Recognizing and Managing Bias
## IN THE AMBULATORY HEALTH CARE SETTING

AUTHORS

Doris Fischer-Sanchez, DNP, APN-BC, CPHRM, Leader, Clinical and Enterprise Risk Management National Healthcare Industry Practice, Willis Towers Watson

Anne Huben-Kearney, RN, BSN, MPA, CPHQ, CPHRM, CPPS, DFASHRM, AVP, Risk Management Group AWAC Services Company, Member Company of Allied World

Moira Wertheimer, Esq., BSN, RPLU, CPHRM, FASHRM, Product Line Manager, Healthcare Client Services, Lexington Healthcare

Benjamin Wilburn, MS, Senior Inclusion and Diversity Specialist, Institute for Diversity and Health Equity (IFDHE), American Hospital Association
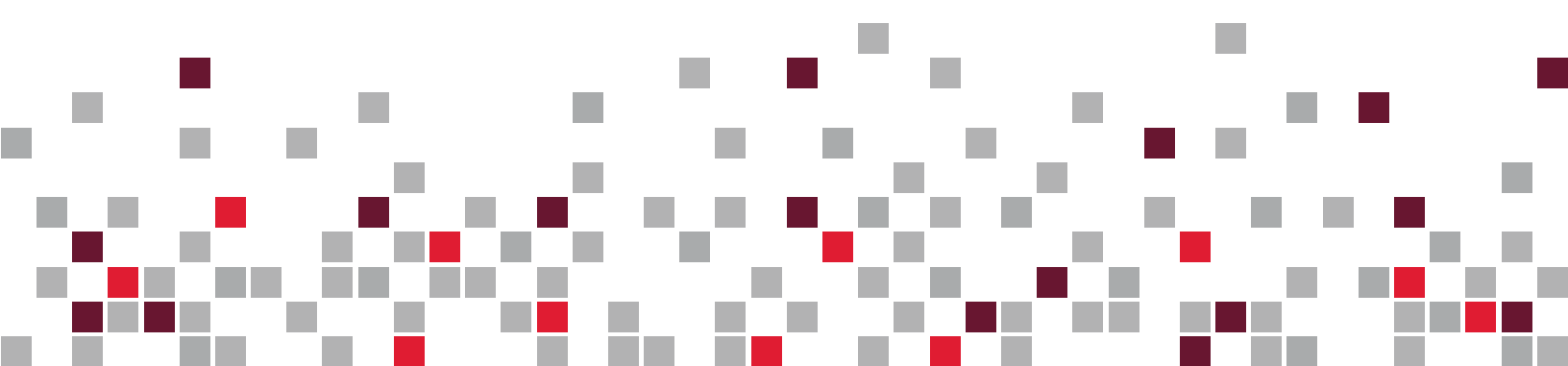
REVIEWERS

Elisa Arespacochaga, MBA, Clinical Affairs & Workforce, American Hospital Association

Sue Boisvert, BSN, MHSA, CPPS, CPHRM, DFASHRM, The Doctors Company

Josh Hyatt, DHS, MBE, MHL, DFASHRM, CPHRM, CPPS, HEC-C, Coverys

Joy A. Lewis, MSW, MPH, Institute for Diversity and Health Equity (IFDHE), American Hospital Association

INTRODUCTION

An individual's beliefs influence their behavior and decision-making. Frequently, these influencing beliefs are unconscious or implicit, that is, they exist outside of our conscious awareness, making them difficult to control and 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]

This white paper series uses real case scenarios to illustrate biases present in health care, including implicit bias that, while unconscious, is no less impactful.

We tend to place others into categories based on gender, age and race/ethnicity, which may then result in inaccurate perceptions about the people we categorize, leading to implicit bias as well as the potential for clinical decisions influenced by those implicit biases.[4] The human brain contributes to bias formation as it continually processes and organizes the vast amount of information we encounter every day and creates an outline of connections to help us process the information more efficiently.

Specific 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)

- **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 (and that anything else is abnormal)

- **Colorism –** Prejudice on the basis of skin shade or tone

- **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 (e.g., responding to disparagement of an ethnic group)

- **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)

Health care professionals, patients, families and visitors all have implicit biases and unconscious beliefs, and the extent to which these biases and beliefs manifest themselves and impact 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. As noted above, negative implicit biases/unconscious beliefs about religion, race, gender/gender identity, ethnicity, sexual orientation, physical limitations, age and mental health 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. This is an important consideration for risk managers and health care providers, as it has been demonstrated 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.

Health care organizations, and specifically health care risk managers, play a unique and vital role in reducing the impact that negative implicit biases have on patient safety and preventing adverse patient outcomes. Risk managers 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 three-part white paper series focuses on assisting health care organizations and health care risk managers 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 service lines.

Throughout the white paper series, subject-matter experts offer their personal and professional experiences in areas such as ageism, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual/aromantic and more) identities, religion, race and mental health, and utilize scenarios to illustrate the presence of and role that implicit bias plays in health care delivery and patient safety. Some of these scenarios may be shocking or upsetting; you may feel strong emotional reactions. For risk managers, these issues are present and pervasive. This white paper series is a primer for risk managers on how to identify and begin to address implicit biases. Further, it provides health care organizations and health care risk managers with appropriate intervention strategies and resources applicable to both current and forward-thinking strategic care models.

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 or legal advice specific to your organization when developing and implementing the measures discussed as part of this white paper series.

AMBULATORY CARE

Unintended bias can occur in any health care setting, including ambulatory practices, which are characterized by constantly varying patient populations, episodic interactions, and clinicians facing high throughput demands and time constraints. Thus, the white paper series begins by discussing the presence and impact of implicit bias in ambulatory care, given ambulatory care's prolific and continued growth in today's marketplace. Health systems have invested heavily in the creation of ambulatory care opportunities, and health care consumers demand greater access to health care outside of the traditional inpatient setting. This transition potentially results in increased encounters between patients and health care providers, and a need to more fully recognize the implicit biases and unconscious beliefs that all parties bring to these interactions.

Pediatric/Adolescent

■ SCENARIO

A 10-year-old obese, Hispanic male child (Luis) is seen in a neighborhood urgent care located within walking distance from his apartment where he lives with his mother and brother, complaining of abdominal pain for three days. Upon entering the examination room, the urgent care provider observes Luis and his mother (also obese) talking about a TV show in Spanish; on the desk is an empty bag of potato chips that Luis recently finished eating. They both say hello in English, and the provider starts the examination by getting Luis's prior medical history. Through questioning, the provider learns that Luis has had burning epigastric pain for three days along with a loss of appetite, but no nausea, vomiting, diarrhea or other symptoms. His physical exam is unremarkable. His mother reports that he eats too fast and eats too much junk food. She is very emotional and is particularly concerned due to a maternal family history of cancer. Following the evaluation, the provider prescribes gastrointestinal (GI) medications, recommends dietary changes, and directs Luis's mother to schedule a follow-up with his primary care provider (PCP).

Luis returns to the urgent care clinic two more times before his scheduled follow-up appointment with his PCP and sees a different provider each time. Luis continues to experience symptoms similar to those he reported at his first urgent care visit. Each time, additional testing is conducted, and after the third urgent care visit, a referral is made to the health system's GI clinic.

The medical record contains information from each visit stating that Luis's Hispanic mother is increasingly anxious and emotional. The mother's concerns continue to center on being worried that Luis eats too much junk food, often hurriedly. At each visit, Luis's mother frequently references their family history of cancer, including a maternal uncle with gastric cancer.

At the GI clinic visit, the health care provider notes that Luis has had a precipitous weight loss over the past two weeks, since his first urgent care visit, and that despite having a previous good attendance record, Luis has not been to school since his symptoms began. Further testing conducted over the next couple of weeks eventually reveals a mass located behind his kidney, later diagnosed as a type of cancer with a poor prognosis. More than a month has passed between his first urgent care visit and diagnosis.

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

This scenario points to ways that health care risk managers can help recognize and address implicit bias in all clinical settings, not just pediatrics.

In the scenario above, there could be the perception that there was a delay in diagnosing Luis's cancer, given that one month elapsed between his initial urgent care visit and cancer diagnosis. When examining whether this potential delay resulted in an adverse outcome brought about in part by potential disparities in health care delivery, consider whether the disparity was caused by implicit biases on the part of the health care providers. If so, how were these implicit biases manifested, and how could they be prevented from impacting health care delivery in the future?

? What explicit or implicit biases were present in the interaction?

Potential implicit biases manifested during the encounter may include issues such as these:

Labeling

- **Documentation describing Luis's mother as an "anxious Hispanic mother"**

  Did this description contribute to the provider's "not hearing" Luis's mother when she discussed the family history of GI cancer?

- **Luis labeled as "obese" given his BMI and his mother's description of Luis eating "too fast" and eating "too much junk food"**

  Did this description impact the provider's not recognizing Luis's rapid weight loss as an important clinical symptom of cancer?

  Did the provider "over-attribute" Luis's symptoms to his obesity, thereby contributing to a delay in diagnosis?

Communication

- **Did implicit biases impact communication…**

  Between Luis/mother and health care providers?

  Between health care providers?

- **Did documenting Luis's mother as an "anxious Hispanic mother" impact the decision-making of subsequent providers?**

  Was communication influenced by language differences between patient/mother and providers?

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

Health care risk managers play an increasingly vital role in helping organizations and providers recognize the prevalence of implicit biases and developing strategies designed to reduce their adverse impacts. Strategies can take the form of organizational supports, skills training and continuing education. On an organizational level, health care risk managers may have input into

identifying and addressing implicit bias in clinical policies and protocols or looking at the role of implicit bias when conducting a failure mode and effects analysis (FMEA) or root cause analysis (RCA). With respect to providers, skills training can include areas such as:

- **Empathy**
- **Perspective-taking**
- **Partnership building skills**

Empathy in its simplest form is one person connecting with another person's emotional state. Educating providers and raising awareness of empathy can help bring patients and health care professionals together within the context of shared experiences, and also shifts the position of power held by health care providers in the relationship so that providers and patients can share decision-making.[6]

Perspective-taking, the act of perceiving a situation or understanding a concept from an alternative point of view, can be a useful tool in helping clinicians empathize with their patients and thereby manage a variety of difficult situations routinely arising in health care. Engaging in perspective-taking involves one person working to understand what another person is thinking and feeling, by imagining themselves in that person's situation. Studies demonstrate perspective-taking to be effective at improving communication, limiting unprovoked aggression, and decreasing stereotyping and prejudice. Further, improvements in patient satisfaction scores have been observed following clinician perspective-taking when providing health care. Moreover, clinicians who have positive clinical encounters will more likely view patients in terms of belonging to an inclusive social group, as opposed to viewing them in terms of their individual attributes.[7]

Given that we all have implicit biases, it is common that issues similar to those in the scenario above often impact communications between health care providers and patients, as well as among health care providers. Keep in mind that communication involves more than just the words spoken or written. Communication encompasses body language, tone of voice, speech cadence and voice volume as well as words.

Engaging in effective communication patterns is especially important in health care, and as health care risk managers know, communication failures are an extremely common cause of unintentional patient harm.[8] Communication is particularly important when treating patients who may be subject to health disparities or who are at particular medical risk, such as elderly patients, non-English-speaking patients, or pediatric patients with acute and chronic conditions needing treatment. Effective communication is crucial to mitigating the effects of implicit biases in health care delivery, and leads to better patient outcomes, increased patient satisfaction, fewer malpractice suits and better treatment adherence.

? How did the biases affect the interaction and the patient outcome?

When clinicians collaborate and communicate with each other, implicit bias on the part of the health care provider can influence patient care and outcomes. For example, labeling Luis's mother as an "anxious Hispanic mother" in the medical record can affect how subsequent clinicians interpret the diagnostic data, thereby activating those clinicians' own implicit biases and impacting their cognitive processes and actions taken. For example, did any of the subsequent clinicians downplay Luis's mother's concerns regarding the family history of GI cancer because they considered them those of a "Hispanic mother"?

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

Risk managers can further improve communication by offering continued risk management education opportunities emphasizing the importance of employing sound documentation principles, including the use of objective and descriptive language. Sound documentation principles, as described above, can help prevent confirmation bias and mitigate the impact of implicit biases documented in the medical record. For example, in the scenario above, instead of labeling Luis's mother as an "anxious Hispanic mother," objectively describing her behavior, perhaps in terms of her speech tone, volume and cadence, as well as using direct quotations in the medical record documentation, helps prevent perpetuating any implicit biases that may impact the decision-making of subsequent providers involved in diagnosis and treatment. Further, health care provider education regarding recognizing the impact of certain phrases, such as "narcotic dependent," "sickler," "frequent flyer," "noncompliant" or "substance abuser," can help prevent stigmatizing language from entering the medical record.

Another area where risk management can affect the role of implicit biases is by evaluating clinical workflows to eliminate or reduce situations resulting in high cognitive loads among clinicians. When cognitive capacity is overwhelmed, their memories are influenced by information that is consistent with implicit biases. As described above, our brains automatically engage in this unconscious process to help us process information quickly and efficiently.

Further, in the pediatric and/or primary care setting, consent to treatment and consent to communicate protected health information (PHI) to third parties is another area where negative implicit biases may influence the clinical quality of health care, as well as clinical decision-making and patient treatment adherence. Aside from clinical participants, potential third-party participants needing patient information may include:

- **Teachers**
- **School administrators**
- **School nurses**
- **Child/family state regulators** (agency names vary by jurisdiction; e.g., Department of Children and Families, Department of Social Services)
- **Case workers**
- **Foster parents**
- **Noncustodial parents**
- **Health plans/third-party payers**

Risk management can play a role in reducing the risks associated with implicit and explicit bias by educating clinicians on the importance of employing sound documentation principles, including objective and descriptive language, in patient information conveyed to these parties.

Adult

The American Medical Association (AMA) *Code of Ethics* indicates that a patient's rights include "courtesy, respect, dignity, and timely, responsive attention to his or her needs."[9] Health care providers, office staff and medical assistants need to recognize that their responsibility to patients goes beyond physical exams, prescriptions and surgical interventions. There is a need to disrupt or dismantle socioeconomic and environmental factors, including structural racism (the system of public policies, institutional practices and cultural representations that reinforce and perpetuate racial inequity; it is not an organizational choice but "a feature of the social, economic and political systems in which we all exist"[10]). In addition, gender inequities, gender biases, mental health and disability issues can and do directly affect patients' health.[11]

■ SCENARIO

A 21-year-old, white, transgender male patient (Aiden Lockhart) visits a walk-in clinic in a rural setting complaining of flank pain, chills and low-grade fever. While Aiden checks in at the front desk, the patient service representative notes that there is no Aiden Lockhart in the system, despite a previous visit. Aiden notes that his name may be under his prior legal name, Sarah. Rolling her eyes, the representative instructs him to take a seat in the lobby. The nurse enters the lobby and calls for "Sarah Lockhart." Reluctantly, Aiden follows her to the exam room. After speaking with Aiden and assessing symptoms, the nurse exits the room. Aiden overhears her tell the physician, "*She* says her name is Aiden." Shortly after, the physician enters the room and refers to Aiden using she/her pronouns and the name Sarah. When Aiden explains his symptoms, he states he has been receiving hormone replacement therapy (HRT) for five years. The physician states that his choice to engage in HRT is likely the reason behind his symptoms and suggests he see an LGBTQ-specific provider. The physician goes on to state that the clinic does not know how to treat transgender patients. Aiden responds that finding a different provider might be difficult in a rural area. The physician suggests he look up a provider online. Two weeks later, with increased pain and malaise, Aiden is seen by a provider three hours away who diagnosed him with a kidney infection.

Following this incident, Aiden now expresses distrust in the medical system and frequently puts off routine care, impacting his overall general health.

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

Health care providers might address bias and communication by encouraging and fostering an environment that encourages active learning and listening. Engaging employees in Project Implicit (see Appendix A) will help practitioners to identify their own thought processes. Health care providers should add mandatory annual training, small group discussions, and sexual orientation and gender identity data collection to assess the experiences of LGBTQIA+ patients.

What explicit or implicit biases were present in the interaction?

Aiden's scenario offers examples of both explicit and implicit bias. Upon his arrival at the clinic the patient representative ignored his request to use his chosen name. As the visit progressed, this refusal snowballed as staff members repeatedly used the wrong name and pronouns. Inquiring about and respecting the use of a patient's pronouns helps to establish a foundation of trust. By asking about a patient's pronouns, providers can avoid mistakes based on assumption. Pronouns, much like language, evolve over time, and some patients may elect to use gender-neutral pronouns such as singular "they" or "zie." Asking patients their pronouns upon arrival will ensure misgendering does not occur.

Additionally, the physician disregarded Aiden's concerns, painting them as an "LGBTQ issue." There was also prevalence of heteronormativity and cisnormativity or the assumption that heterosexual and cisgender individuals are "normal" or "default" and others' identities are not.

How did the biases affect the interaction and the patient outcome?

The patient did not receive proper care or diagnosis, which resulted in a worsening of his condition. After the experience, the patient has mistrust in the medical system and disregards his own preventive health to avoid this situation. The patient also spoke to local friends and LGBTQIA+ allies and warned them of the physician on staff.

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

Patient: Aiden left this interaction with feelings of otherness (the quality or fact of being different), disrespect, embarrassment and misunderstanding. He felt prejudged prior to entering the exam room and was concerned about the quality of care he might receive. Unfortunately, as his fears were confirmed, he felt unworthy of the physician's space and time.

Provider: The provider exhibited behaviors associated with prejudice and bias. The provider had a general lack of education related to transgender care, specifically regarding the effect of hormone replacement therapy. There was a lack of empathy for Aiden, as he was in pain and instructed to conduct research on his own to identify a provider who treats transgender patients.

What was negative about the experience for the patient and the provider?

Patient: The patient felt he did not receive basic respect (name, pronoun use, etc.) from his first point of contact. Despite being in pain and feeling unwell, he found that his needs were dismissed and viewed as an issue related to hormone replacement therapy, which is widely used by transgender people to access gender-affirming care. Aiden left the appointment distressed emotionally and physically. As his condition continued to worsen, Aiden began to feel unworthy of care. After this incident it became increasingly difficult for him to seek routine or immediate care. Transgender people routinely experience travel distance as a barrier to receiving gender-affirming and quality health care.[12] The actions of this provider emphasized this disparity.

Provider: The patient elected not to return to the clinic, and other members of the LGBTQIA+ community learned of the negative interaction. As this is a small community, the provider likely lost potential patients. Given the explicit nature of this incident in addition to loss of patients, an internal review of the management of the care would be suggested.

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

To provide relevant care to LGBTQIA+ patient populations, specifically the transgender community, providers need to identify and make an ongoing attempt to eliminate their biases.

Understanding transgender people and the specific challenges associated with their care is a critical first step in providing competent care. According to the 2015 U.S. Transgender Survey, roughly a third of transgender people reported prior mistreatment by a health care professional causing them to delay or avoid preventative care. In addition, 23 percent of respondents did not see a doctor when they needed to for fear of mistreatment.[13] Although disheartening, these statistics provide a foundation for where to begin. Transgender people routinely delay care due to these incidents.[14]

Training front desk staff on handling name differences, updating gender identity on registration forms, and understanding non-inclusive or offensive language are great places to start. Creating policies and procedures,[15] implementing annual training and instituting competency validation may also open a door for more comprehensive patient-centered care.

Promising strategies include those aimed at getting providers to see a patient as an individual rather than as a stereotyped member of a group, helping patients become more engaged with their treatment plan and fostering patients' sense of being "on the same team" as their doctor.[16]

Some strategies to overcome unconscious bias include:

- **Recognize stereotypical thinking**
- **Replace biases and assumptions**
- **Understand the individual**
- **Explore a new perspective**
- **Increase opportunity for positive contact[17]**

■ **SCENARIO**

A 32-year-old, white, female patient, Molly Scott, visits her primary care provider (PCP) for her annual physical. During her appointment Molly's PCP asks about her sexual health. Molly, having felt comfortable with her PCP up to this point, explained that she identifies as asexual. (Asexuality is a sexual orientation, like being gay, heterosexual or bisexual. Asexuality often exists on a spectrum where some may experience a lack of sexual or romantic attraction.) Molly noticed that her PCP began to shift in their seat and had widened eyes. In disbelief, her PCP said, "There must be something wrong with you — what happened?" Immediately Molly felt uncomfortable and regretted her decision to share this information. Her PCP told Molly to seek mental health counseling and asked about past trauma. Going a step further, her PCP stated there is a "cure" to asexuality and many behavioral health solutions are available. Shocked, Molly asked to end the appointment early and left feeling embarrassed. Later, Molly contacted her PCP's office and requested a referral to a new provider.

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

The provider could have made this conversation more comfortable by asking clarifying questions and not assuming that all people are sexually active. The provider must also consider that, although lack of interest in sex can be associated with depression and other mental health diagnoses, not all people fit into this category. The assumption that the lack of sexual desire was a mental health crisis or "something wrong" was based on the PCP's implicit bias.

? What explicit or implicit biases were present in the interaction?

The PCP assumed that those who choose not to engage in sexual activity are "broken." In addition, the PCP seemed to assume that they knew Molly's identity better than Molly. The provider demonstrated discomfort in their nonverbal cues — widening eyes and shifting in their seat.

? How did the biases affect the interaction and the patient outcome?

Molly did not complete her exam, left feeling defeated, and lost faith in her once trusted provider.

? What are the probable feelings elicited in the interaction for the patient (and family if applicable) and the provider?

Patient: Molly felt shame, fear, mistrust and embarrassment. The provider, in making several assumptions, unintentionally "othered" Molly. Molly, who had previously trusted her provider, felt taken aback by the comments made by the provider. The incident had a ripple effect as a microaggression quickly resulted in the end of the appointment.

Provider: The provider showed shock and misunderstanding when Molly shared her identity.

? What (if anything) was positive about the experience for the provider or the patient?

The patient was able to find a LGBTQIA+-competent provider at a health care organization in the city.

? What was negative about the experience for the patient and the provider?

Molly did not complete her exam and left with the impression that her PCP felt there was something wrong with her identity. She felt ashamed and immediately sought new care.

The provider lost an established patient and missed opportunities to connect with the patient and the greater LGBTQIA+ community.

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

Implicit and unconscious bias is hard to unlearn if training for medical students is not implemented from the beginning of their education. The lack of inclusive curriculum will only impede the process of discovering and eliminating one's biases. A large study of first-year medical students demonstrated that nearly half reported having negative attitudes toward people in the LGBTQIA+ community. Over 80 percent reported having negative evaluations of LGBTQIA+ people compared to their heterosexual counterparts.[17,18] Providers must also consider implementing an ongoing commitment to learning about gender identity and sexual orientation. In this scenario, the provider was unfamiliar with the evolving definition and understanding of the asexual spectrum. As an estimated 1 percent of the population is asexual, this scenario may have been avoided with heightened awareness and ongoing training.[19] The lack of education on issues such as this contributes to unfortunate encounters like the one Molly experienced.

To better serve the LGBTQIA+ patient population, it is important to recognize that LGBTQIA+ identities are not one-dimensional. As is true for many demographics, the LGBTQIA+ community branches far beyond the letters of the acronym. To stay current with evolving language, organization staff should recognize the intersections present within the LGBTQIA+ community and how they may influence quality of care. For example, some individuals may have differing romantic and sexual orientation; although sexual orientation is often used as a primary identifier, romantic identities hold equal validity.

Definitions

- **Asexual –** An adjective used to describe people who do not experience sexual attraction (e.g., asexual person). A person can also be aromantic, meaning they do not experience romantic attraction.

- **Cisgender –** A term used to describe people whose gender identity corresponds with the sex they were assigned at birth (i.e., people who are not transgender).

- **Gender identity –** One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

- **Lesbian –** A woman who is attracted to women. Sometimes also or alternatively termed "same-gender-loving woman" or "woman loving woman."

- **Romantic/affectional orientation –** Describes the pattern of a person's romantic attraction, or the gender of the people a person falls in love with or desires to partner with.

- **Sexual orientation –** Describes the pattern of a person's sexual attractions based on gender. Sexual attraction and romantic attraction are often lumped together as if they are the same, which is not always the case.

To better illustrate this concept, the Venn diagram below can be used as an example regarding Molly. Molly is a cisgender woman who is a lesbian and is also asexual. This means Molly is romantically attracted to other women but does not experience sexual attraction. All of her identities hold substance and play a significant part in her lived experience. In this scenario, the bias that impacted Molly was related to her asexuality. Acknowledging and respecting the whole person and their unique identities is imperative in providing competent care.

Molly's Identities

Cisgender Woman

Lesbian

Asexual
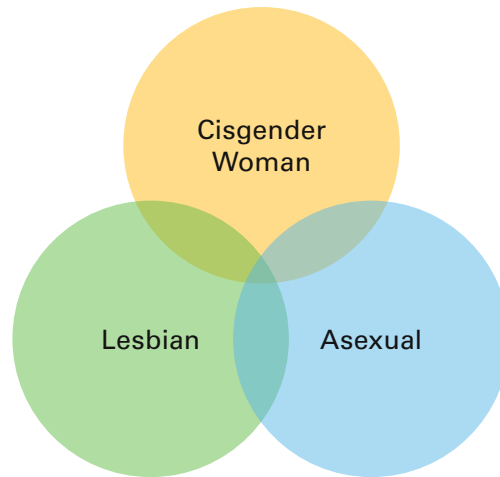
Graduate medical education has been trying to resolve some of these emerging issues. One study showed that when medical students had lower implicit-bias scores upon entry to medical school, they were more likely to have had frequent contact with LGBTQIA+ faculty, residents, students and patients. Those with higher scores were more likely to have been exposed to faculty who exhibited discriminatory behavior. Further, in terms of race, the study found that students who entered medical school with lower implicit-bias scores and many positive past experiences with people of different races were more likely to build on those experiences during medical school. The authors of the study concluded that medical students who come with less implicit bias have less anxiety toward, greater empathy toward, and less difficulty treating LGBTQIA+ patients and patients of different races, ethnic origins, gender identities, etc.[20]

A 53-year-old, white, female patient, Valerie, had an exposure to COVID-19 and presents to an urgent care clinic for a COVID-19 test. Valerie, a registered nurse and director at a local community health center, is in good health, well groomed, well spoken, and knowledgeable about her exposure. Valerie is well versed about COVID-19 testing as she organizes the process for her clinic sites. After checking in, Valerie is told to come back in several hours for her testing appointment. Valerie arrives back at the clinic when she was told to and presents to the front desk. Another patient arrives after Valerie; however, he is called into the exam room for his appointment immediately. The next patient called back to the exam room is another person who was behind Valerie in line, followed by the next four patients who checked in after Valerie.

Valerie has Tourette's syndrome, a disorder that involves repetitive movements or unwanted sounds (tics) that cannot be easily controlled. Her tics consist of head movements and some wrist/arm movements to her chest. While these are distracting, Valerie exhibits no other behaviors. Most of the time the tics are in relatively good control; however, with stress and excess caffeine, they tend to get worse.

Valerie is delayed returning to work and continues to become more anxious and frustrated, as she needs to get back to the center. Somehow, this testing process has unexpectedly taken up most of the day. Finally, after many trips to the front desk to check on the status, she is called into the exam room for her test. The medical assistant completes the COVID-19 test and tells Valerie to wait for the provider to come in for an exam. Wondering why this is necessary for a COVID-19 test, Valerie waits for approximately 10 minutes.

The provider enters the room, and her first comment is "I see you have tics. How long have you had them?" Valerie answers, "I've had them for many years. It is fine — I am just here for a COVID-19 test." Yet the provider asks again, "So how old were you when they started? Are you being medically managed for them?" Valerie replies again, "Really, it is fine. I am medically managed." (She does not take any medications for them, as they do not work for her, but for lack of anything else to respond, she implies she is treated.) The doctor looks at Valerie's chart and states again, "Are you sure you are treated for them? They are very noticeable." "Yes, I am managed," Valerie says, "and again, I only came for the COVID-19 test. I do not need anything else from you, I am good." The doctor questioned how the tics affected her life. Increasingly frustrated, Valerie states she is fine and really needs to get back to work. After performing a quick exam, the physician completes the appointment and, on her way out the door, the physician states, "If you need any help with your tics or anything else, I would be happy to help you."

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

For a person with Tourette's, as with many other diagnoses, if health care providers or staff think that they are pointing out something that the person is not aware of, they are sadly mistaken. Additionally, continuing to bring up the syndrome makes the situation worse for the patient, and nothing can be done at that moment in time. Starting the visit by addressing the chief complaint of the patient will help establish rapport and open the opportunity for exploring added medical history.

❓ What explicit or implicit biases were present in the interaction?

Initially, Valerie felt as though the tics were the reason why she was not called for her appointment at the correct time. Each time the next patient was called before her, was the clinic making Valerie wait after looking in her chart and seeing the Tourette's diagnosis listed? Whether the physician thought she was being helpful or not, her continued questioning was evidence of explicit bias — the physician's assumption was that Valerie needed something other than what she was there for and that clearly she needed medication so the tics would go away.

❓ How did the biases affect the interaction and the patient outcome?

The interaction did not affect the outcome of the exam; however, the physician did outwardly show her bias and potentially her limited knowledge of Tourette's syndrome, its treatment, and how a person with Tourette's navigates the world.

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

Valerie felt annoyed and dumbfounded at having experienced yet another example of a health care provider assuming that her physical movements are a huge red flag and needed to be removed or taken care of no matter what the situation.

She may have thought the physician was trying to be helpful, but still the provider exhibited ignorance and an inability to focus on the reason for the visit.

❓ What was negative about the experience for the patient and the provider?

Again, the interaction was irritating. Valerie indicated that Tourette's had nothing to do with the reason for the visit. Valerie acknowledged that tics can be distracting; however, providers must be able to focus on the patient, not stare or noticeably gawk at what is going on — again, it makes things worse and is uncomfortable for the patient. "The provider would undoubtedly not gawk if I were overweight or missing a limb," Valerie concluded. "Conversations such as this potentially make one feel unseen and feel that this one insignificant diagnosis is what the person is, not just a small part of the person."

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

The AMA has initiated proactive intervention strategies for providers and office practice staff toward recognizing and dealing with bias in the office setting:

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices, physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication, and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.[21]

Risk managers are in the unique position to be able to interact with providers and staff at all levels of practice in the outpatient environment. Their communication and education about mitigation strategies to reduce implicit bias in the ambulatory care setting is a proactive risk management approach that will add value to both the patient and provider experience.

Geriatric

■ SCENARIO

An 85-year-old woman, with medical comorbidities and mild cognitive impairment, was referred by her PCP to a gastroenterologist (GI). At her first GI appointment, accompanied by her daughter, the appointment started with the front desk staff calling the patient "Honey," to her dismay, and continued with the physician calling her by her first name. Her response: "I don't know you. My name is Mrs. Cleary." The doctor proceeded to basically ignore her, and talked to her daughter, who moved to stand behind her mother so the doctor would at least look in her mother's direction. The daughter asked the doctor to talk to her mother, not about her mother. The doctor talked over the patient when she discussed her symptoms; she felt he was not listening to her, was determining her treatment plan without actually assessing the problem and was treating her as though any GI problems were related to aging. The patient proceeded to get angrier and stopped listening to the doctor, deciding that she was not going to follow any advice from him since he ignored her concerns and treated her so dismissively.

The patient spoke with the office manager to address her concerns about the experience, but the office manager was defensive, kept saying what a good doctor he was, and did not listen to the patient's complaint. As she was leaving, the patient overheard the office manager say to the aide: "I don't know what these old people want. It's not like they are still productive members of society. All the money spent on them. They've outlived their usefulness. And she has the nerve to complain."

After hearing that discussion, the patient decided that she was no longer going to seek treatment for her problem and told her daughter she might as well die. The daughter called the hospital administrator since the GI practice was part of the hospital system.

? What explicit or implicit biases were present in the interaction?

This interaction had numerous flags of implicit bias in the form of microaggressions. A microaggression is "a statement, action, or incident regarded as an instance of indirect, subtle, or unintentional discrimination against members of a marginalized group such as a racial or ethnic minority."[22]

These microaggressions were present in this situation:

- Calling the patient "Honey" rather than by her name
- Calling the patient by her first name without asking if that is acceptable to the patient
- Talking to the daughter and not the patient without even assessing the patient's mental capability, assuming her age made her incapable of speaking for herself
- Ignoring the daughter's request to speak directly to the patient
- The office manager's giving a defensive response, blaming age for the complaint, and ignoring the issue

In this scenario, the microaggressions were related to 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."[23]

Ageism is pervasive, insidious, often unnoticed, and very rarely called out. Nonetheless, it can have consequences for health care: "Old people usually are the ones who receive less expensive and less innovative treatments compared to young people."[24]

In a systematic review published in *PLoS One* on January 15, 2020, scientists found evidence that ageism bias adversely affects older people's health in 96 percent of the studies.[25] This report stated:

■ "Analysis of targets who are at most risk of ageism found older persons with lower levels of education were more likely to experience adverse health effects of ageism. This finding is in line with broader health-inequity literature that suggests members of disadvantaged social groups are more likely to become targets of discrimination."

■ "This review also found a concerning trend of increasing ageism-health associations over time when health care professionals were targeters [persons perpetrating ageism]. This pattern echoes other reviews that revealed the growing practice of structural ageism by health care professionals. For instance, two recent systematic reviews showed that nurses' as well as nurse-trainees' attitudes toward older persons have grown more negative over the last decade. The increasing ageism-health associations in health care providers may be due to the growing time pressures: they are often required to see patients more quickly and to add [to their tasks] the input of clinical information into electronic medical records."

? How did the biases affect the interaction and the patient outcome?

The patient became reluctant or unwilling to seek appropriate medical care, leading to unnecessary pain and suffering.

This type of response can lead to increased health care costs as the patient in this scenario and others of age are denied access to care, causing health problems to worsen.

For the provider, the incident had an impact on the practice's reputation as the patient discussed her experience with friends at the senior center, where the patient is the president of the center's community group.

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

By avoiding stereotyping, health care providers demonstrate recognition of the humanity of each patient, regardless of age and cognitive abilities. Despite a patient's declining cognitive function, including the patient in the conversation is indicative of respect and inclusion.

A 68-year-old Asian man, Michael Cho, has been experiencing frequent headaches, muscle weakness, and a light rash on the cheeks and nose. Michael asks his daughter to accompany him to his appointment with a new physician and arrives at a physician's practice in rural Iowa. During check-in, the patient service representative notes that Michael is having a difficult time communicating in English and can tell he is growing frustrated in describing his symptoms and the reason for his visit. The representative responds with patience and lets him know that his daughter is welcome to assist in explaining his headache, muscle weakness and rash.

When called to the exam room, Michael goes alone. Behind the scenes, the patient service representative lets the physician and nurse know that a translator may be helpful in providing Michael with the most patient-centered care. The physician and nurse arrive in the exam room and ask Michael if he would like a translator. The translator, presented via tablet, suggests that Michael's daughter attend the exam as well, and he consents. After establishing guidelines, the two are able to work in tandem, with the translator providing medically accurate information and with his daughter offering clarity between the translator and Michael. Michael is able to receive a proper diagnosis in the language most comfortable to him and his family. Michael later returns to this provider for his primary care and feels supported within the practice.

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

This scenario offers a positive look at addressing the needs of a patient who speaks English as a second language. To continue these positive interactions, health care providers should consider training their staff on implicit bias associated with speaking another language and/or implicit bias as it relates to a person's accent or tone of voice. Additionally, organizations should consider hiring individuals who speak more than one language, when possible.

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

Michael received a diagnosis in an environment where he felt he received compassionate and culturally competent care. He will be more likely to return to receive follow-up care and will have further trust in the medical system. Although this is not guaranteed, Michael may share his experience with others in his community, continuing to generate community trust and practice referrals. As many people in marginalized communities express distrust with regard to 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 appreciative of the provider's sensitivity. There was a sense of inclusion and belonging.

Family: The family felt they could trust the system and felt relief that their father received culturally competent care.

Provider: The physician appreciated that the information needed to provide safe and appropriate care was available and used in the patient's care and treatment, thus decreasing risk for a wrong or missed diagnosis. The health care team was not frustrated by trying to figure out what the patient was saying and were able to meet his needs. The daughter did not need to act as an interpreter, thus avoiding inaccurate translation of medical terminology and/or the potential that the daughter would supply her own responses to the questions asked, especially with any sensitive information needed from the patient.

? What (if anything) was positive about the experience for the provider or the patient?

This was a positive experience for both the patient and the providers. Michael received quick access to a translator, and then the care team was able to meet his comfort level by including his daughter as he received a diagnosis. The providers can walk away from this interaction knowing that they did not let the patient's language impact his care.

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

In the future, the care team can assess their readiness to respond to patients who speak English as a second or additional language. This may include access to a translator, having translated forms readily available, and offering an annual training on best practices to ensure that this type of positive interaction continues to remain the norm.

■ SCENARIO

A 75-year-old, Black, lesbian patient went to the urgent care clinic late one evening last spring and filled out paperwork, including the gender "female." She reported: "At the time, I was wearing short hair, no bra, and a shirt and pants. I was in a lot of pain. I had to wait quite a long time to be seen by the physician. Others who came in after me were seen before me without any explanation." After an hour, she said, "I asked when I could be seen since my pain was getting worse" and got mumbling about "another angry old Black woman. I asked the receptionist to clarify what she said, but she just turned away. I am so tired of being stereotyped as an aggressive or hostile Black woman when I speak up while others can rant and rave without any repercussions. I feel sometimes that I am lower than pond scum: Black, lesbian, and old."

The patient continued: "The same receptionist called me 'sir' when I registered and rolled her eyes when I corrected her. She continued to call me 'sir' throughout the evening although my name was clearly female. When I got a 'what kind of service did you receive?' survey form two weeks later, I filled it in and got no response although I asked for one. The nearest other emergency department or urgent care clinic is over an hour away, and I have not chosen to go to it although I remain uncomfortable about going to this urgent care clinic."

? What explicit or implicit biases were present in the interaction?

The interaction involved bias in these ways:

- Persistence in calling her "sir" even when corrected
- Rolling eyes when corrected about gender identity
- Mislabeling the patient based on her appearance
- Delay in being seen after registration
- Stereotyping the patient as "another angry Black woman"
- Ignoring the patient's request for a response to the survey

? Did age and race play a part in the bias?

The older, Black, LGBTQIA+ community faces fears of discrimination and poor health outcomes.[26] For LGBTQIA+ persons of color, concern about discrimination due to their sexual orientation or gender identity can be hard to separate from concerns of discrimination due to their race or ethnicity.[27]

? What are the probable feelings elicited in the interaction for the patient?

Consider what the patient and those of her age group have dealt with over time. In 1973, homosexuality was removed from the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-II) classification of mental disorders and replaced by the category "Sexual Orientation Disturbance." This represented a compromise between the view that preferential homosexuality is invariably a mental disorder and the view that it is merely a normal sexual variant. While the 1973 DSM-II controversy was highly public, more recently a related but less public controversy involved what became the DSM-III category of Ego-dystonic Homosexuality, which proposes that what is at issue is a value judgment about heterosexuality, rather than a factual dispute about homosexuality.[28] This patient would have been in her 20s in 1973. People who came out at that time had to deal with the stigma of mental illness, homosexuality and criminality.

The LGBTQIA+ person in this age group, living with these stigmas, experiences fear of illness and dependency. Most LGBTQIA+ people lack a provider whom they consider to be their personal doctor and often find themselves seeking medical care from a provider with whom they do not have a trust relationship. Their gender identity may be a secret they have kept for years, and now they may be uncertain how to tell their sexual orientation to providers. One patient reported that her primary care practice included "lesbian" on her problem list in their medical records.

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

Provide educational opportunities for all staff who interact with patients via role-playing exercises and/or anticipated scenarios related to providing care with cultural humility. Consider repeating training on (at least) an annual basis to reinforce the expectations for behavioral norms and the culture of safety for both the organization and the individual staff/provider.

ADDITIONAL MEASURES TO IDENTIFY AND ADDRESS IMPACTS OF NEGATIVE IMPLICIT BIASES IN THE AMBULATORY CARE SETTING

Whether the aim is preventing litigation, complying with state/federal regulatory requirements and/or meeting accreditation standards, some commonalities include the need for documentation, policies and procedures, training/education, competency verification, and recognition that implicit-bias training/education/awareness (or lack thereof) can impact litigation exposure, accreditation, and regulatory compliance regardless of the type of ambulatory care setting. As described above, the risk manager plays a pivotal role in advocating that the organization commit to educating staff on implicit-bias awareness, providing cultural competence skills training, and instituting system processes designed to reduce the clinical impact resulting from encounters involving negative implicit biases.

In addition to the strategies discussed throughout this white paper, a foundational tool widely used to help begin the process of awareness and identification of individually held implicit biases is the Implicit Association Test (IAT). The IAT is a five-part, timed cognitive test, and during the test, participants are asked to sort and group facial images (African American faces and European American faces) and words expressing "good" or "bad" evaluations and/or stereotypes. The score is based on the difference in time taken to sort and group these images; the individual's speed in sorting the images demonstrates the individual's implicit-bias preferences. Further, taking the IAT often reveals a difference between implicit attitudes about race measured by the IAT compared with the test taker's self-reported or explicit attitudes and stereotypes about race.[29,30]

Additional measures to help reduce and respond to the presence of negative implicit biases in the ambulatory setting may include the following:[31]

- Educating providers and staff on cultural sensitivity and implicit-bias awareness, using tools such as the IAT

- Creating a diversity and inclusion committee to address overall cultural competence within the organization

- Implementing policies and procedures that support cultural competence and person-centered care

- Providing language assistance as required by federal law and periodically validating the cultural competence and linguistic fluency within the organization

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

- Providing education and training regarding the importance of using objective, descriptive documentation practices

- Engaging executive leadership and relevant stakeholders, such as the board of directors, in understanding state/federal antidiscrimination laws and their application within health care

CONCLUSION

Bias manifests itself in a variety of ways and to varying degrees in the ambulatory care setting. Negative implicit biases lead to less than positive health care experiences and outcomes. While most implicit-bias studies in health care treatment have been conducted with Black patients and non-Black providers, other researchers are investigating the presence and impacts of implicit bias in relation to other ethnic groups, people with obesity, sexual and gender minorities, people with mental health and substance use disorders, older adults and people with various health conditions.[32]

Growing recognition and acknowledgment of bias and its effect on patient experiences in the ambulatory setting demonstrates that change is necessary, and approaches to solutions must be multifaceted. The health care risk manager plays a major role in advocating for system changes and mitigating the impact that negative bias has on our health care delivery system. As always, when implementing risk mitigation strategies, it is important to know your federal, state and local regulations in addition to developing sound organizational policies and procedures and to seek legal advice where appropriate.

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APPENDIX A:
ASSESSMENTS, GUIDES AND CHECKLISTS

Material	Demographic Focus	Description and Utility
Becoming a Culturally Competent Health Care Organization	All ages	A guide best used to implement cultural humility and competency best practices at an organizational level
Implicit Association Test	All ages	Test serving primarily as an individual assessment of one's own biases
An Implementation Checklist for the National CLAS Standards	Adult	Checklist of implementation and best practices in providing culturally and linguistically appropriate services (CLAS)
Project Implicit Study Materials	All ages	Background and materials for the Implicit Association Test
4 Ways Health Care Organizations Can Utilize the Implicit Association Test	All ages	An organizational approach to utilizing the Implicit Association Test
Implicit Bias Resource Guide	Pediatric	Tools and resources for children's health organizations related to implicit bias
Inclusive Services for LGBT Older Adults: A Practical Guide to Creating Welcoming Agencies	Geriatric, LGBTQIA+	A brief checklist to ensure a welcoming organization for LGBTQIA+ older adults; addresses stereotypes and special considerations
Healthcare Equality Index	All ages, LGBTQIA+	Benchmarking tool that evaluates health care facilities' policies and practices related to the equity and inclusion of their LGBTQIA+ patients, visitors and employees
Cultural and Linguistic Competence Health Practitioner Assessment	All ages	Self-assessment tools for providers
Proven Strategies for Addressing Unconscious Bias in the Workplace	Adult	Tools, checklists and case studies on addressing bias in the workplace
EveryONE Project Implicit Bias Training Guide	Adult	Facilitator guide for those interested in discussing implicit bias

APPENDIX B:
ADDITIONAL RESOURCES ON IMPLICIT BIAS
IN AMBULATORY HEALTH CARE

Child and Adolescent

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