, with funding from the Robert Wood Johnson Foundation, established a framework for doing so, built on validated measures of patient-reported experience. As a result, NBEC's antiracism and birth equity trainings for maternal health providers and staff were revamped to include helping providers learn to trust their patients. Joia Crear-Perry, M.D., founder and president of NBEC, said, "We would never have known to do that had we not started by asking what birthing people want rather than assuming that we know what's best."[57]

NBEC's trainings yielded positive change. In a hospital in Kalamazoo, Michigan, the new CEO invited its board to undergo the same training. Dr. Crear-Perry saw that as a "big win" because it demonstrated that one of the hospital's highest power structures was willing to engage in confronting racism embedded in all parts of the organization.[58]

Additionally, the Reproductive and Sexual Health Equity Framework defined an approach to comprehensively meet people's reproductive and sexual health needs, with explicit attention to structural influences on health and health care and grounded in a desire to achieve the highest level of health for all people and address inequities in health outcomes. Principles of the framework include centering the needs of and redistributing power to communities, having clinical and public health systems acknowledge historical and ongoing harms related to reproductive and sexual health, and addressing root causes of inequities.[59]

Strategies for quality improvement, such as focused provider training, are also emerging from patient surveys and patient simulations designed to model respectful quality care.[60]

As national and state initiatives seek to address the disparities with Black maternal morbidity and mortality, risk professionals can work on a local level and address their organizational opportunities to improve the care and treatment of pregnant Black women by:

- Listening to Black women and ensuring that they are empowered to make the best use of resources that have the greatest impact on their health and well-being, as well as that of their newborn

- Developing and investing in community engagement for participatory policy-making ("nothing about me without me")
- Having courageous conversations about race and racism

AGEISM

SCENARIO

An **84-year-old female** living independently was admitted to the hospital for elective surgery. During the course of hospitalization, she complained to her daughter that several of the health care providers spoke to her as if she were a child, using a high-pitched, exaggerated "saccharine" tone and speaking in a loud volume, which her roommate overheard, including personal questions. "My hearing is just fine, but no one asked me." She reported that they called her "Sweetie" or "Honey" and did not use her name. She felt that the practitioners were not actually listening to her and that they ignored her complaints and requests, such as the need to walk to the bathroom rather than using a bedpan. The patient developed urinary incontinence, which the staff laughed off as "part of old age," although she was not incontinent at home. After several days of incontinence and spiking a temperature, she was diagnosed with a urinary tract infection.

The patient felt that the caregivers failed to provide comprehensive information as she expected and did not go into details of her procedure and recovery plan, which made her confused about the expectations of the care team and unclear of the purpose of the tests and procedures. Post surgery she developed a wound dehiscence with minimal explanation about what happened (she was only told "these things happen") and needed wound care for the open incision. The patient became increasingly agitated and confused about what was happening to her, which was interpreted by the staff as uncooperativeness and dementia.

At the time of discharge, the physician stood at the bottom of the bed and rushed through the discharge plan, including wound care at home; he talked over the patient when she started to hesitantly ask questions and did not listen to the patient. The nurse came in right after the physician and let the patient know the wheelchair was ordered and that transportation was ready to bring her home. The nurse quickly reviewed the medications, wound care and follow-up appointment as she was packing up the patient's belongings and getting her into the wheelchair. The patient was distracted, needing to call her daughter to meet her at her home, and, with the bustling activity in the room, was not given time to understand the discharge instructions.

The patient was so stressed about going home that she could not recall what she needed to do, what the home health nurse would be doing or when they would be coming, and how and when to take the medications prescribed at discharge.

The daughter, who was not aware of the timing of her mother's discharge, called the risk professional to complain about her mother's experience, the postoperative complications, the inadequate discharge preparation and the lack of communication with her and her mother.

What explicit or implicit biases were present in the interaction?

- **Ageism –** The World Health Organization (WHO) defines "ageism" as "stereotyping, prejudice and discrimination" based on age and reports that it is "an incredibly prevalent and insidious problem" that "affects not only individuals but how we think about policies."[61]

How did the biases affect the course of hospitalization and the patient outcome?

- The patient felt disrespected and humiliated when the health care providers did not use her name, rolled their eyes when she spoke, and spoke to her as if she were a child.
- She was embarrassed in front of her roommate (and anyone else nearby) when the health care team asked questions about her bowels and bladder habits and other personal questions; when they talked at (not with) her from the bottom of the bed, raising their voices to be heard; and when they used childish terms in the questions.
- She experienced unnecessary harm when her incontinence was treated as part of the aging process rather than being evaluated objectively and thus she experienced a delay in treatment. By not listening to the patient's requests, especially regarding her ability to go to the bathroom, the staff were complicit in her urinary tract infection.
- Her agitation increased with the development of the wound dehiscence and inadequate information about what was happening to her, making her appear confused and uncooperative.
- Her anxiety level was heightened when she felt unprepared for her discharge and care at home because of the inadequate and rushed discharge communication.
- She hesitated to seek further care and treatment for preventable conditions, including physical weakness and ongoing wound care.
- The patient was anxious and felt uninformed about what to expect for her procedure and the course of postoperative care. She became angry, lashing out at the staff when "something else new" was asked of her, which resulted in her being labeled as "cranky" and "uncooperative," as well as raising questions regarding her cognitive abilities.
- The patient experienced depression after hospitalization, which extended her recovery time. She had to continue treatment for her urinary tract infection, which was uncomfortable and resulted in additional medication.

What are some suggestions to improve the interactions and eliminate demonstrated bias?

According to the U.S. Census Bureau, "By 2060, nearly one in four Americans will be 65 years and older, the number of 85-plus will triple, and the country will add a half million centenarians."[62] "In 2016, there were 49.2 million children under 18 and 73.6 million adults 65 and older; by 2060, these numbers are predicted to grow to 80.1 million and 94.7 million, respectively. As the elderly population grows, the demand for health care will increase and potentially exacerbate ageist attitudes."[63]

The health vulnerabilities of older adults may amplify the health effects of discrimination. One study found that experiences of discrimination are frequent among the elderly population, with 63% and 31% of older adults reporting everyday discrimination and major discriminatory events, respectively. Discrimination based on age was most common. After controlling for general stress, everyday discrimination still had effects on emotional health, such as depressive symptoms and self-reported health decline in older adults.[64]

The risk professional needs to promote staff education and competency toward:

- Adopting individualized, person-centered approaches to treatment, not stereotyping a patient's condition based solely on age.
- Obtaining information on the patient's level of independent living and abilities rather than assuming that older individuals reside in a group setting or with family members.
- Rejecting stereotypes of ageism to decrease the chances of patients developing psychological problems such as posttraumatic stress disorder (PTSD) or anxiety.
- Understanding their own biases toward older adults. When older adults are viewed objectively, it benefits their physical and mental health, promotes a society that is more aware of their needs, values their contributions and does not dismiss them as irrelevant.

One resource to consider is the Age Friendly Health System, an initiative of The John A. Hartford Foundation, which is focused on investing in aging experts and practice innovations that transform how the care of older adults is delivered. Among other priorities and with the American Hospital Association, the Hartford Foundation (johnahartford.org) is working to create health systems that are age-friendly.

The Implicit Association Test from Project Implicit, mentioned previously, can also be used to uncover any implicit biases staff may have toward older adults. After test completion, the risk professional and the organization can begin to actively work to identify, recognize and circumvent the stereotyping behavior and attitudes that affect interactions with older adults.

BIAS TOWARD HEALTH CARE PROVIDERS

Bias Toward Neonatal Nurse

You may recall this case from 2013. Or you may have experienced a similar situation. What would you as a risk professional do?

SCENARIO

An **experienced Black registered nurse** was working in a teaching hospital's neonatal intensive care unit (NICU) when a man walked into the NICU; the nurse was at an infant's bedside. He reached toward the child but before he could do so, the nurse introduced herself to him and asked to see his identification band to identify the man as one of the baby's parents. In return, the man said curtly that he needed to see the nurse's supervisor. The charge nurse spoke separately to the man and upon her return told the nurse that the father didn't want "African Americans" to care for his child. Further, the charge nurse told the nurse that the father had rolled up his sleeve to expose what appeared to be a swastika. The charge nurse passed the request to her supervisor, and the Black nurse was reassigned.

The hospital agreed to the man's request that no African American nurses care for his newborn, including posting a note on the assignment clipboard reading "No African American nurse to take care of baby." Even after hospital officials removed the sign that had been placed for a short time on the assignment chart, Black nurses were not assigned to care for the baby for about a month "because of their race."

The Black nurses were confused and conflicted. One Black nurse commented: "You know what really bothered me? I didn't know what to do if the baby was choking or dying. Am I going to get fired if I go over there?"

The Black nurses sued the hospital for punitive damages for emotional stress, mental anguish, humiliation and damage to their reputation. They expected the hospital to have turned down such a request.[65]

What explicit or implicit biases were present in the interaction?

- **Explicit racism –** the father's insistence that no Black nurses care for his baby was overtly racist.
- **Conformity bias –** the hospital's accommodation of the father's request and assignment of employees based on the father's racist bias effectively instituted his bias.

How did the biases affect the course of hospitalization and the patient outcome?

- The baby lost the opportunity to be cared for by a registered nurse with over 25 years of neonatal nursing experience.

- The interactions with the father created increased stress and a difficult work environment for the nurses caring for the baby.
- The partnership between clinical staff and the parents was irrevocably harmed as the staff were angry, outraged, and intimidated by the father.
- Hospital administration was concerned with the safety of the staff, resulting in additional tension within the organization, compounded by the NICU staff actually feeling unsupported by leadership.

What are some suggestions to improve the interactions and eliminate demonstrated bias?

This is a challenging situation. Hospitals may try to accommodate a patient's request (in this case it was the patient's significant other) for providers with a certain religion or gender, such as a female gynecologist for a patient with a history of sexual abuse or cultural practices, but a request for a doctor based on race is different. While clinicians might receive such requests from time to time, employers must guard against racial discrimination. In fact, in a survey from the National Commission to Address Racism in Nursing, nurses of color reported discrimination from patients and their families but also from their co-workers and supervisors. According to the results, 92% of Black nurses surveyed (n=1,972) reported that they had personally experienced racism in the workplace, as did 69% of Hispanic nurses (n=369), 73% of Asian nurses (n=461) and 74% of nurses of other or multiple races (n=531). Among the 3,523 respondents, 70% of Black nurses said they experienced racism from a manager, supervisor, or administrator, as did 51% of Hispanic nurses, 57% of Asian nurses, and 60% of nurses of other or multiple races.[66]

Health care organizations must be constantly aware of the laws prohibiting discrimination, including the 1964 Civil Rights Act and the 2010 decision by the 7th U.S. Circuit Court of Appeals, which held that the federal Civil Rights Act prohibits nursing homes from making staffing decisions for nursing assistants based on residents' racial preferences, among others.

Health care organizations, physicians, and other health care providers and staff may not discriminate based on gender, sexuality, race, religion or national origin, among others, when they treat patients. Patients may be able to select their providers in an outpatient setting based on their personal preferences or bias. In this situation, while the patient's father may have the right to select the hospital to treat the child, the father does not have the right to exercise control over the hospital's policies and practices that govern staffing assignments.

Hospitals, extended care facilities and health care systems need to use caution when accommodating a patient's and/or family's request. For example, it is appropriate and a right for a non-English speaking patient to be accommodated with translation services and/or a clinician who speaks their language. The circumstances are different when patients refuse a caregiver based on the patient's discriminatory views. Moreover, as ethicist Kwame Anthony Appiah writes, "for health care professionals who work in hospital systems, incidents of patient bias can be wounding. That's why hospitals should, when possible, try to accommodate staff members who don't want to be assigned to patients who display bias toward them. A doctor's primary concern is the best care of her patients, and we rightly hold physicians to a higher bar than we do patients. But a health care system must attend, as well, to the welfare of its staff members."[67]

Of note, the hospital paid nearly $200,000 to settle the lawsuit, reflecting discrimination against the nurse.[68] With inflation, that settlement would be about $250,000 in 2022 dollars.

Bias by Residents Toward Certified Nursing Assistant in Extended Care Setting

SCENARIO

A **nurse at an extended care facility** commented in a blog that, “one of my CNAs (certified nursing assistants) comes to me in tears and asks to not have to take care of a certain resident anymore. She was taking vital signs and this guy wasn’t in the mood to be bothered and he told her to go back to her country. The resident went on to state that she and all her family came to this country to ‘steal our jobs.’ The resident has no cognitive impairment and was just being uncooperative and nasty.

The CNA told me that back in her country she was kidnapped twice for ransom. That’s why she left and is now a naturalized American. But when the resident made those statements to her, she cried that she wanted to go back to her country.

Residents and fellow staff have no idea of the kinds of dangers the CNAs were fleeing. They don’t acknowledge the CNAs are hard workers!

Please be kind to the immigrant CNAs and nurses you may work alongside. You don’t know their story.”

What explicit or implicit biases were present in this interaction?

- **Explicit bias –** The behavior was based on the CNA’s ethnicity and her not being a “real American” in the resident’s view since she was not White.
- **Microaggression –** disparagement about her motive for coming to the United States to work.
- **Confirmation bias –** the CNA’s competency was not respected since she was non-White.
- **Affinity bias –** the expectation of the resident that the CNA would accept the verbal abuse since that was “part of her job.”

How could the biases affect the interaction and patient outcomes?

- The CNA did not want to care for that resident, which could impact the staffing assignments.
- The CNA might have hesitated to respond promptly if that resident experienced an emergency.
- The other staff were aware of the interaction and reluctant to care for the resident, which could result in the resident receiving inadequate or suboptimal care.

- There may be delays in responding to the resident's needs due to the staff's unwillingness/reluctance to respond to his call bell, assist with meals, etc.
- Retention and recruitment may be affected, depending on how the extended care facility responds to the situation.

The nurse to whom the CNA reported this situation immediately went into the resident's room to support the CNA, explaining that this CNA took care of the nurse's own family member and was "one of the best." The nurse then followed the chain of command, with the result that the director of nursing met with the resident and his family to explain the code of conduct for residents and to inform them that further incidents could result in the resident being discharged to another facility.

What are some suggestions to improve the interaction and eliminate demonstrated bias?

While the extended care facility could not control the words of any resident, this organization effectively used the chain of command when negative incidents affected the staff, not just the residents. They had a code of conduct with behavioral expectations for the residents. The director of nursing promptly met with the resident and family to enforce the code of conduct and to remind them of the potential consequences of verbal abuse toward staff.

The negative comments toward any of the staff were not condoned by colleagues or administration, which demonstrated support for the individual staff member and all the employees.

In a similar situation, occurring in September 2022, the U.S. Equal Employment Opportunity Commission (EEOC) sued a nursing home over allegations that it allowed patients to racially abuse Black staff members. The suit says that starting in 2020, certain White residents (male and female) of the nursing home repeatedly directed offensive racial slurs and physically assaulted the nursing home's Black nurses and nursing assistants. The Black nurses and nursing assistants had reported the harassment and physical abuse to the nursing home management. The EEOC suit states that "an employer cannot ignore egregious racial harassment simply because the harassers are long-term care facility residents." The suit seeks compensatory and punitive damages for the affected employees and the prevention of future workplace racial harassment.[69]

Bias Toward Neurosurgery Resident Physician

SCENARIO

A **Muslim neurosurgery resident physician,** wearing a hijab, walked into a patient's room with the attending physician and several other resident physicians. Before she could be introduced, the patient asked why she was there and continued, "Don't you deliver the meals?" Even though the resident physician was attired in scrubs as were the other members of the neurosurgical team, the patient apparently assumed she could not possibly be part of the medical team. The resident physician admitted that while she was tempted to respond, "I am not here to serve you lunch but to save your life," she hesitated. The older attending just laughed it off and did not respond to the patient but continued with the patient assessment. The other resident physicians stood by awkwardly. No one spoke up.

What explicit or implicit biases were present in this interaction?

- **Explicit bias –** the patient's statement demonstrated his belief that the individual wearing a hijab could not be a member of the team because of her ethnicity.
- **Confirmation bias –** that the resident physician could not, simply based on her wearing a hijab, be competent to provide the medical care the patient needs.
- **Conformity bias –**evidenced by each of the resident physicians' individual inclination to behave similarly to the attending physician and the other resident physicians, irrespective of their own beliefs and instead of their exercising their own judgment and speaking up.

How could the biases affect the interaction and patient outcomes?

- The patient-physician relationship may be strained and uncomfortable for both when this resident physician is on call during the patient's hospitalization.
- The patient might discount or disregard the information or advice the resident physician provides, not as a result of her role but solely based on the resident's physical presentation.
- It is possible that the resident physician would be less engaged in this patient's care.
- The disrespect from the patient and the lack of support from her peers may impact the resident physician's relationship with the attending physician and other members of the medical team.

What are the probable feelings elicited in the interaction for the patient and the resident physician?

- The Muslim resident physician was embarrassed to not be seen as equal to the other resident physicians.

- The other resident physicians were surprised by the patient's expression of explicit bias and, as a result, were possibly uncomfortable around their Muslim colleague because of their embarrassment for not supporting her.
- By not responding in a supportive manner, the attending and fellow resident physicians exacerbated the problem of disrespectful behavior by ignoring it, thereby tacitly accepting such behaviors.

What are some suggestions to improve the interaction and eliminate demonstrated bias?

Hospitals across the country are reporting an uptick in disrespectful, discriminatory or violent behaviors from patients toward health care providers, including physical violence and verbal mistreatment or abuse, according to a study published May 6, 2022, in *JAMA Network Open*.[70] Although these instances have increased in frequency and severity, they are not new to health care. In 2013 the Institute for Safe Medication Practices repeated a national survey initially conducted in 2003 regarding intimidation in the workplace.[62] The survey respondents ranked, by frequency of occurrence, the behaviors most often encountered:

- Negative comments about colleagues or leaders (encountered by 73% at least once, by 20% often)
- Condescending language or demeaning comments or insults (68% at least once, 15% often)

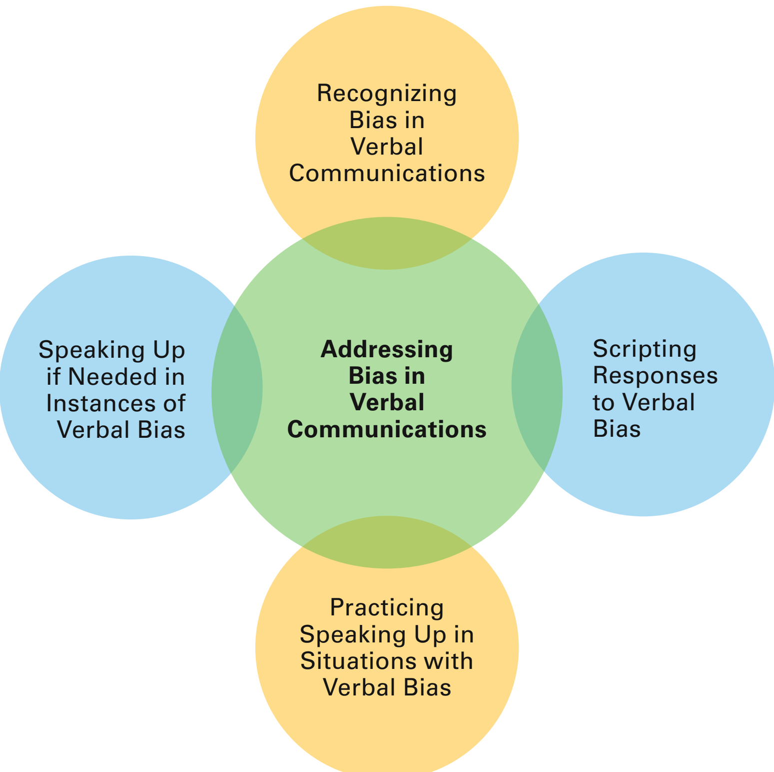
The least frequent disrespectful behaviors encountered at least once during 2013 survey included:

- Shaming, humiliation or spreading malicious rumors (46%)
- Insulting or slighting an individual due to race, religion or appearance (24%)[71]

When staff see examples of workplace violence or hear a derogatory remark made about a colleague, they may be caught off guard and may not be able to think of an appropriate response. In these instances, silence is not helpful and, in fact, may be hurtful. Instead, risk professionals can help staff by providing not only cultural competence education and training, but also helping staff feel empowered to respond, by scripting potential responses to biased remarks for them to practice responding with and using in situations involving patients and colleagues. Statements to consider include[72]:

- That's not how we do things here.
- That's not funny to me.
- That sounds racist.
- That was not necessary.
- Is the person's race relevant to your story?
- I'm sorry, what?
- I need a moment to process that.
- Let's be careful that our words are respectful of everyone.
- Racial jokes are not okay.
- That comment makes me uncomfortable.
- Maybe you don't realize the impact of your words.

These statements can calmly and succinctly be used with patients, supervising staff, or colleagues.[73] As illustrated in the diagram, this implemented method of communication becomes inherent in the organization's culture.



To address the disrespectful behavior that exists among all levels of health care organizations and staff, and the increasing verbal abuse from patients and families, risk professionals can work with their organizations to implement the following strategies:

- **Establish a no-retribution policy** for those who report disrespectful behavior. This policy can also serve as the foundation of organizational efforts to reduce and ideally eliminate disrespectful behaviors.
- **Open a dialogue about disrespectful behavior** by using staff surveys of patient safety from the Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov/sops/surveys/index.html. Managers can incorporate questions about disrespectful behaviors on rounds and hold focus groups to have frank discussions on the issues and approaches to address potential responses or interventions.
- **Create and enforce a code of conduct (or code of professionalism)** to serve as a model for interdisciplinary collegial relationships and collaboration fostering mutual trust and respect that produces willing cooperation. It is important that the code clearly articulate the standards of behavior desired, as well as unacceptable behaviors.
- **Establish an escalation policy** to manage conflicts about the safety of a situation when the standard communications process fails to resolve an issue. This policy should guide staff on who to call for help to obtain a satisfactory resolution and provide an avenue for resolution outside the typical chain of command in the event the conflict involves a subordinate and their supervisor.

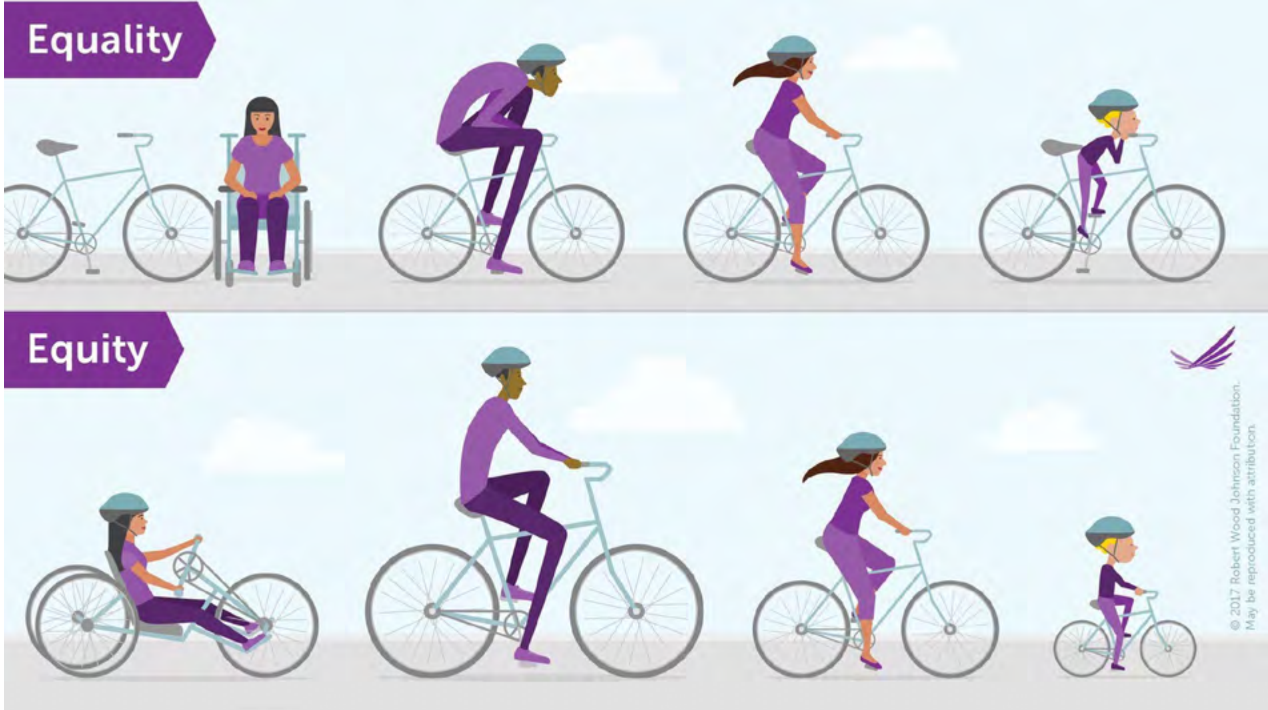
- **Develop an intervention policy** that has full leadership support to consistently address disrespectful behaviors. An effective policy includes zero tolerance for disrespectful behaviors regardless of the offender's standing in the organization, fairness to all parties, consistency in enforcement, a tiered response to infractions, a restorative process to help people change their behavior, and surveillance mechanisms. This policy should also take an enterprise risk management approach and address any system issue that perpetuates disrespectful behavior (e.g., issues that affect workloads, staffing, budgeting, education, communication, handoffs, environmental hazards, stressors).
- **Provide mandatory education and validation** for all staff about appropriate professional behavior and the impact of disrespectful behavior on teamwork and patient safety.

EQUALITY AND EQUITY

The overarching theme of this white paper is that equitable policies and institutions are essential in health care. Hospital policies and practices should reflect equality in treatment and equity in care of all patients.

Equality is all about treating others so that the result is the same for everyone. This entails putting measures in place to assist individuals to achieve similar results, for example, clinical protocols. As illustrated, with equality, everyone is given the same bicycle.

Equity pertains to justice and fairness and differs from equality. While equality means giving the same to others, equity reflects that we all do not always begin from the same position or need the same supports. It also shows that we should acknowledge and correct imbalances. Again, in the illustration, equity means giving the individual a bicycle that best meets their specific needs.



Credit: Robert Wood Johnson Foundation 2017

The risk professional may need to spend time increasing understanding of the terms *equity* and *equality.* The difference between these two concepts cannot be overstated. There is a tendency to blur equality, which dictates that everyone should be given the same access to opportunity regardless of their starting place, and equity, which recognizes the need for adjustments to account for differences in access to opportunities and pervasive obstacles to health and well-being that may be faced by people of different backgrounds and physical and/or mental abilities.[74]

AUTHENTIC CONVERSATIONS

Risk professionals play a vital role in raising awareness of bias and guiding health care staff to develop processes to minimize its impact. By raising awareness and providing education, risk professionals help staff learn how to conduct essential, difficult and much-needed authentic conversations with diverse patient populations.

Authentic conversations about biases are difficult, uncomfortable and far too infrequent. But as concerns about the impact of bias in health care rise, the question "How do we talk about bias?" is finally being asked. In board rooms and cultural spaces, at home and in health care organizations, in houses of worship and educational settings, there are signs that people want to talk authentically about bias and are eager for guidance.[75] Risk professionals, due to their cross-functional roles, are key players in facilitating these discussions at many levels within an organization.

One organization with a strategic resource for authentic conversations is the Hear Me Now storytelling and listening program of the Providence Institute for Human Caring (hearmenowstories.org).[76] This program was started in 2016 and now has the largest library of storytelling recordings of any health care system in the United States. Hear Me Now celebrates diversity, equity and inclusion to promote trust, understanding and healing. Patients, loved ones and providers share their stories to provide their perspectives on their health care and life experiences. There are stories about a deaf patient and her interpreter, patients diagnosed with long COVID or cancer, disparities in health care between White and Black women, virtual health care, mobile clinics, religious holidays of multiple religions, and many more. There is power in storytelling, which illustrates the pain of being Black in the United States and of being discriminated against because of a disability or for being different.

Another tool for authentic conversations is the use of Rx Racial Healing Circles (RHCs). Created at the Center for the Advancement of Well-Being at George Mason University, RHCs are designed for community building and racial awareness. This framework is rooted in spiritual and community-sustaining models in many Indigenous cultures. The power of the RHC experience comes from sharing stories — telling personal stories (reaching the heart space) rather than simply relating to an event (reaching the mind space).[77]

Authentic conversations can help clinicians understand their patients and help people gain trust in their health care providers. When people feel threatened, fearful or distrustful, they are less likely to seek health treatment or engage with the medical system. To trust health care providers and institutions, the community needs to know the clinicians, who earn trust through initiatives to:

- **Increase participation of community members in their own health and well-being.**

  Examples include contributing toward more equitable access to health care and treatment of LGBTQIA+ people in health care settings and helping increase access to services for children with autism by working with their parents.

- **Intentionally document knowledge.**

  Examples include creating digital stories, data visuals, presentations, and reports that gather and analyze insights from patient interviews and community focus groups. This requires highlighting and valuing the community knowledge that emerges, paying attention to and mapping the problems and potential solutions that are found within the stories.

- **Use that documented knowledge to inform action.**

  Examples include engaging in community conversations; conducting interactive presentations; developing educational materials; and advocating, organizing, and networking, by actively listening to community voices and integrating their feedback into actions that it will take to improve the care experience of all populations served.[78]

CONCLUSION

Health care risk professionals play an integral role in identifying bias within their organization, whether individual or systemic, in order to reduce the negative impact of implicit or explicit biases on patients and providers.

Health care risk professionals can consider the following recommendations for their organizations:

- **Observe interactions with patients and among staff.** Listen to the communication between patients and staff, and among staff, as a "secret shopper" to observe communication styles and see if implicit bias is demonstrated in the interactions.

- **Emphasize individualized patient care.** When the opportunity arises, help staff learn about the patient's manner of speaking, strengths and weaknesses, communication styles, and identity as well as their cultural and racial background, gender, age and other factors.

- **Support compliance with state and federal regulations and accreditation standards,** such as:

  - The Joint Commission:
    Patient Rights – Sexual Orientation/Gender Identity Standard (Standard RI.01.01.01)
    Leadership – Reducing Health Care Disparities (Standard LD.04.03.08)
  - State and federal equality regulations
  - State and federal antidiscrimination regulations

- Potential claims or state board actions:
  Discrimination
  Failure or delay in diagnosis
  Failure to provide or delay in providing treatment

- **Facilitate language assistance** as required by federal law and periodically validate the cultural competence and linguistic fluency within the organization.

- **Review and assess current written and multimedia materials** (forms, instructions, accessibility, etc.) to ensure they are easy to understand, in the appropriate font size, and consistent with health literacy best practices.

- **Provide education and training** regarding the importance of using objective, descriptive documentation practices, and periodically review clinical documentation to identify and address implicit or explicit biased descriptors.

- **Conduct focus groups.** Connect with members of diverse communities to hear their stories of their experiences with health care. Encourage the group to reflect on those stories and then ask the participants to retell them as they wished they had unfolded — "rewriting the script" in the process.

- **Engage leadership/governance support** to encourage integration of equality and equity in all the operations of the hospital/health care system.

Finally, remember:

- **Knowledge matters.**

  All health care providers should learn about the role of racial, sexual orientation, physical, religious and socioeconomic biases and ways to overcome their impacts.

- **Language matters.**

  The manner in which health care providers communicate with patients, their families and communities, and other health care professionals is essential. Evaluate all written and digital materials, toolkits, checklists, bundles and educational documents to ensure that they reflect the patient populations served.

- **Action matters.**

  Risk professionals should advocate for change in didactic education and clinical training, to achieve nondiscriminatory, safe, equitable, quality health services for all patients. To achieve these goals, risk professionals need to challenge themselves, their colleagues and health care organization leaders to promote clear and directive actions with built-in accountability measures.

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APPENDIX A: ASSESSMENT, GUIDES AND CHECKLISTS

Implicit Association Test

https://implicit.harvard.edu/implicit/takeatest.html

Test serving primarily as an individual assessment of one's own biases, measures, attitudes and beliefs

Project Implicit Study Materials

https://www.projectimplicit.net/resources/study-materials/

Background and materials for the Implicit Association Test

4 Ways Health Care Organizations Can Utilize the Implicit Association Test

https://www.aha.org/guidesreports/2019-04-18-4-ways-health-care-organizations-can-utilize-implicit-association-test-iat

An organizational approach to utilizing the Implicit Association Test

Implicit Bias Resource Guide

https://www.nichq.org/resource/implicit-bias-resource-guide

Tools and resources for children's health organizations related to implicit bias

Becoming a Culturally Competent Health Care Organization

https://www.aha.org/ahahret-guides/2013-06-18-becoming-culturally-competent-health-care-organization

A guide best used to implement cultural humility and competency best practices at an organizational level

An Implementation Checklist for the National CLAS Standards

https://thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistfortheNationalCLASStandards.pdf

Checklist of implementation and best practices in providing culturally and linguistically appropriate services (CLAS)

Action Research for Community Health and Wellbeing

https://ar4chw.com/

Focusing on action research, methodologies, activities and projects through collaboration, sharing of knowledge, and co-learning in the community

The Asian & Pacific Islander American Health Forum

https://www.apiahf.org/

A health justice non-profit organization, dedicated to improving the health and well-being of more than 20 million AAs and NHPIs living in the United States and its jurisdictions

National Birth Equity Collaboration

https://birthequity.org

- Sister Song
- Groundswell Fund
- Birth Justice Initiative – Ms. Foundation for Women
- National Birth Equity Collaborative

Recognizes that the implicit bias and structural racism influencing maternal and infant health outcomes must be addressed. Supports established organizations, such as those listed, that fund constituency-led, grassroots community efforts

National Commission to Transform Public Health Data Systems

https://www.nationalcollaborative.org/transform-public-health-data-systems/

Charged with identifying how data can better illuminate the ways in which structural racism drives health inequities. Funded by the Robert Wood Johnson Foundation to address the lack of racially disaggregated data, delays in data reporting, and limited data tracking and sharing across sectors by race, gender and ethnicity—all of which contribute to disproportionate impacts on low-income communities and communities of color.[79]

Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare™

https://www.marchofdimes.org/our-work/health-professionals/continuing-education-courses

March of Dimes professional education course that provides health care professionals and nursing and medical students with important insights to recognize and remedy implicit bias in maternal and infant health care settings

Beyond Labels: Do Your Part to Reduce Stigma

https://beyondlabels.marchofdimes.org/

An interactive site from the March of Dimes designed to help people who work in health-related fields learn how stigma can impact the health care and support women need, seek and receive

Institute for Perinatal Quality Improvement SPEAK UP Program

https://www.perinatalqi.org/page/SPEAKUPRegister (opqic.org)

Provides interactive web-based education designed for health care workers who care for individuals who are Black, Indigenous, and people of color who are or may become pregnant

Association of Women's Health, Obstetric and Neonatal Nurses Insights Podcast Series

https://www.awhonn.org/podcasts/

Features leading experts in the field who share their perspectives on topics ranging from postpartum hemorrhage to perinatal opioid use disorder, including the episodes of particular interest as noted

The Impact of Implicit Bias in Health Care

https://www.awhonn.org/awhonn-insights-podcast-the-impact-of-implicit-bias-in-healthcare/?preview=true

Insights on racism, implicit bias, stigma and disrespectful care, with tools provided for moving forward

Native American and Alaskan Native Heritage Month

https://www.awhonn.org/awhonn-insights-podcast-native-american-and-alaska-native-heritage-month/

Information about the Indian Health Service and the health disparities within Native American and Alaska Native communities

Respectful Maternity Care

https://www.awhonn.org/awhonn-insights-podcast-respectful-maternity-care/

Overview of respectful maternity care, ways in which COVID-19 has exacerbated health care inequities, and respectful care strategies that listeners can implement at their institutions

Centers for Disease Control and Prevention HEAR HER Campaign

https://www.cdc.gov/hearher/index.html

A campaign that seeks to encourage partners, friends, family, coworkers and health care providers to listen when pregnant and postpartum women say that something does not feel right. Acting quickly could help save lives.

Inclusive Services for LGBT Older Adults: A Practical Guide to Creating Welcoming Agencies

https://lgbtagingcenter.org/resources/resource.cfm?r=487

A brief checklist to ensure a welcoming organization for LGBTQIA+ older adults; addresses stereotypes and special considerations

The Fenway Institute

https://fenwayhealth.org/the-fenway-institute/education/the-national-lgbtia/health-education-center/

Provides educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people

Healthcare Equality Index

https://www.hrc.org/resources/healthcare-equality-index

Benchmarking tool that evaluates health care facilities' policies and practices related to the equity and inclusion of LGBTQIA+ patients, visitors and employees

Proven Strategies for Addressing Unconscious Bias in the Workplace

https://www.cookross.com/docs/UnconsciousBias.pdf

Tools, checklists and case studies on addressing bias in the workplace

APPENDIX B: RESOURCES

Implicit Bias

Michigan Department of Health and Human Services. (2022). *Health equity, implicit bias, stigma and antiracism* [trainings and resources]. https://www.michigan.gov/mdhhs/keep-mi-healthy/maternal-and-infant-health/health-equity

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USC Annenberg Center for Health Journalism. (2022, June 28). Telling the story of racism in American health care [webinar recording]. *YouTube.* https://www.youtube.com/watch?v=mlS7lyWT_tQ

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Maternity Care

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Ageism

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Duquesne University School of Nursing. (n.d.). *Issues people with disabilities face in the healthcare system.* https://onlinenursing.duq.edu/post-master-certificates/disability-health-care-advocacy/

Centers for Disease Control and Prevention. *Disability & Health Resources for Facilitating Inclusion and Overcoming Barriers.* https://www.cdc.gov/ncbddd/disabilityandhealth/disability-resources.html

Centers for Disease Control and Prevention. *Disability and Health Overview.* Disability and Health Overview | CDC

Centers for Disease Control and Prevention. *Disability and Health Information for Health Care Providers.* https://www.cdc.gov/ncbddd/disabilityandhealth/hcp.html

Centers for Medicare and Medicaid Services. Improving Access to Care for People with Disabilities. https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/Improving-Access-to-Care-for-People-with-Disabilities

Diversity and Health Equity

AHA Institute for Diversity and Health Equity, Health Equity Resource Series. (n.d.). Data-driven care delivery [Toolkit]. https://ifdhe.aha.org/health-equity-resources

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