Diversity and Inclusion in Quality Patient Care

Your Story/Our Story – A Case-Based Compendium

Marcus L. Martin
Sheryl Heron
Lisa Moreno-Walton
Michelle Strickland
Editors

Second Edition

Springer

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"A powerful narrative of voices, Your Story/ Our Story should help all people – doctors, nurses, patients, and our communities – understand and reflect on the role bias plays in our lives. Whether we are patients or providers, a must read for us to understand and bring forth solutions to create a healthy environment."

—Kenny Leon
Tony Award-winning director and producer
True Colors Theatre Company

"This sentinel book, edited by experts in the field, not only examines the damaging impact of unconscious bias on patient care, but on the professional development and effectiveness of healthcare professionals and trainees. The chapters in this book are ideal training cases and discussions relevant for medical education seminars and simulations. They supply not only realistic scenarios, but credible solutions for managing knowledge gaps and establishing equity in health care. A must read for practitioners, educators and consumers alike."

—Richard Carmona, M.D., M.P.H., F.A.C.S.
17th Surgeon General of the United States
Distinguished Professor at the
University of Arizona

"As medical care becomes a global concern, the role of unconscious bias, cultural competency, and attitudes of inclusion becomes imperative for discussion in healthcare practice and education. This book takes several steps in raising awareness and proposing solutions that can lead to a decrease in the disparities we now see around the world. Access to care is more than just being able to get to the place where care is given. It means getting to the person who has the ability to understand the problem and the motivation to leverage the resources to fix it. For healthcare providers who want to be that person, this book is a tool towards getting there."

—Lee Wallis
Immediate Past President of the
International Federation of Emergency
Medicine and Past President of the African
Federation of Emergency Medicine

Preface

Diversity and Inclusion in Quality Patient Care: Your Story/Our Story—A Case-Based Compendium expands upon our first textbook, *Diversity and Inclusion in Quality Patient Care*. It illuminates the narratives of individual's experiences with biases in various healthcare environments and settings. This textbook is to be used as an educational resource by all levels of healthcare providers, patients, and those who serve and advocate for them. Our editors have extensive backgrounds in clinical and academic health care as well as leadership and expertise in equity, diversity, and inclusion. The three editors who published the original book (Drs. Martin, Heron, and Moreno-Walton; *Diversity and Inclusion in Quality Patient Care*), during the journey from student to full professorship, have experienced many of the scenarios you will be reading. In addition, they have mentored countless healthcare professionals through their individual journeys. This book considers the stories of students, nurses, residents, advanced practice providers, staff, and physicians in the various stages of their professional lives, as well as the patients they serve.

We recognize that a tremendous knowledge gap exists in research on the impact of implicit bias in health care. However, the significance on individuals of the various microaggressions they experience daily in seeking or providing care must be addressed and cannot be ignored.

Included in the 69 chapters are pre-case and case-based content written to provide an in-depth understanding of biases as well as real-life scenarios of race, culture, sexual orientation, religion, gender, disability, and other unique human attributes. Above all, our teaching cases recognize the influence of unconscious bias, also known as implicit bias, microaggressions, and the sensitive approach of healthcare providers to the diverse groups they will encounter. The names of the providers and patients have been changed to protect confidentiality; however, the circumstances are authentic.

The proliferation of literature on unconscious bias and microaggressions has raised public awareness. Biases are bidirectional and include patients, families, communities, providers, and trainees. This case-based compendium addresses how healthcare providers can respond with professionalism and dignity to unconscious

bias and microaggressions and these lessons extend to patients, families, and trainees within their environments where biased assumptions and attitudes exist.

Big journeys begin with small steps. Each chapter in this book provides a step toward your/our understanding that we all have biases. We hope that the *Diversity and Inclusion in Quality Patient Care: Your Story/Our Story—A Case-Based Compendium* will inspire you to take these steps toward change.

Charlottesville, VA, USA — Marcus L. Martin
Atlanta, GA, USA — Sheryl Heron
New Orleans, LA, USA — Lisa Moreno-Walton
Charlottesville, VA, USA — Michelle Strickland

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We specifically acknowledge the efforts of Lindy Steiner, Stephanie Bossong, Emmanuel Agyemang-Dua, DJ Cunningham, and Gail Prince-Davis for their research efforts and assistance with editing.

In addition to serving as one of our editors, Michelle Strickland provided outstanding project management and communications with authors and the publisher.

Three of the editors are founding members of the Academy for Diversity and Inclusion in Emergency Medicine (ADIEM) which is within the Society for Academic Emergency Medicine (SAEM), committed to eliminating healthcare disparities by recognizing the role that implicit biases and microaggressions play.

Your Story/Our Story would not be possible without the strong contributions of the many authors dedicated to providing culturally competent care while addressing disparities and bias in health care.

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Editor Biographies

Marcus L. Martin, M.D. is a professor and past chair of the Department of Emergency Medicine at the University of Virginia (UVA). He held the chair position from July 1996 to December 2006. Dr. Martin's emergency medicine responsibilities included the adult and pediatric emergency departments, chest pain unit, express care, Pegasus air ambulance, the Blue Ridge Poison Center, paramedic training program, emergency medicine residency program, and several emergency medicine fellowship programs. During his tenure at UVA, Dr. Martin served as the assistant dean of the School of Medicine and assistant vice president, associate vice president, and interim vice president and chief officer for diversity and equity. In 2011, he was appointed vice president and chief officer for diversity and equity. Dr. Martin is the principal investigator of the Virginia-North Carolina Alliance, a National Science Foundation-funded Louis Stokes Alliance for Minority Participation (LSAMP) program. He is the founder of Emergency Medicine Center for Education Research and Technology (EMCERT) and initiated the medical simulation program at the University of Virginia School of Medicine.

He earned his Bachelor of Science degrees in Pulp and Paper Technology (1970) and Chemical Engineering (1971) from North Carolina State University and was employed as a production chemical engineer at WESTVACO in Covington, Virginia. A member of the charter class of Eastern Virginia Medical School and the first African-American graduate, he earned his medical degree in 1976.

Dr. Martin was commissioned by the US Public Health Service and later served as a general medical officer at the Gallup Indian Medical Center in New Mexico. He completed his emergency medicine residency training at the University of Cincinnati in 1981 and held a series of staff and administrative/teaching posts at Allegheny General Hospital in Pittsburgh.

He was a board member for 12 years and past president of the Society for Academic Emergency Medicine (SAEM). He is a past president of the Council of Emergency Medicine Residency Directors. He is the recipient of the 2008 SAEM Diversity Interest Group Leadership Award, named the Marcus L. Martin, MD Leadership Award in his honor. Dr. Martin is the lead editor for the books *Diversity and Inclusion in Quality Patient Car*e (Springer International Publishing, 2016) and

West Indies Health Care and Disaster Preparedness (Create Space Independent Publishing, 2015). The UVA Board of Visitors established the Marcus L. Martin Distinguished Professorship of Emergency Medicine in December 2016.

Sheryl Heron, M.D., M.P.H. is a professor and vice chair of Administrative Affairs in the Department of Emergency Medicine, the assistant dean for Medical Education and Student Affairs on the Grady Campus, and the associate director of Education and Training for the Injury Prevention Research Center at Emory (IPRCE). Prior to attending medical school, Dr. Heron obtained her Masters in Public Heath degree from Hunter College in New York City in 1989 and focused on community health education. She graduated from Howard University College of Medicine in 1993 and subsequently completed her emergency medicine residency training at the Martin Luther King/Charles Drew Medical Center in 1996. That year, she joined the faculty of Emory University School of Medicine as the first African-American woman in Emergency Medicine. In 2002, she was sworn in by the governor to serve as a commissioner on the Georgia Commission on Family Violence and worked to craft a medical protocol to address family violence in the state of Georgia.

Dr. Heron has lectured extensively on the medical response to intimate partner violence as well as wellness/work-life balance and diversity/disparate care in emergency medicine. She has received several awards including the 2011 Women's Resource Center's Champions for Change, Partnership Against Domestic Violence's HOPE Award, the Woman in Medicine Award from the Council of Concerned Women of the National Medical Association, and the Gender Justice Award from the Commission on Family Violence and was named a hero of Emergency Medicine by the American College of Emergency Physicians. Dr. Heron served as a chair of the National Medical Association's Emergency Medicine section where she mentored several faculty, residents, and students in their career path within emergency medicine. From her efforts, Dr. Heron was selected as the first recipient of the Marcus L. Martin, MD Leadership Award, presented during the SAEM annual meeting in Atlanta in 2009, and served as the inaugural president of the Academy for Diversity and Inclusion in Emergency Medicine (ADIEM) of SAEM. Dr. Heron is also the inaugural recipient of the Emory School of Medicine Excellence in Diversity and Inclusion Award for 2018. She is sought after to be a visiting professor and has lectured extensively on diversity and inclusion in emergency medicine and implicit bias.

Lisa Moreno-Walton, M.D., M.S., M.S.C.R., F.A.A.E.M. is the Nicolas Bazan professor of Emergency Medicine, Department of Medicine, Section of Emergency Medicine, in the School of Medicine at Louisiana State University Health Sciences Center-New Orleans (LSUHSC-NO) and secretary-treasurer of the American Academy of Emergency Medicine.

Dr. Moreno-Walton's academic and professional appointments are numerous. Along with her appointment as a full professor, she serves as the director of the Division of Research, the Division of Diversity, and the Viral Testing Program for the Section of Emergency Medicine at LSUHSC-NO. Dr. Moreno-Walton holds an

academic appointment in the Department of Surgery at Tulane University School of Medicine.

Prior to her appointment at LSUHSC-NO, Dr. Moreno served as a faculty physician in emergency medicine at the North Bronx Healthcare Network and at the Lincoln Medical and Mental Health Center, both in the Bronx, New York. She is board certified in emergency medicine and completed her residency training at the Jacobi-Montefiore program in the Bronx.

Dr. Moreno-Walton is the recipient of numerous teaching awards. She has developed graduate and postgraduate curricula for core content and research in emergency medicine and has mentored 300 undergraduates and medical students, residents, and junior faculty to successful career development and research productivity.

Dr. Moreno-Walton earned her Master of Science in Clinical Research from Tulane University in June 2011. Since that time, she has been awarded 20 grants to study trauma, HIV, healthcare disparities, hepatitis C, and syphilis. She has given over 450 abstract presentations and 250 invited presentations and has more than 100 scholarly publications. Dr. Moreno-Walton has won 15 research awards and, in 2013, was named a National Institutes of Health PRIDE Research Scholar. She recently created a curriculum for developing emergency medicine research in resource-poor environments, a course that she teaches internationally. She lectures widely on the topics of cultural competency, healthcare disparities, HIV, and trauma.

Dr. Moreno-Walton wrote the charter to found the Academy for Diversity and Inclusion in Emergency Medicine (ADIEM), Society for Academic Emergency Medicine (SAEM), and continues to serve on its board. In 2013, she was the recipient of the Marcus L. Martin, MD Leadership Award presented during the SAEM meeting in Atlanta, Georgia. In 2014, she was the only physician in the United States to receive the Alpha Omega Alpha Professionalism Award for her work to eliminate healthcare disparities. In 2015, she was designated as a master educator by the Academy for Scholarship, Council of Emergency Medicine Residency Directors.

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Part I
Bias in Health Care

Chapter 1
Introduction

Marcus L. Martin, Sheryl Heron, Lisa Moreno-Walton, and Michelle Strickland

Diversity and Inclusion in Quality Patient Care, Second Edition: Your Story/Our Story—A Case-Based Compendium Part I is a pre-case section containing relevant chapters addressing bias in health care. The seven chapters that follow are complimentary to those published in our first textbook on *Diversity and Inclusion in Quality Patient Care* (DIQPC), which emphasizes culturally appropriate care, requiring healthcare providers to recognize and understand medical education traditions, and other impeding factors potentially fueling biases. Quality care is created through a community sensitive to differences in race, culture, sexual orientation, disability, religion, socioeconomic status, and any other human variations. DIQPC provided a broad array of chapters and teaching cases to educate the healthcare community about quality patient care, including the following topics in the pre-case section:

Defining Diversity in Quality Care
Racial/Ethnic Healthcare Disparities and Inequities: Historical Perspectives
Educating Medical Professionals to Deliver Quality Health Care to Diverse Patient Populations
Culturally Competent Faculty
Culturally Sensitive Care: A Review of Models and Educational Methods

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Interpreter Services
The Patient-Physician Clinical Encounter
Spiritual Care Services in Emergency Medicine
Lesbian, Gay, or Bisexual (LGB): Caring with Quality and Compassion
Culturally Competent Care of the Transgender Patient
Looking Past Labels: Effective Care of the Psychiatric Patient
Disability and Access
Racial and Ethnic Disparities in the Emergency Department: A Public Health Perspective
Vulnerable Populations: The Homeless and Incarcerated
Vulnerable Populations: The Elderly
Vulnerable Populations: Children
Religio-cultural Consideration When Providing Healthcare to American Muslims
Disparities and Diversity in Biomedical Research

In Part I of *Diversity and Inclusion in Quality Patient Care, Second Edition: Your Story/Our Story—A Case-Based Compendium*, pre-case topics include unconscious bias, microaggressions, gender and transgender bias, cultural competencies in the deaf patient, and the impact of bias on global health care. In Parts II–VI, teaching cases are presented that address bias in health care related to the experiences of patients, medical and nursing students, residents, nurses, staff, advanced practice providers, and attending physicians.

Chapter 2
The Inconvenient Truth About Unconscious Bias in the Health Professions

Laura Castillo-Page, Norma Iris Poll-Hunter, David A. Acosta, and Malika Fair

"Not everything that is faced can be changed, but nothing can be changed until it is faced." – James Baldwin

Introduction

In 2003, the Institute of Medicine (now the National Academy of Medicine) released two reports that focused widespread attention on the crucial issue of disparities in healthcare access [1, 2]. These pivotal reports documented that Americans' access to quality care was fractured along racial and socioeconomic lines and concluded that "bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care" [1]. The reports included equity of care as one of the six pillars of quality health care and pointed out that, as long as health disparities exist, our health system cannot claim to deliver quality care to all patients [1, 2].

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More than 15 years later, a multitude of studies demonstrate examples of health disparities and inequities in healthcare delivery. Patients of color—especially black and African-Americans, Hispanics, and Native Americans—have higher overall risks and poorer outcomes than whites with a wide range of conditions, including asthma, diabetes, HIV/AIDS, hypertension, obesity, preterm births, and tuberculosis. Racial and ethnic minority patients have less access to quality care and have lower life expectancies and higher mortality rates [3]. These differences cannot be explained away solely by socioeconomic status, patient preference, lack of health insurance coverage, or other external factors. While health inequity is a multifactorial problem, health professionals must also recognize the role provider attitudes, behavior, and clinical decision-making play in unequal care and disparate health outcomes [3–5].

Despite federal Title VI protections in place against overt discrimination in the workplace or in patient care, incidences of explicit bias—in which individuals are aware of their prejudices toward certain groups—persist [6]. There is also a subtler form of prejudice that can be more difficult to address. This is called unconscious—or implicit—bias, meaning the prejudices we are not aware of.

With today's intense focus on the population's health, healthcare organizations and healthcare professionals of all types are looking at ways to improve the delivery of quality health care. It is clear that meeting the goals of the Triple Aim—to improve the healthcare experience, improve the health of populations, and reduce the costs of care [7]—requires that we confront the unconscious biases that influence quality care [4].

Discussion

Unconscious Bias in Health Care

Healthcare professionals pledge to "do no harm," adhere to ethical standards, and support the rights of patients to receive equal care. Many clinicians would deny that they treat patients differently based on characteristics such as race, gender, weight, age, sexual orientation, or disability [4]. However, reports of discrimination and inequitable care remain common [3–5, 8–11]. This disconnect is likely a direct result of unconscious bias.

Unconscious bias affects everything from the admissions processes at health science schools to the hiring and promotion of healthcare professionals, the administration of healthcare organizations, and—ultimately—the delivery of care to patients [5, 8, 12, 13].

What Is Unconscious Bias?

Based on research into unconscious bias, our brains operate on associations—automatic responses or shortcuts that allow us to quickly interpret and respond to our environment. In the blink of an eye, the brain takes in bits of data, interprets them,

and leads us to conclusions—all without us realizing it is happening. By quickly categorizing situations, people, images, and sounds, we recognize friends, family members, symbols, and letters on the page, for example. This sorting is involuntary and happens in a millisecond, without conscious thought. Our capacity to sort helps us learn, keeps us safe, and allows us to build on previous knowledge [14, 15].

While this process is normal, and very human, it also has unintended consequences—especially in health care—where quick thinking can make the difference in a patient's diagnosis and treatment. Sometimes these split-second judgments provide us with accurate, useful, and even lifesaving information. But some may also be inaccurate and unintentionally obstruct our decision-making and relationships with patients and even inflict unintentional harm [5, 9, 10, 14–17]. This is unconscious bias.

None of us are immune to unconscious bias; it permeates all aspects of society. Scholars have detected and documented unconscious bias in education, criminal justice, and employment practices [17]. A recent review of the literature found that the prevalence of unconscious bias in the health professions is as high as it is in the general population. The same review determined that 20 out of 25 studies found at least some evidence of bias in clinicians' diagnosis, treatment, or interaction with patients based on characteristics such as race, ethnicity, sexual orientation, gender, weight, mental illness, substance abuse, disability, and social circumstances [18]. Moreover, the high-stress environment of health care may increase the incidence of unconscious bias [17, 19]. Researchers found that cognitive stressors such as time pressure, competing demands, overcrowding, stress, and fatigue were associated with an increase in implicit bias among emergency room physicians [20].

In 2016, the Joint Commission issued a Quick Safety bulletin on implicit or unconscious bias. The authors wrote:

> The ability to distinguish friend from foe helped early humans survive, and the ability to quickly and automatically categorize people is a fundamental quality of the human mind. Categories give order to life, and every day, we group other people into categories based on social and other characteristics. This is the foundation of stereotypes, prejudice and, ultimately, discrimination…. Studies show people can be consciously committed to egalitarianism, and deliberately work to behave without prejudice, yet still possess hidden negative prejudices or stereotypes [21].

What the Research Shows

In their 2017 literature review, FitzGerald and Hurst found that despite advanced training in a profession that strives for objectivity, clinicians are just as likely as anyone else to harbor unconscious bias. They reviewed 42 peer-reviewed journal articles that examined unconscious bias in different aspects of health care over the course of a decade and noted that there is a complex relationship between clinical decision-making and a clinician's unconscious bias. While this may not always translate into negative treatment outcomes, a trusting relationship between a healthcare professional and her patient is essential to providing good treatment. Thus, it seems likely that the more negative the clinical interaction, the worse the eventual