



Perspectives on Bias in Medicine

Perspectives on Bias in Medicine

As Experienced by Health Professionals and Patients

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Aiko Yonamine | December 6, 2017

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Chapter 1 - Introduction

Introduction



Bias.....Mocks | Mocks 108 | CC BY-NC-SA 2.0

In this book, we will explore the impact of bias on the experiences of healthcare providers, learners preparing to be providers, and patients in the healthcare setting.

All human beings have biases, which seem to be a type of primal defense mechanism that is hard-wired. Implicit or unconscious biases deal with thoughts and behaviors that happen without our awareness and outside of our control; they are triggered by social judgments and inferences which we often do not notice as having an impact on our cognition. These judgments and inferences are in turn triggered by personal appearance or other obvious characteristics of an individual, often compounded by social stereotypes regarding those characteristics. Having formed an unconscious bias regarding an individual, we then may tend to use information learned later to confirm our preexisting beliefs.¹

Experts have found that time pressure, fatigue, stress, and information overload increase our tendency to use unconscious biases to shortcut our decision making.¹ These factors are prevalent parts of the medical landscape for patients and providers.

Unconscious or implicit biases may often lead to decisions that one would not make based on rational thought, stated or deeply—held personal beliefs, or egalitarian principles; the results can be prejudicial, and can negatively affect patient care, interprofessional and collegial behaviors, educational decisions, and quality of life.¹

Fortunately, unconscious or implicit biases can be exposed and acknowledged, and their impacts reduced to allow a more diverse and inclusive medical environment.²

The IAT, or Implicit Association Test, is available online at implicit.harvard.edu and reveals implicit biases of test takers toward a variety of characteristics. Awareness of our biases is the first step toward reducing them and their impacts on our daily lives and the lives of others. Among the findings of Project Implicit, which has analyzed over 4.5 million IAT results between 1998 and 2006, are that implicit biases are pervasive; that they impact behavior; and that people are not aware of their own biases.¹

Fortunately, there is a way forward; once biases are discovered, they may be reduced and their effect on decisions in the healthcare arena may be reduced. Several strategies are offered by the Institute for Healthcare Improvement to accomplish these goals. These include: Stereotype replacement (adjusting the response to acknowledge the stereotype one would otherwise address); Counter-stereotype imaging (imagining the individual as opposite of the stereotype); Individuation (learning about the individual as a person and about their health care context, vs. looking at them as representative of the bias they would otherwise represent); Perspective-taking (putting oneself in the other person's place); and Increasing networking and Partnership building with diverse persons, framing them as equals. The rigorous practice of employing evidence-based medicine, regardless of the identity of the patient, has also proven a way to de-bias patient care.²

Purpose of this Book

“Perspectives on Bias in Medicine” begins each chapter with the IAT that correlates with the bias being discussed in that passage. The exception is Poverty, which generates bias but has no assigned IAT; an alternative opening exercise is recommended for this Chapter. The technique of individuation, or allowing health providers and patients affected by bias to speak for themselves so you can see through their eyes, is used to helping reduce bias and is incorporated in the form of patient interviews and videos. Questions at the end of each chapter are designed to help you recall factual details relevant to the discussed bias, alluded to in the accompanying chapter text which amplifies on the bias being discussed. They should also serve as a springboard to allow you to reflect on how to further reduce and speak out against the incorporation of bias into collegial relationships and patient care in the future.

We hope you enjoy this book.

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Chapter 2 - Race and Ethnicity

2.0 Race and Ethnicity

Leon McDougale MD MPH and Camilla Curren MD

We begin this book with this chapter where we will look at race and skin-tone bias.

Introduction

The purpose of this chapter is to provide an overview of racial bias and attitudinal disadvantages experienced by people.



Blurred Lines | Chrisena Allen | CC BY-SA 2.0

Learning Objectives

By the end of this chapter, you should be able to do the following:

- Identify racial bias in the medical community.
- Identify racial bias in physician/patient relationships.
- Describe techniques to neutralize the effects of racial bias or to ameliorate its severity.
- Describe the negative effects of racial bias and discrimination when it is not recognized or addressed, from the perspective of the interviewee.

Self-Exploration:

Prior to reading the Race Chapter, you will be asked to take a self-test.

1. Read the **Preliminary Information** and **disclaimer**, then click on “**I wish to proceed**” to take the test. [Click to complete the Race-IAT and Skin-tone IAT located in Harvard University’s Project Implicit website.](#)
2. After taking the test, read the next section to see perspectives on racial and ethnic bias in health care.
3. You will then have the opportunity to complete a knowledge check to see if you gained a heightened understanding of racial and ethnic bias in health care.
4. Use this opportunity to learn more about conscious and unconscious bias in health care, to retake the IAT test(s) and to reflect on how you can apply what you’ve learned in this chapter.

2.1 Acknowledging Racial and Ethnic Bias in Patient-Healthcare Provider Relationships

Leon McDougale MD MPH and Camilla Curren MD

Overview of racial and ethnic bias in patient-healthcare provider relationships

Racial and ethnic bias held by patients and healthcare providers may lead to unequal treatment outcomes.¹⁻⁴ Establishing a therapeutic relationship between patients and healthcare providers requires mutual respect and a willingness to overcome bias and cultural barriers to effective communication. More commonly in recent years, healthcare providers are participating in self-reflective exercises such as taking the Implicit Association Test (IAT) and completing implicit bias awareness and mitigation classes. The goal of this approach includes becoming self-aware of unconscious bias and consciously adjusting attitudes to allow for receptiveness to providing patient-centered and culturally competent care.⁵⁻⁷

Whereas most of the focus has been on providing tools for healthcare providers, the growing use of patient – healthcare provider electronic communication platforms via the electronic medical record may provide future opportunities for implicit bias awareness and mitigation training for patients.⁸⁻⁹ This is critical since bias of patients toward healthcare providers may result in negative healthcare outcomes including inadequate patient compliance and decreased healthcare provider job satisfaction.¹⁰⁻¹³

It's not uncommon for healthcare providers who are from groups underrepresented in the health professions to observe the differences between European American male privilege and themselves when providing cross-cultural care.¹⁴ Examples include how an underrepresented healthcare provider may be overlooked by a patient in favor of a more junior European American male healthcare provider or trainee when entering a hospital room or clinical office. To illustrate this point, Dr. Darrell Gray has observed a relatively high frequency of being asked to provide an extensive listing of details about where he went to college, medical school, and residency when providing cross-cultural care.

Prejudice and bias in the medical community based on race and ethnicity among professionals?

Microaggression, also known as microinequity is a term developed in 1970 by a psychologist named Dr. Chester M. Pierce. These repetitive manifestations of bias may be unintentional but the impact can accumulate over

time. These subtle, stunning and often automatic and non-verbal exchanges which are ‘put-downs’, whether intentional or unintentional, communicate hostile, derogatory, or negative racial slights and insults toward people of color.¹⁵⁻¹⁶

Dr. Darrell Gray, who is board certified in both internal medicine and gastroenterology, reported how a hospital nurse sought approval of his evidence-based orders by an accompanying European American male who was a trainee with less experience and expertise.

Dr. Alejandro Diez, who is board certified in both internal medicine and nephrology, reported how other healthcare professionals can make misguided comments that question his Latino ethnicity based on stereotypes and lack of awareness about the diversity of the Hispanic and Latino populations. “He doesn’t look Latino.” “How am I supposed to know you’re Hispanic.”

[Prejudice and bias in the medical community w/ Drs. Darryl Gray and Leon McDougale](#)

Prejudice and bias in provider/patient relationships can be based on race and ethnicity

Unconscious bias may also result in healthcare provider acceptance of unsubstantiated beliefs about differences in patients based on race and ethnicity. For example, an African American female patient complained that she had experienced racism during her hospitalization. When the registered nurse (RN) caring for her tried to administer an abdominal heparin injection, the needle did not go in on the first attempt. The second attempt was successful and the patient said “ouch.” The RN “explained” that pigmented skin is more difficult to inject. The patient remembers the comment as “It is this dark skin that is keeping the needle from going in.” The patient was very disturbed by the comment and told the RN, who was likewise upset by the patient’s reaction. The charge RN was made aware and went to see the patient. The patient says that the charge RN confirmed to the patient that it has been her experience as well that this is true.

This important quality of care issue also appears to be related to a somewhat common, but false belief and has implications for pain management. A survey study from the Proceedings of the National Academy of Medicine

reported that 25% of the 28 participant European American medical residents polled falsely believed that Black skin is thicker than White skin.³

This may also be a case of personally mediated racism whereby differential assumptions about race led to differential action. Such racism can be unintentional or intentional and was manifested by a perceived difference in skin thickness that may have caused the RN to stick the African American patient twice instead of once.¹⁷

This patient complaint led to additional education for the nurses involved and provided an opportunity for continuous quality improvement across the hospital to help maintain compliance with the [Joint Commission pain management statement](#).

Techniques to reduce the severity of racial and ethnic bias in healthcare

Providing micro-affirmations by communicating how someone from a cross-cultural background has been an asset to the achievement of goals may counteract and provide protection against microaggressions and microinequities. Whereas microaggressions and microinequities diminish opportunities for therapeutic relationship building, micro-affirmations build confidence, resilience, and relationships.¹⁶

Dr. Gray observed that acknowledging bias is the first step and that racial and ethnic bias may be impacting patient-healthcare provider relationships. Identifying commonalities of values or interests may serve as a method to repair or build an effective therapeutic relationship between the patient and healthcare provider. Dr. Gray notes that identifying personal values and commonalities shared by patients and healthcare providers may place them on a more even playing ground and improve interpersonal relationships.

Dr. Diez states that the common thread is recognition of bias. Healthcare providers should take the opportunity to explain how the biased statement was offensive. However, there is a fine line between being confrontational and informative. For instance, if a person uses the term “Oriental” a response could be to explain how the inappropriate term may make others feel. This could include a statement similar to “I think you meant to say Asian” to facilitate an informative and respectful discussion.

[Alejandro Diez, MD, Nephrologist at OSU Wexner Medical Center discusses “Counteracting Bias in Medical Relationships” with Leon McDougale, MD MPH](#)

Negative effects of unidentified or unaddressed bias and discrimination

Research has shown that increased levels of healthcare provider bias towards a patient lead to less “team-ness” in decision making and decreases the likelihood that the therapeutic plan will be followed.¹⁸ Dr. Gray states that unrecognized bias may lead to fewer options for care being offered including a decreased likelihood of affected patients being asked to participate in clinical trials. This may create disparate healthcare outcomes and lead to negative interactions between the healthcare community and discordant racial, ethnic, and cultural groups.

Dr. Diez states that unrecognized bias and discrimination may reflect poorly on the institution and healthcare provider. The opportunity cost may be reflected in persons from that community seeking care elsewhere. In addition, the poor experience may lead to avoidance of healthcare providers and result in higher morbidity, mortality, and healthcare expenditures for emergency care.

An example from Dr. Diez involves how the provider’s tone and lack of explanation prior to removing family members from a Latino patient’s room to perform a procedure may be off-putting to the patient and family. Allowing the patient to be more involved in the decision and to take ownership of the disease treatment may result in a better relationship with patient and family.

2.2 Race and Ethnic Bias Knowledge Check

Complete the following knowledge check to see how people experience racial and ethnic bias.

[Diving Deeper with Racial and Ethnic Bias Knowledge Check](#)

2.3 Race and Ethnic Bias References

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Chapter 3 - Obesity

3.0 Obesity

In this chapter, we will look at bias against people with obesity.

Introduction

The purpose of this chapter is to provide an overview of bias and attitudinal disadvantages experienced by people with obesity.



127 between Chubby Cherubs | Mackenzie-Campbell John | CC BY-NC-ND 2.0

Learning Objectives

By the end of this chapter, you should be able to do the following:

- Identify bias in the medical community against people with obesity in Interprofessional relationships.
- Identify bias against people with obesity in physician/patient relationships.
- Describe techniques to neutralize the effects of bias against people with obesity, or to ameliorate its severity.
- Describe the negative effects of bias and discrimination against people with obesity when it is not recognized or addressed, from the perspective of the interviewee.

Self-Exploration:

Prior to reading the Obesity Chapter, you will be asked to take a self-test.

1. Read the **Preliminary Information** and **disclaimer**, then click on “**I wish to proceed**” to take the test. [Click to complete the Weight-IAT located in Harvard University’s Project Implicit website.](#)
2. After taking the test, read the next section to read perspectives on bias against people with obesity.
3. You will then have the opportunity to complete a knowledge check to see if you gained a heightened understanding of bias against people who have obesity.
4. Use this opportunity to learn more about conscious and unconscious bias in health care, to retake the IAT test(s) and to reflect on how you can apply what you’ve learned.

3.1 Understanding Bias Against People with Obesity

Camilla Curren MD

The Patient Perspective

“You need to lose weight,” “Stop eating so much,” and, “You get bigger every time you are admitted; I guess you just can’t stop eating,” are common pieces of advice and personal observations bestowed upon Mark Collins and Mariah Marsh, two Columbus patients who have experienced bias against obese patients –even as they have fought to resolve this acknowledged medical problem within the recommendations of the medical system. They have not found the remarks, delivered by healthcare providers, to be helpful.



“You can boycott a barber shop or store where the people are rude to you, but you need medical care and cannot boycott the medical establishment.”

“You can boycott a barber shop or store where the people are rude to you, but you need medical care and cannot boycott the medical establishment,” points out Collins. A patient who has explored every known medical avenue for weight loss, Collins has comorbid conditions caused directly by obesity that compel him to see several different specialists and to attend a few appointments and studies a month just to maintain his current level of health. Sometimes, he admits, he is uncomfortable leaving the house because “people look at me funny,” and so he just does not go to medical appointments or to exercise or PT appointment for his obesity-related orthopedic issues. “Bias has kept me from seeking help I should have and from follow-ups I should do.”

The Last Acceptable Bias?

In fact, bias against people with obesity has been well documented and is nearly pervasive in patients and in society as a whole, including medical trainees and practitioners. This leads healthcare providers to make careless or insensitive remarks that fall below the standard of helpful or actionable patient counsel. ^{1,3} This finding has led to increased attention to obesity as a medical illness and to multiple types of interventions to decrease students’ and physicians’ expression of bias in medical fields. ^{1, 2, 8}

Bradley Needleman, MD, Medical Director of the Comprehensive Weight Management & Bariatric Surgery Center of The Ohio State University Wexner Medical Center, agrees that obesity is one of the last biases generally treated as if it is acceptable by many in the medical profession. Needleman notes that he has witnessed providers

making unflattering remarks about the size of bariatric surgery patients in the operating room in a joking manner and that it is difficult to extinguish this type of behavior. He notes that this bias extends to discrimination against overweight or obese peers, as evidenced by negative evaluations of obese residents by program directors, who may view being overweight as evidence of poor self-care skills. Needleman believes that this discounts the complexity of obesity as a disease, and the multiple factors that go into weight control.

Reducing the Impact of Bias

Some of the most promising interventions shown to reduce expressions of bias against individuals with obesity involved the use of the arts and theater as a springboard to discussion of obesity scenarios. While it did decrease explicit prejudicial behaviors, the use of theater techniques was not shown to increase empathetic interactions between medical students and obese patients.¹ Students undergoing only traditional medical lecture-based curricula were more likely, compared to those with added behavioral sciences approaches to the problem, to deliver traditional advice to lose weight to obese patients, and to demonstrate lack of understanding of the perspective or motivations of the obese patient.^{1,2}

Social Determinants Contribute to Illness

Morbidly obese patients face other obstacles to adequate or commensurate health care, including costs for comorbidities related directly to obesity and a lack of resources that may have contributed to the problem in the first place. While nutritious and low-calorie foods are difficult to obtain in areas with few supermarkets or with limited transportation, they are also more expensive.¹⁰ This information is corroborated by Marsh, a health professions student currently on disability for her asthma, a condition worsened by obesity. She is dependent on city buses for transportation and has trouble getting to appointments and has difficulty affording medications and nutritious foods prescribed as part of her overall therapy. So does Collins.

Improving Quality of Care by Reducing Bias



“Health care professionals need to be aware of contributors that lead to poor weight loss or to gain in obese patients who are actually trying very hard to reduce body mass indices (BMI).”

Marsh can cite several instances in which she feels her other medical conditions, including headaches, (which turned out to be pseudotumor cerebri) and shortness of breath (which turned out to be life-threatening asthma) were ignored or misattributed to being “out of shape” by providers. She feels that health care professionals need to be aware of contributors (such as high dose prednisone for asthma and many other medications, such as several antidepressants) that lead to poor weight loss or to weight gain in obese patients who are actually trying very hard to reduce body mass indices (BMI). In addition, she makes a plea for more individualized, patient-centered care that would help the obese patient to be less stigmatized and anxious in health care settings and would help detect other problems, related or unrelated to obesity, and treat them promptly.⁴

Marsh’s wishes are echoed in some healthcare literature, which recommends measures such as bias training for medical staff (instruments such as the IAT and zero tolerance policies for BMI-related jokes), using adequate sized office furniture and handicapped equipped venues to avoid awkward physical situations for obese patients, and educating providers on the many and multiple genetic, environmental, biological, psychological and social contributors to weight.^{4,7} Providers who understand the interrelated health factors leading to obesity show more positive and comprehensive health care behaviors in managing the health of overweight patients.^{4,5} This more comprehensive, personalized information is likely more helpful for their patients than paternalistic messages like “exercise more and eat less.”⁶ Subsequently, obese patients treated in a more comprehensive fashion may be more likely to overcome common obstacles and to succeed to a greater degree in weight loss programs and will be less likely to let poor body image or fear of embarrassment preclude their attendance at medical appointments for routine medical care. Routine care is avoided, as Collins suggests, by many obese patients when compared to their contemporaries with a more normative BMI.⁷

[Improving Quality of Care by Reducing Bias Brad Needleman Interview w/ Dr. Cami Curren](#)

The impact of bias on reducing the prevalence of obesity

Once she attains her degree, Marsh is likely to face the increased stigma of patients against obese healthcare professionals. According to a 2013 study published in the *Journal of Obesity*, patients viewed overweight or obese physicians with less trust and were less inclined to follow their medical advice and more inclined to change physicians; this behavior persisted regardless of the body mass index of the patient.³ This finding is in keeping with the high bias against obesity in society at large.^{1,7}

Research has indicated, in fact, that public policies designed to combat the obesity epidemic will need to combine interventions in social and environmental determinants of health with an emphasis on individual responsibility for weight control in order to be effective and acceptable to the American public.⁹

3.2 Bias Against People with Obesity Knowledge Check

Complete the following knowledge check to see how people with obesity experience bias.

[Diving Deeper with Obesity Bias Knowledge Check](#)

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Chapter 4 - Age

4.0 Age

Laurie Belknap DO and Camilla Curren MD

In this chapter, we will look at age bias.

Introduction

The purpose of this chapter is to provide an overview of bias and attitudinal disadvantages experienced by older adults.



Couple of Couples | neovain | CC BY-SA 2.0

Learning Objectives

At the end of the Age Chapter, you will learn to:

- Identify age bias in the medical community in interprofessional relationships
- Identify age bias in physician-patient relationships
- Describe techniques to neutralize or ameliorate the effects of age bias
- Describe the negative effects of age bias and discrimination when it is not recognized or addressed

Self-Exploration:

Prior to reading the Age Chapter, you will be asked to take a self-test.

1. Read the **Preliminary Information** and **disclaimer**, then click on **“I wish to proceed”** to take the test. [Click to complete the Age-IAT located in Harvard University’s Project Implicit website.](#)
2. After taking the test, read the next section to read perspectives on unconscious age bias.
3. You will then have the opportunity to complete a knowledge check to see if you gained a heightened understanding of age bias in health care.
4. Use this opportunity to learn more about conscious and unconscious bias in health care, to retake the IAT test(s) and to reflect on how you can apply what you’ve learned in this chapter.

4.1 Acknowledging Age Bias in Medicine

Laurie Belknap DO and Camilla Curren MD

Understanding Age Bias

Barbara is a 90-year-old woman who recently moved to a rural Ohio town to be closer to her youngest son. She is independent and healthy, and until a year ago lived alone in a cabin in the Colorado Rocky Mountains.

The elevation and isolation of the cabin became problematic as Barbara aged, and her family became concerned about access to health care. The only hospital was a regional care facility about 45 minutes away.

After relocating to Ohio, Barbara decided to establish care with a primary care physician. She scheduled her appointment in an outpatient Family Medicine office. When she arrived in the waiting area, the receptionist spoke to her in a very loud voice even though Barbara has no problems with hearing. Barbara laughed when the receptionist mistakenly assumed that her son was her husband. The medical assistant escorted her back to the examination area and asked what medications Barbara was taking. Barbara replied that she uses Natural Tears for dry eyes, but that she has never taken any medications. The medical assistant asked repeatedly for medications and dosing. “Perhaps she just doesn’t remember,” she said to the patient’s son.

The physician was pleasant and polite, but also seemed a bit frustrated with Barbara’s visit. “I just don’t know how I will be able to bill this since there is nothing wrong with you,” she told Barbara. “Medicare won’t pay if you are healthy.” Barbara was not sure what to offer in order to help the physician but felt as though she was pressured to have some kind of physical ailment. “I think I need a tetanus shot,” she said, remembering that her daughter in law had mentioned that she might need one when they spoke the day before. “And I need to see an eye doctor about my vision,” even though Barbara had already seen an ophthalmologist a few months before leaving Colorado. That seemed to make the physician happy, and so Barbara left the office after receiving a tetanus shot and a referral to an eye doctor for presumed decreased vision.



Barbara likes to garden and enjoys shopping for flowers.

What messages are being sent to Barbara about her health through her experience with the providers? What actions, by the providers were the result, either directly or indirectly, of attitudinal bias? How did provider bias impact the care that Barbara received? What might the primary care practice have done differently that could have improved Barbara's care?

Aging and Bias in the Medical Community

Ageism is a term used to describe stereotyping that can ultimately lead to discrimination against older people. While ageism may vary in different cultures, causes for bias against older people can be multifactorial and socially complex, and may possibly originate in childhood or early clinical training experiences.¹ Health care providers may further be predisposed to the development of ageism due to increased exposure to chronically ill or medically fragile patients at the end of life.²

In fact, bias against the elderly may be the strongest and most socially acceptable bias.¹ In one study, groups of nursing students and working nurses exhibited negative implicit attitudes towards older people, though nursing students had less implicit attitudinal bias than working nurses.³ In another study, evidence was found to suggest that mental health providers believed that mental illness was a normal part of aging and that older adults would not benefit from psychotherapy.⁴ Medical care providers with more experience had decreased negativity in attitudes toward older patients, but this article also suggests that clinical experience and level of training are not predictive of a provider's attitude toward the elderly.²

Anti-aging bias among healthcare providers can affect decisions regarding the evaluation and treatment options that are offered to older adults and could result in disparities in health care for the elderly.^{4,5}

The Medical Impact of Bias Against Older Persons

The presence of attitudinal bias in the medical community can transcend the confines of the profession and impact patient care at many levels according to a recent literature search. While several studies have looked at the impact of ageism among primary care providers^{2,5} others have demonstrated age-related bias among other providers including rehabilitation professionals.⁶ The cause of bias may be multifactorial.¹ Several factors are theorized as being contributory to physician or health care provider preconceptions about aging and older adults.

One study suggested that a lack of general knowledge or decreased understanding of normal aging processes among primary care physicians can result in inadequate or improper patient care.² The degree of contribution of knowledge deficit to bias seems to depend upon the age of the provider, as well as on his or her ethnicity and/or race. The contribution of ethnicity and race to the development of bias against the aging has been termed in one study "cultural ageism."⁷ Another study investigated the presence of beliefs about declining memory as an age-related change across the lifespan. High school aged students, college students; middle-aged and older adults in the community were studied. The findings supported the author's hypothesis that high school students and younger participants had more stereotypical and less accurate views of memory decline with aging than did the other groups.⁸

There are many other common misperceptions about older people. Common beliefs include the ideas that older adults are unable to adapt to change or learn new information, that they are often bored, irritable or angry, or

that they become more religious with age. One study found that the vast majority of the time, these assumptions are incorrect.² In addition, healthcare providers often assume that older people are not sexually active, or are not interested in sexual activity. But one article suggests that this is simply not true and that one half to two-thirds of older adults are sexually active. This study also suggests that the biggest limitation to sexual activity is the lack of a partner, especially for older women.⁹ Older patients may not be appropriately counseled about or screened for sexually transmitted infections due to erroneous provider assumptions about their sexual activity.^{9,10}

Hearing loss is also commonly associated with aging by healthcare personnel.

“They think we are all deaf,” says Lois, age 75, “but I can hear just fine.” Her reflection is supported by one study, which suggests health care providers often assume hearing loss is associated with normal aging. And while hearing can decline with age and can even contribute to profound sensory impairment that increases social isolation, it is not inevitable or usually untreatable.^{11,12}

Physician and Provider-Patient Relationships: The Cost of Attitudes About Aging

Despite known implicit biases among medical students and healthcare professionals, there can be a clear dissociation between implicit bias and explicit attitudinal and behavioral measures.^{13,14} What we say or do may differ from what we believe, but the relationship between elderly people and their health care providers can be significantly impacted by implicit or explicit bias.

“They all think we are demented,” says one elderly woman. “I like my doctor’s office, but they always act like I am forgetful.” Her point is supported by evidence that age-related memory decline is likely due to decreased cortical volume which can result from disease or chronic conditions. Interestingly, cumulative years of education has been shown to have a protective effect on cortical volume with preservation of memory.¹⁵

A literature search supports other patients’ observations that mental health professionals may believe that mental illness is normal in aging.⁴ Given this misconception, accurate diagnoses or appropriate treatments may be overlooked by the physician. One study confirmed that, despite the knowledge that depression and suicide is a major national health problem, physicians were less willing to treat older or retired patients despite recognizing suicidal ideation.¹⁶ Healthcare professionals’ perceptions of older adults could also be disadvantageous to seniors in need of less critical mental health care. The same symptoms of mental health issues were judged to be clinically less severe in older adults than in younger patients according to one study.⁴ Another study suggested that primary care physicians were less likely to treat depression and suicidal ideation in older patients, despite adequate recognition of the presence of either condition.¹⁶ The underutilization of mental health services by seniors is likely a result of many factors, but bias among mental health providers or primary care physicians may be a contributing cause.⁴

Yet another study found that there is age bias often found in physician recommendations for physical activity for arthritis management in adults⁵, with physicians consistently recommending exercise to younger patients but not conveying that standard advice to their older ones.⁵

Bias in Interprofessional Relationships

Bias by colleagues against older physicians “begins earlier than you think it does”, according to Pat Ecklar,

MD, a retired Columbus internist with 40 years of experience in treating adults of all ages, including many senior patients. Dr. Ecklar previously served as the internal medicine residency director for Mt. Carmel Health and is now a faculty member at the OSU College of Medicine. Ecklar points out that remaining competent and up-to-date on medical care advances is incumbent upon all physicians, but that these skills are sometimes questioned by learners and colleagues when the physician is over 50 years of age. Similarly, studies indicate that physician cognitive performance¹⁷ and stress tolerance¹⁸ decline with aging, although the overall effects on patient care are difficult to determine due to the complex mix of factors that go into clinical care provision.¹⁷ Nonetheless, the relevance of the older physician as clinician or medical teacher may be questioned by patients and learners who define medical care and competence more narrowly, according to Ecklar. And calls for proven competency maintenance through simulation or other means have been made by various medical societies where older physicians are concerned.¹⁸ Nonetheless, Ecklar points out that the breadth of experience of older physicians is often valuable to colleagues as well, and that some seek the advice of more experienced clinicians. And Beverly Laubert points out that, at a recent conference of Ohio Medical Directors, older physicians were front and center embracing telehealth, advanced technologies, and inclusive language to benefit the care of older patients.

[Interprofessional Perceptions of Older Doctors w/ Drs. Pat Ecklar and Laurie Belknap – YouTube Video](#)

Strategies to Reduce the Effects of Bias

Strategies to reduce attitudinal bias and its effects among healthcare providers should begin early in training, if not in elementary and middle schools, and should be approached in several ways according to Beverly Laubert, Ohio's Long-Term Care Ombudsman. Several studies suggested that cross-cultural education about elderly people and aging would be beneficial to reduce negative attitudes about aging and to benefit interactions with older adults.^{4,7} Older people should blend in as an unremarkable part of the community, and aging should be normalized, according to Laubert. One recent study found that although primary care providers did not appear to have negative bias toward older people, knowledge of normal aging was lacking.² Laubert points out that all physicians should be learning more about taking care of aging patients as the geriatric population percentage increases; this increased patient volume will not be able to be managed by geriatric specialists alone. . The same study also suggested that educational interventions to improve knowledge of age-related physiological changes, as well as training to improve physician competencies in working with a multidisciplinary team, were successful in helping primary care providers deliver a holistic approach that improves care for seniors.²



Beverly Laubert, Ohio's Long-Term Care Ombudsman since 1994, leading advocacy efforts for older adults. She has led the development of Ohio's [Long-Term Care Consume Guide](#) and earned the Governor's Award for Employee Excellence in 2012.

Findings from medical education literature suggest personal bias can be reduced, and resulting patient care can be improved.¹ Most of the studies described learning methods primarily focused on the recognition of implicit personal bias in providers and provision of training to reduce these influences on provider actions and decision making.

The positive impact of faculty role modeling was also noted in one study, with a benefit to trainee shown by faculty members exemplifying enthusiasm for providing geriatric care.^{1,19} The same study showed that students are given the opportunity to participate in service learning with seniors and then to apply their experiences in subsequent classroom activities not only learned from their experiences but also recognized the individuality of the seniors and experienced personal attitudinal or emotional growth.²⁰

Laubert, Ecklar, and the seniors interviewed for this chapter agree that “treating everyone the same” and ignoring age-related bias negates the individuality and special traits of seniors that would otherwise allow them to age as they have lived the rest of their lives— and to maintain maximal health.

[Strategies to Reduce the Effects of Bias with Beverly Laubert and Dr. Laurie Belknap – YouTube Video](#)

[Dr. Pat Ecklar talks with Dr. Laurie Belknap about Healthy Older People in Our Society – YouTube Video](#)

4.2 Age Bias Knowledge Check

Complete the following knowledge check to see age bias in medicine.

[Diving Deeper with Age Bias in Medicine Knowledge Check](#)

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Chapter 5 - Poverty, Class, and Privilege

5.0 Poverty, Class, and Privilege

Laurie Belknap DO and Camilla Curren MD

Introduction

The purpose of this chapter is to provide an overview of bias and disadvantages experienced by those in poverty or with socioeconomic disadvantage.



poverty | Aaaarrrrgggghhhh! | CC BY 2.0

Learning Objectives

At the end of this chapter, you will learn to:

- Identify bias in the medical community in interprofessional relationships with providers with a

background of poverty.

- Identify bias in physician/patient relationships with patients with poverty.
- Describe techniques to neutralize or ameliorate the effects of bias against persons with poverty in the medical setting.
- Describe the negative effects of bias and discrimination against persons with poverty when it is not recognized or addressed.

Self-Exploration:

Prior to reading the Poverty, Class, and Privilege Chapter, you will be asked to take an exercise, watch and read articles on Poverty, Class, and Privilege.

1. There is no IAT Test on Poverty nor Privilege but in this section, you will still be able to explore your own experience by looking at [Beyond the Privilege Walk at Tolerance.org](#)
2. Read [Privilege as a Social Determinant of Health in Medical Education: A Single Class Session Can Change Privilege Perspective](#)
3. Watch [What is Privilege? – YouTube](#)
4. Read the next section to read perspectives on Poverty, Class, and Privilege bias.
5. You will then have the opportunity to complete a knowledge check to see if you gained a heightened understanding of Poverty, Class, and Privilege bias.
6. Use this opportunity to learn more about conscious and unconscious bias in health care, to retake the IAT test(s) and to reflect on how you can apply what you've learned in this chapter.

5.1 Acknowledging Poverty, Privilege, and Class Bias in Medicine

Laurie Belknap DO and Camilla Curren MD

Origins of Poverty and Social Class Differences

Persons at lower income levels have consistently demonstrated less social mobility overtime than have more wealthy Americans. So generally speaking, if you started out life at the bottom of the economic ladder, you have a decreased likelihood of moving up compared with those starting at higher levels.¹ What is the influence on health and well-being of starting out at a lower socioeconomic status? The role of poverty and its social impact on childhood development is well established, as is the fact that poverty has a significant role in creating lifelong limitations and in continued promotion of poverty for future generations.² The stunting of physical growth and cognitive development can make it less likely that a child will attend school, and can cause problems with social and emotional development that contribute to poor performance in school.² Childhood poverty and the resulting consequences cause high levels of social and emotional stress.³ Social conditions such as foster care and the involvement of child protection agencies can lead to emotional dysfunction and predispose affected children to the development of mental illness later in life.³ Children from underprivileged backgrounds or from backgrounds of social and economic deprivation are more likely to perform poorly in school, leading to a lack of education that causes profound and lifelong impact.³

Socioeconomic status has been identified as a prominent stratification factor for determinants of health

Economically advantaged people have better health outcomes than the less advantaged.⁴ One study demonstrated that sociodemographic factors created additional access barriers for Hispanic patients with diabetes resulting in lower utilization of healthcare and higher disease management expenditures. The same study found that Hispanic patients with diabetes were typically younger, but had higher poverty rates, less education, and lower physical activity levels when compared to non-Hispanics in the general U.S. population.⁵ Another study demonstrated that a person's neighborhood of residence can predict cardiovascular mortality.⁶ Low socioeconomic status is known to be linked to increased cardiovascular risk factors.⁷ The results of another empirical analysis showed that those with higher perceived socioeconomic standing and greater resources have better health than those who have

lower standing and fewer resources. In this study, self-reported health, dental health, and happiness were strongly associated with subjective assessments of social position.⁸

The prioritization of daily necessities for disadvantaged populations can become a way of life, which can sometimes mean that health needs are postponed or not addressed at all when resources are scarce. Healthcare and medical insurance can come long after meeting basic needs for many people who experience financial constraints or poverty.⁹ For example, Pamela Taylor, a resident clinic patient with several chronic medical problems, regularly uses a food pantry and must often decide between going to the grocery or to physician's appointments as she can only afford 1/8 tank of gasoline per benefit check. Even given this frugality, she has difficulty making house payments and may soon end up homeless.

[Socioeconomic Status as Prominent Stratification Factor for Determinants of Health w/ Miss Pamela Taylor and Dr. Cami Curren – YouTube Video](#)

Poverty and Bias Against Patients

Dr. James Mann, an Internal Medicine Resident at The Ohio State University Wexner Medical Center, recalls several instances while he was working in the Emergency Department as an aid (before he entered medical school), where physicians or other medical staff made incorrect assumptions about patients because the patient was homeless or underprivileged.

“I don’t feel like there had been a lot of education about poverty in a medical school, or probably most medical schools, at this point, so most people wouldn’t really know how to deal with those types of people unless they had some type of experience with that.”

Dr. Mann, whose family comes from an economically disadvantaged background, noted that often providers had the perception that poverty or homelessness was a choice.

As with many biases, provider perceptions may originate from a remotely related factual cause. The role of health and perceived control at the individual level were examined in one study. The authors hypothesized that a lack of autonomy and lack of optimism combined with a perception of having little control over life would result in a low level of trust in social institutions and negatively affect the health of the population. The findings of the study were consistent with this model and showed an association between low control and self-rated poor health.^{10,11} Suggestions for causes of this finding included contributory health behaviors and potential neuroendocrine pathways.¹¹

Pamela Taylor notes that patients living in poverty often are not aware of medical options that are available to more wealthy patients and that lower health literacy is a usual contributor to the problem. Lower health literacy is a pervasive problem when poverty interferes with adequate education. She feels she has been made more aware of health care options by being associated with a University residency clinic which has a team care approach including social work support but notes that advocacy for patients seeking reduced-cost or episodic care for problems vs. those with a medical home may be lacking. “There is no booklet on how to be poor and get good care,” she adds.

[Poverty and Bias Against Patients w/ Drs. Laurie Belknap and James Mann – YouTube Video](#)

Structural and Attitudinal Barriers to Health Care for Patients in Poverty

The structural organization of healthcare systems contributes to adverse patient outcomes when the result is a lack of access to resources. One study found that health outcomes were worse for patients who lived in an area with fewer resources when concentrations of deprivation and privilege were used to compare health outcomes. In this study, a numeric assessment called the Index of Concentration at the Extremes was used as an indicator of health equity and found to be more indicative of population health status than measuring poverty levels.¹²

Dana Vallangeon, M.D., is a family medicine physician and a graduate of the Ohio State University College of

Medicine. She is the founder and C.E.O. of the Lower Lights Christian Medical Center which provides health care to approximately 14,000 underserved patients in the Franklinton neighborhood of Columbus.

“In the last 15 years there has been more diversity in the neighborhood, but still with a lot of underserved. Only 48% of the children in Franklinton complete high school,” says Vallangeon. She notes, “Franklinton has many strengths and assets, but some of the areas it has struggled with over the years has been healthcare and food because it is a food desert and we have a lack of food opportunities for individuals.”

Dr. Vallangeon notes that, in addition to a lack of physical health care resources, physician behaviors that may arise from bias can form barriers to healthcare for patients with limited resources.

[Barriers to Health Care for Patients in Poverty w/ Drs. Laurie Belknap and Dana Vallangeon – YouTube Video](#)

Dr. Mann agrees. “It is our job as physicians and healthcare providers to make judgments in general, and that is a good thing in many cases in order to treat patients. However, making judgments based on your perceptions of what’s normal for you and what’s different with the patient, or if you make judgments because you don’t really understand the culture, then you aren’t really treating the patient effectively.”

The physician-patient relationship can become challenged by the lack of understanding of the patient circumstances, or by challenges with the patient’s compliance with treatment. Noncompliance can result from a multitude of problems, including inadequate resources, or a lack of education to enable understanding, says Dr. Mann. Provider assumptions can also contribute to a patient’s lack of compliance with care. “Sometimes after discharge from the hospital or clinic, you are making assumptions that the patient has money to pay for prescriptions, or has a car,” says Dr. Mann. “Anytime you are making assumptions it can be bad for healthcare.”

Challenges with patient compliance can also stem from misperceptions about privilege and discrimination, as suggested by a recent study that found that patient-perceived discrimination in health care tends to promote the underutilization of health services, including preventive screenings, medical testing, and acute treatment. This study suggested that patients who perceive socioeconomic status discrimination by providers in the health care

system may have lower levels of compliance, and report lower satisfaction with care or with patient-physician communication.⁴ Patient perspectives of the physician/patient relationship were also thought to contribute to problems with compliance or treatment adherence.⁴

Bias in Healthcare Provider Relationships

Dr. Mann, who describes himself as coming from a background of poverty, notes that he has never met with overt discrimination from other healthcare providers during his training. However, he believes that poverty restricts many potential physicians' horizons. People living in poverty may not know physicians or of how to become a physician, and may not even consider this as a career option due to a lack of mentoring. Lack of promotion of medicine as a career option to a diverse population, in fact, has been linked to the fact that under 2% of medical students in the UK are from poorer backgrounds.¹³ Furthermore, costs of medical school and inability to get student loans with poor credit, as well as difficulty navigating the maze of financial hurdles entailed in completing an MD or DO degree, prove barriers to some less wealthy applicants, according to Mann. And, once the student has been accepted to medical school, he adds, career choices and money management prove problematic to many whose families are not able to provide guidance in these areas.

Strategies to Reduce Bias in the Setting of Poverty

The need for training and education of health care providers to recognize and reduce attitudinal bias is clear. The linkage between cultural competency and reducing health care disparities has been demonstrated by multiple sources, including the Institute of Medicine Report of Unequal Treatment from 2002.¹⁴

Several methods of reducing attitudinal bias and improving both communication and relational skills in medical care providers are suggested. One study explored the use of simulation and role-playing in poverty based scenarios for new medical interns interacting with community volunteers posing as family members. Post experience debriefing and discussion were used to solidify learning.¹⁵ The post experience debriefing promoted the use of reflection and dialogue about the challenges faced by low-income families. Another article outlined an interactive educational module for medical students and residents to enhance communication skills, self-awareness and reflection. This served to further understanding and knowledge of poverty and the importance of responsiveness to people living in poverty.¹⁸ The module also promoted self-reflection and recognition of personal biases and limitations.¹⁶ Another study evaluated the unconscious biases of health care providers in a large metropolitan health system by providing training to further understanding of privilege and to promote cultural competency. The study suggested that cultural humility may be useful in reducing health care inequities as providers integrate new skills into their daily work.¹⁷

And, finally, according to both Taylor and Mann, diversification of the physician and medical provider applicant pools to ensure providers from a range of economic and social backgrounds seems a logical step toward resolving the problem of bias in medicine.

[Strategies to Reduce Bias in the Setting of Poverty with Drs. Laurie Belknap and James Mann – YouTube Video](#)

5.2 Poverty, Class, and Privilege Knowledge Check

Complete the following knowledge check to see how Poverty, Class, and Privilege impact bias.

[Diving Deeper with Poverty, Class, and Privilege Knowledge Check](#)

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Chapter 6 - Disability

6.0 Disability

Camilla Curren MD

Introduction

In this chapter, we will look at the bias against people with disability.



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Learning Objectives

By the time you successfully explore this chapter, you will be able to

- Identify bias in people with disability in the medical community in interprofessional relationships
- Identify bias in physician-patient relationships with regards to people with disability
- Describe techniques to neutralize the effects of bias in disability or ameliorate its severity
- Describe the negative effects of bias in people with disability and discrimination when it is not recognized or addressed based on the perspectives of the interviewees

Self-Exploration:

Prior to reading the Disability Chapter, you will be asked to take a self-test.

1. Read the **Preliminary Information** and **disclaimer**, then click on **“I wish to proceed”** to take the test. [Click to complete the Disability-IAT located in Harvard University’s Project Implicit website.](#)
2. After taking the test, read the next section to read perspectives on bias against people with disability.
3. You will then have the opportunity to complete a knowledge check to see if you gained a heightened understanding of bias against people who have a disability.
4. Use this opportunity to learn more about conscious and unconscious bias in health care, to retake the IAT test(s) and to reflect on how you can apply what you’ve learned.

6.1 Understanding Disability Bias in Medicine

Camilla Curren MD

Acknowledging Bias Against Persons with Disabilities in the Health Care Setting



John Moore, CEO/Executive Director of the Ohio Department of Deaf Services

Bias against persons with disabilities is longstanding, notes John Moore, CEO/Executive Director of the Ohio Department of Deaf Services. Starting with being called a “retard” in his high school, where he was the only deaf student in his class, Moore has experienced discrimination and bias in health care settings and elsewhere and has developed a prominent career as an advocate for the deaf, helping other hearing-impaired persons reach their greatest potential. Moore, who often finds himself in the thick of debates with insurers over coverage of deaf patients, once considered the field of healthcare law but notes “it was just too dry.”

Moore finds that his experiences are similar to those of others with “invisible” disabilities not immediately apparent to health care providers. Physicians and nurses may mistake agreeable behavior such as smiling and nodding on the part of a patient with disabilities for understanding. “In fact, they just may be too embarrassed to admit that they do not understand what is being conveyed, and medical staff is not aware of this,” he states. This type of misunderstanding, which can lead to medical errors and to disparities in health care delivery to patients who are deaf, can be avoided with the standard use of a medical interpreter, or by the health provider learning basic signing or writing out questions and information on a whiteboard.^{1,2} “Different persons have different needs

like they have different allergies,” Moore contends; paying attention to these differing needs and taking the extra time to allow for personalized adequate communication with patients with disabilities can go a long way towards collecting adequate information and meeting health care goals.¹

Identifying Bias in Physician/Patients with Multiple Disabilities

Jody Burris, mother of 37-year old Trisha Burris, affected since childhood by cerebral palsy and severe developmental delay, has had a range of experiences in navigating healthcare for her daughter. She notes that when patients with multiple or more obvious disabilities encounter the medical establishment, their needs for more time and different communication and examination strategies may threaten the provider’s intention to be inclusive in providing unbiased medical care even in the best circumstances.³ Jody feels that whenever possible the patient should be involved in their own healthcare decisions and should be assumed to be able to hear and understand conversations about themselves in the exam room.² A simple measure like sitting down with and speaking directly to, rather than standing above and talking over, an individual in a wheelchair establishes a level of respect and shared humanity, that reduces bias and defensiveness on both sides.³ While the Burris family has been successful in establishing a comfortable primary care relationship, Trisha and her family continue to search for a dentist who will discuss methods of cleaning and restorative dental work. “I certainly can’t help but wonder if she was a normal 37-year-old with the same situation if the outcome of this particular consultation would have been the same. Her teeth are a health and self-esteem concern as it would be for anyone,” Jody Burris adds.

[Jody Burris on Bias Against People with Disability – YouTube Video](#)

Negative Effects of Bias and Discrimination

In a study of Medicare recipients, 64% reported more than one disability and 25% reported at least one.⁴ While 98% of survey respondents felt that their physicians were competent and well-trained, those with disabilities reported more dissatisfaction with their doctors on the following measures:

- 2.4 times the rate of respondents without disabilities for “physician understanding their condition”
- 2.4 times the rate of respondents without disabilities for “physician completely discussing their health problem”
- 2.3 times the rate of respondents without disabilities for “physician answering all questions”
- 1.6 times the rate of respondents without disabilities for “physician always seeming hurried.”

This suggests to the study authors poorer communication strategies and less thorough care are provided to patients with disabilities. Medicare recipients with disabilities were also more dissatisfied with the quality of their care and access to their own doctors and to specialists.⁵

According to the International Classification of Functioning, Disability and Health approved by the World Health Organization in 2001, individuals are classified by the typical patterns of function they exhibit and not by type of disability.⁶ Patients with **mental illness** are considered the most disadvantaged in terms of accessing equitable health care, with patients who are deaf faring nearly as poorly in our health care system and people with visual or physical disabilities less severely affected, though also incurring discrepant health care delivery.⁷ Contributors to unequal health care access for patients with disabilities have long included transportation barriers, poorer access to medicines and specialists, and financial/insurance coverage barriers. However, provider bias and failure to provide longer appointments and communication strategies amenable to interviewing patients with disabilities are thought likely factors adding to this problem.⁸

Identifying Bias Against Physician w/ Disabilities



“If you have an obvious physical disability, it’s already out there, you have no control over that—mostly I just use my personality and overcompensate with mental ability.”

Phil Jonas, MD, is a hospital-based physician with a strenuous professional practice who cares for ill medical and surgical patients in the OSU Wexner Medical Center. For Dr. Jonas, providing excellent and equal care to all patients takes on special meaning. Jonas, a graduate of the OSU Internal Medicine Residency program and Northeast Ohio College of Medicine, has used a wheelchair since the age of three when he had a spinal cord tumor resected, leaving his legs paralyzed. Jonas never considered that he would be unable to pursue his goal of an internal medicine hospital-based practice despite physician mentors who recommended to him a more sedentary

or “talking” specialty such as psychiatry. In his time at OSU, he has not met with ongoing bias or detractors in the professional setting, noting only some “over-help” from nurses who may be concerned about his ability to perform lines and bedside procedures expediently.

For Jonas, medical school acceptance was the hurdle he actually dreaded the most—he notes that, while no college professors recommended to him against practicing medicine from a wheelchair, he actively avoided potential medical school reference letter writers who would challenge his physical or academic abilities and attributed his rejection letters to his average college grades rather than to his mobility limitations. In fact, he included in his medical school application essays a description of his disability and has been very comfortable with it over the years. However, although he has been treated as an equal peer by colleagues and staff, difficulties with inaccessible examination rooms in clinics and ICU’s and with finding accessible restroom facilities in the Medical Center complex have made his days more difficult at times.

While caring for patients, Jonas estimates he experiences references to his disability at least weekly but has developed strategies for reducing the impact of bias on his job responsibilities and rapport with families. “If you have an obvious physical disability, it’s already out there, you have no control over that—mostly I just use my personality and overcompensate with mental ability.” Jonas tries to build early rapport with the patient to reduce bias and does not hesitate to answer frequent questions about how he functions in a wheelchair as a physician. “This helps with my job to establish a relationship and trust—it gets all the other stuff out of the way,” he contends. It also helps, he feels, to avert the “looks and body language” that betray the subtle forms of bias he frequently encounters from family members. “We need a doctor in a white coat who is standing here being paternalistic,” may be the unspoken message when subliminal bias is noted, he thinks, but this can often be overcome by openly discussing both visible and less obvious forms of disability so that the patient knows his or her physician shares a sense of vulnerability and is able to empathically problem solve with the patient, as both are imperfect in their physical being at the moment.

This theory is exemplified in data collected by Steele and published in January 2016 regarding the performance of recommended basic cancer screenings in primary care practices.⁹ Steele found that while persons with disabilities received screenings at rates lower than those without disabilities, the size of the discrepancy in screening percentages varied by disability type. Most persons with disabilities were adequately covered by health insurance, and scheduling and transportation to the screening studies proved the biggest barriers to completion. When controlling for social and demographic variables, the study found that, when compared with women without disability, the odds of receiving a Pap test within the previous 3 years were significantly lower among women with disability (AOR, 0.77; 95% CI, 0.60-0.99) and were lowest among women with a mobility limitation (AOR, 0.58; 95% CI, 0.42-0.80). Women with cognitive disabilities received the fewest mammograms. Compared with persons with no disability (6.4%), the study population for this article reported fair or poor health more often, and this reporting varied as well by disability type. Fair or poor health was perceived most often among persons with a mobility disability (63.3%), with overall poorer than average scores also among patients with a cognitive disability (38.4%), a visual disability (29.4%), or a hearing disability (17.4%).⁹ Physician recommendation was the most important factor in the completion of a recommended screening cancer study among this group,⁹ yet physicians recommend routine health maintenance services less often to patients with disabilities than to patients without disabilities.¹⁰

[Ameliorating Disability Bias w Jodi and Trisha Burris and Dr. Cami Curren – YouTube Video](#)

6.2 Bias against Disability Knowledge Check

Complete the following knowledge check to see how people with disability experience bias.

[Diving Deeper with Disability Bias Knowledge Check](#)

6.3 Bias in Disability References

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10. Ramirez, A, et al. **Disability and Preventive Cancer Screening: Results from the 2001 California Health Interview Survey,** American Journal of Public Health, November 2005.

Chapter 7 - Religion and Spirituality

7.0 Religion and Spirituality

Camilla Curren MD

Introduction

The purpose of this chapter is to provide an overview of religious and spiritual bias and inherent attitudinal disadvantages in medical and interprofessional relationships.



Koran | Anita Gould | CC BY-NC 2.0

Learning Objectives

By the end of this chapter, you should be able to do the following:

- Identify religious or spiritual bias in the medical community in interprofessional relationships.

- Identify religious or spiritual bias in physician/patient relationships.
- Describe techniques to neutralize the effects of religious or spiritual bias or ameliorate its impact.
- Describe the negative effects of religious and spiritual bias and discrimination when it is not recognized or addressed- based on the perspectives of the interviewees.

Self-Exploration:

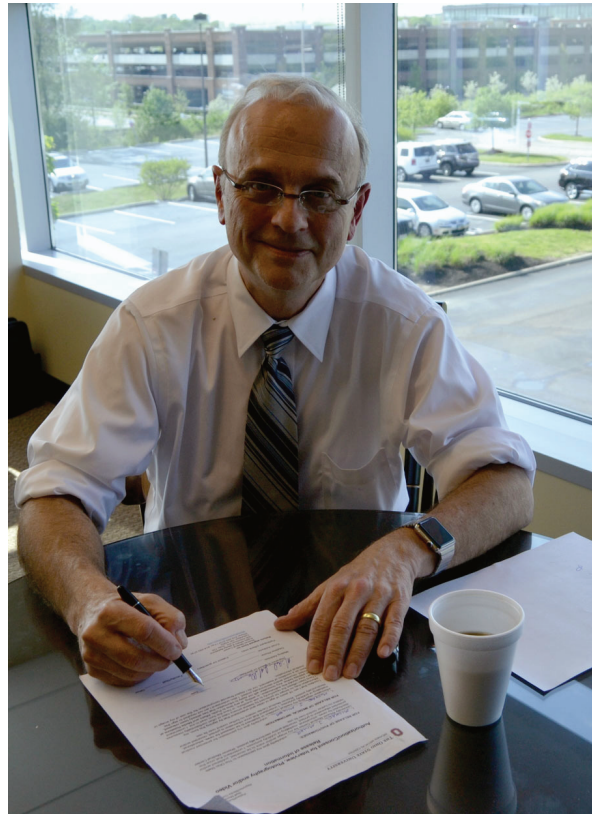
Prior to reading the Religion and Spirituality Chapter, you will be asked to take a self-test.

1. Read the **Preliminary Information** and **disclaimer**, then click on **“I wish to proceed”** to take the test. [Click to complete the Religion-IAT, the Asian American IAT, and the Arab-Muslim IAT](#) located in [Harvard University’s Project Implicit website](#).
2. After taking the test(s) read the next section to read perspectives on religious or spiritual bias in health care.
3. You will then have the opportunity to complete a knowledge check to see if you gained a heightened understanding of religion or spiritual bias.
4. Use this opportunity to learn more about conscious and unconscious bias in health care, to retake the IAT test(s) and to reflect on how you can apply what you’ve learned.

7.1 Understanding Religion and Spirituality Bias

Camilla Curren MD

Religious Beliefs in Modern Medicine



Mike Miller MD, Chief of Plastic Surgery, The Ohio State University Wexner Medical Center

“There is a God-shaped vacuum in the heart of every man”, is one of Dr. Mike Miller’s favorite quotes. These words by the philosopher Blaise Pascal were intended to amplify upon a universal need to believe in a deity or higher power. However, this belief system, according to Miller, the Chief of Plastic Surgery at The Ohio State University Wexner Medical Center (OSUWMC), has fallen out of favor in modern society and now, according

to the words of a medical student and patient at OSU, persons with a religious belief system feel they need to “explain to others or to justify how being a person of faith is compatible with being an intelligent individual.”

This documented increase in secular versus religious beliefs in our society¹ persists despite demonstrated health benefits, particularly in the reduction of the anxiety and depression associated with a plethora of complex health problems, statistically associated with faith and spirituality.² Bias toward professional colleagues and against patients who are perceived as religious or spiritual was, in fact, one of the most-noted forms of discrimination in US public medical schools among students polled in 2008.⁶

Bias and Differing Belief Systems



Lana Alghothani, MD, Pulmonary/Critical Care Fellow, The Ohio State University Wexner Medical Center

Lana Alghothani, MD, a pulmonary/ critical care fellow at OSUWMC who wears a hijab, notes that female medical students are often surprised that she can relate to them and to their concerns—likely due to her obvious religious affiliation. However, she does not feel that she has really been the victim of interprofessional bias in her time at OSU due to being a Muslim-American. (Nationally, 25% of Muslim physicians of diverse national origin feel they have faced bias or workplace discrimination by peers.²) She does note instances in which patients have treated her differently than they have treated her physician associates. Miller, on the other hand, believes that he was marginalized and his learning given less priority during his residency some years ago since he did not react well to coarse jokes and swearing on rounds; he believes his stated beliefs as a “spiritual person” (Miller is a Protestant who describes his personal philosophy as “metaphysical realism”) likely cost him some residency spots. And as recently as 2 years ago, a Catholic medical student at OSU reports being criticized by residents on her team for her discomfort in writing for oral contraceptive medications. She also notes that she has seen Catholic patients repeatedly advised to have tubal ligations or to start oral contraceptives despite their stated discomfort with these measures and without physician inquiry as to the reasons for their decision-making.⁴ This has caused her to perceive a bias toward Catholics that has made her determined to avoid revealing her religious beliefs (she remains anonymous for this publication) since she feels that others will view her as frivolous or as less intelligent and hardworking than she truly is, whether in the physician or the patient role. According to

the Pew Research Center on Religion and Public Life, most Americans of Jewish descent do not believe they are discriminated against in healthcare settings, especially compared to Muslims, blacks, and LGBT persons whom they feel face more discrimination; however, 15% of the Jewish citizens surveyed noted being snubbed or called an offensive name in the last year as a form of cultural discrimination.⁵ And patients who adhere to religious faiths not well represented in a geographic area, like Hindu or Buddhist patients in Ohio, may experience discomfort in medical settings since their customs and behaviors surrounding illness are poorly understood by medical personnel and subsequently ignored.⁹

Origins of Religious Bias in Medicine

Miller believes that the lack of philosophy as a common educational requirement has made it harder for all US citizens, whether in the role of physicians or of patients, to understand the roots of religious bias, as well as of bias in general, and has created additional difficulties in overcoming it. “Students do not understand the philosophical nature of reality and of knowledge”, he believes, and so do not have a background in reality testing and transcendent principles that would allow them to critically think about religion, or to understand and accept those who do not agree with them regarding any aspect of existence. He believes that, in overcoming bias in medicine, it is critical to identify and to examine what characteristics of a person are influencing how one deals with that individual. Everyone has bias, but it is important to sort appropriate from inappropriate distinctions (for example, it is advantageous and appropriate to be biased against persons trying to do you active harm, and this type of bias is likely based on evolutionary principles; however, having bias against everyone with the same hair color as the harm-doer would constitute maladaptive and inappropriate bias). This type of bias testing, Miller believes, would function productively in the best interest of human relationships and particularly of patient care; he feels this type of bias testing would help with reducing religious discrimination.

Ameliorating Religious Bias and Discrimination in Medicine

In his personal dealings with patients, Miller finds that acceptance helps overcome bias, and keeping foremost the concept that every person has value helps with this acceptance. Miller believes that every person was made with a purpose by God; this concept helps him to think more objectively about people and to assist him in helping families deal with difficult problems and interactions at work as well as to deal constructively with colleagues. And studies have in fact verified the links between a spiritual nature or having faith, humility, and positive interactions with others and have positively correlated these traits with lower degrees of burnout, and with better medical outcomes in chronic illness.^{3,6}

Similarly Alghothani notes that the conscious acts of realizing that people are more nuanced and complex than we initially believe they are, and of being willing to engage in discussion and provide on-the-spot education about religious and cultural differences, goes a long way toward neutralizing the effects of bias toward patients and healthcare providers of different faiths and ethnicities. For instance, when a patient told Alghothani (who was reared in Upper Arlington, a suburb of Columbus, OH) that she was “the first brown person I saw who spoke English fluently” or when a patient asked her about her affiliation with ISIS, she recognized these as good opportunities to bring up bias, acknowledge it, and educate around it with the patient and family. She hopes that, in time, broader cultural education will reduce bias overall, but until that time comes, she feels that avoiding generalizations about different religious and cultural groups will go far toward preventing misunderstandings.

Currently, accessing available literature on cultural and religious beliefs of patients, as well as asking questions of the patient when understanding is lacking, may avoid discomfort and biased behaviors on medical teams.⁹

As an example of bias, Alghothani points out her encounter with a large family of ethnic descent whose behavior seemed troublesome and irrational to the ICU staff; staff blamed family religious beliefs for the disconnect. Further investigation, however, revealed that a combination of financial constraints and illness among other family members played into the difficulties and that religion was not a factor at all.

While we cannot eliminate bias we do need to be cognizant of it and work to negate its effects, our interviewees agree. For instance, addressing ridicule directly or through reporting channels, and avoiding offhand disrespectful remarks referential to distinct groups, as well as educating on-the-spot as Alghothani recommends, will help physicians to learn to be more respectful about others' convictions and to be positive in their relationships with peers and patients. And it is also important to note that many physicians, who espouse secular beliefs, actually behave in a spiritual fashion and hold some religious beliefs, most often acted upon by psychiatrists when dealing with patients.⁸

[Ameliorating Religious Bias and Discrimination in Medicine with Drs. Cami Curren and Mike Miller – YouTube Video](#)

According to Reverend Timothy Ahrens, a prominent Columbus pastor and lecturer on the social gospel movement whose columns have been widely published in the *Wall Street Journal*, the *Washington Post*, and many other places, physicians can best avoid discriminatory behavior by recognizing their own biases and by looking for the origins of them, realizing that religion is very experiential and that only by experiencing worship in a given faith can one understand its intricacies. While Ahrens, a liberal Protestant pastor, has warm acquaintances across all religious faiths locally, he has noted that fundamentalist colleagues are less well accepted by medical professionals, particularly when the issue of praying with patients comes to light. Yet acknowledging a patient's religious beliefs, he feels, is part of delivering personalized health care. He also notes that voicing demeaning comments about minority religious views is damaging to the morale of the entire healthcare team....and that one

way of ameliorating religious bias is to note that the medical and religious support teams for the patient are usually seeking the same healing outcome. Ignoring this fact, Ahrens believes, prevents the optimal provision of holistic health care that best serves patients and the medical system.



Rev. Dr. Timothy Ahrens, Sr. Minister of First Congregational
United Church of Christ, Downtown Columbus, OH

7.2 Religion and Spirituality Knowledge Check

Complete the following knowledge check to see how people experience religious or spiritual bias.

[Diving Deeper with Religion and Spirituality Knowledge Check](#)

7.3 Bias Against Religion References

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Chapter 8 - Women

8.0 Women

Laurie Belknap DO and Camilla Curren MD

Introduction

The purpose of this chapter is to provide an overview of the bias and inherent attitudinal disadvantage often imposed upon women in medical and interprofessional relationships.



Woman. | Gaby Av | CC BY 2.0

Learning Objectives

At the end of this chapter, you will learn to:

- Identify bias against women in the medical community in interprofessional relationships.
- Identify bias against women in physician-patient relationships.
- Describe techniques to neutralize or ameliorate the effects of bias against women in health care.
- Describe the negative effects of bias and discrimination when it is not recognized or addressed.

Self-Exploration:

Prior to reading the Women Chapter, you will be asked to take a self-test.

1. Read the **Preliminary Information** and **disclaimer**, then click on **“I wish to proceed”** to take the test. [Click to complete the Gender Science-IAT located in Harvard University’s Project Implicit website.](#)
2. After taking the test, read the next section to read perspectives on unconscious bias against women.
3. You will then have the opportunity to complete a knowledge check to see if you gained a heightened understanding of bias against women in health care.
4. Use this opportunity to learn more about conscious and unconscious bias in health care, to retake the IAT test(s) and to reflect on how you can apply what you’ve learned in this chapter.

8.1 Acknowledging Bias Against Women

Laurie Belknap DO and Camilla Curren MD

Understanding Bias Against Women in Professional Settings in Medicine



Photo from CDC.gov

Bias against women can impact healthcare in many ways due to the multiplicity of interactions in which women engage, both in providing and in seeking care. As we begin to understand how bias can affect women in health care, consider this situation. A group of academic medical faculty is meeting to discuss program development and the design of a new curriculum for a college of medicine. The group consists of professors of several ranks, all physicians. As the meeting begins, the program organizer sets the stage by asking the members to introduce themselves and to give a brief description of their roles at the University and in education. Addressing one of the men, the organizer asks, “Dr. Stevenson, please tell us a little bit about your background and teaching interests.” Addressing one of the women, he asks, “Nicole, please tell us about yourself and your role here.”

Do you think this is an uncommon scenario? What messages are being sent to the group by this person’s choice of language and tone? What messages are being sent to the women present about their importance and position in the group and in the project overall?

Bias against women is unfortunately common in the medical workplace. One study suggests that women perceive this bias in the academic medicine climate as creating obstacles to professional development.¹ Looking at styles of introduction by a speaker for presenters in formal medical grand rounds at one academic institution, one study suggested that speaker introductions can reveal implicit gender bias.² According to this study, professional titles imply the perceived expertise and authority of the individual, and the use of less formal first names only for introducing women, in particular, can marginalize the individuals, demean the professional status of women, and reveal underlying gender bias held by the speaker. Gender bias is noted by the authors to be the main driver in gender disparities in academic medicine.²

Attitudinal bias can also pose challenges to work-life balance, professional productivity and academic

achievement for women. As of 2016, women were noted to earn 90 cents for every dollar earned by men in academic medicine.³ One study found that while productivity levels of men and women faculty were similar, women were more significantly affected than men by a negative departmental climate or lack of departmental support.⁴ Another recent article noted that while the number of women and men in medical training and academic medical professions is approximately equal, the number of women in leadership positions is still relatively few.⁵ The article suggests two main theories that stem from attitudinal bias and describes the “glass ceiling” and “leaky pipeline” as analogies for a lack of advancement to leadership by women faculty. The “glass ceiling” theory suggests that institutional culture limits the leadership opportunities for women, and the “leaky pipeline” theory suggests that work-life balance challenges, lack of mentorship, and lack of leadership training contributes to attrition that limits the advancement potential for women.⁵

[The Glass Ceiling in Leadership for Female Physicians w/ Drs. Joanne Turner and Laurie Belknap – YouTube Video](#)

For women, clinical professional opportunities can also be limited by attitudinal bias. One study examined reasons why the specialty of orthopedics has the lowest percentage of women practitioners of all the medical specialties. The study found that women medical students lacked mentorship in Orthopedics⁶, and that gender bias was found in residency interview questions more often for women applicants than for men.⁷ Yet another study examined the reasons why women are underrepresented in surgical specialties in the United States.⁷ The article noted several potential reasons for this underrepresentation, including gender bias resulting from the hiring practices of surgeons in previous generations, high attrition rates of women during surgical training for careers, and less achievement of academic goals such as publications and grants, as well as slower progress toward promotion.⁸ Data from the American Association of Medical Colleges showed that women are less likely to advance to leadership positions; one study estimating that it won't be until 2096 when women achieve 50% representation as full professors of surgery.⁹ Interestingly, one study suggested departmental differences, with more primary care women faculty reporting feeling unwelcomed than men.¹⁰

Interprofessional bias against women can also be found in medical training. One study found that both male and female nurses rated male OB/GYN residents consistently higher than women residents on evaluations.¹¹ Health professions students rated a male voice as being more effective at teaching than a female voice in an evaluation

of different faculty voicing an identical online teaching module.¹² An electronic survey showed that women surgeons preferred having female colleagues over having male colleagues.¹³

Gender Bias in Physician-Patient Relationships

For women as clinicians, bias can come from patients as well as colleagues.

A news story about the recent all-female graduating class of surgical residents from the University of Rochester describes challenges faced by the residents. The women describe common misperceptions about the care team, such as the conclusion that the tallest male in the group was the person in charge. One resident described a story in which she was involved in the lifesaving care of a trauma patient, only to have the patient request to speak to the male intern when she checked on him in the recovery unit.⁹ And a recent meta-analysis of medical trainee abuse in several countries identified being a female student as a statistically significant risk factor for increasing the risk of sexual or gender-related abuse by patients and patient families.¹⁴

Bias against Female Patients: the Cost of Care

While women healthcare providers can face professional challenges, bias against women can also negatively affect women as patients seeking healthcare. One study noted that women presenting to the emergency department with chest pain and an acute myocardial infarction had their symptoms minimized and triage protocols delayed by emergency department nurses.¹⁵ Women had longer door-to-protocol activation times than men for ST-segment elevation acute myocardial infarction.¹⁶ Another study demonstrated that patients with chronic obstructive pulmonary disease were treated differently by primary care providers based on gender and that diagnostic and therapeutic efforts by both male and female physicians were lower for female patients.¹⁷ Another study demonstrated that male patients were more likely than female patients to receive physiotherapy and chronic pain assessment by a multidisciplinary team at a Chronic Pain clinic.¹⁸ Men were more likely than women to have CDC compliant care and detailed medical record documentation of symptoms when seen in the emergency department for sexually transmitted infections.¹⁹ One study found that, among patients 50 years of age or older with similar illness severity scores, men were more likely to be admitted to an Intensive Care Unit (ICU) and to have aggressive lifesaving procedures than were women; women were more likely to die of their illnesses than were men.²⁰ Stereotyping and gender bias may further disparities in healthcare delivery for women, and impair social interactions between patients and providers, especially for black women and ethnic minority groups.²¹ Similarly, these or unmeasured factors were thought by researchers to contribute to study findings among ICU patients; study authors also cited the differences in women's health care decision-making as compared to men's as a potential contributor to results.²⁰

Pamela McCarthy, a lifelong social worker, notes that "Communication is different when the patient is female." As a patient in outpatient and inpatient settings, McCarthy emphasizes that she places a great value on being a collaborator in her own care, but notes that her opinion is not elicited as often as was that of her husband when he was a patient, and when complex healthcare issues were involved. McCarthy notes that women are relational, and that thorough, deliberate communication with female patients should be a goal in order to prevent them from feeling condescended to or dismissed. These feelings, she believes, make some her colleagues and clients

avoid healthcare settings lest they feel “judged”. McCarthy also notes that, since women are often responsible for family care needs, this behavior can be deleterious to a number of people in addition to the patient.

[Pamela McCarthy, Exec Director of Central Community House – What Happens When Women Are Alienated from Seeking Healthcare – YouTube Video](#)

Strategies to Acknowledge and Reduce Bias Against Women in the Workplace

From review of the current literature, communication and cultural competence is key to acknowledgment of attitudinal bias. For women in academic medicine and science, clear communication and directly addressing gender bias can often be effective.

[Strategies to Acknowledge and Reducing Bias Against Women in the Workplace w/ Megan Letson MD – YouTube Video](#)

In some academic medical institutions, development of leadership skills for both male and female faculty and departmental leaders can improve the overall climate for women, formalize promotion and work duty structures, and mitigate perceptions of discrimination.¹ Data from the article suggested that medical schools could also promote and retain more women faculty by improving professional interactions and networking between men and women faculty.¹

[What Happens When the Gender Bias is Not Addressed w/ Joanne Turner PhD and Laurie Belknap DO – YouTube Video](#)

Improvements in patient care delivery could result from providing training in cultural competency and increasing knowledge of healthcare disparities in women. Gender bias is evident and creates disparities in multiple health care areas including cardiac and critical care, behavioral health, stroke, osteoarthritis, pain management, organ donation and transplantation, and trauma patient triage. The glaring discrepancies appear significant and impact the lives of women. Acknowledging that gender bias exists may be the first step in reducing or eliminating it.^{22,}
²³ Creating educational activities and curriculum for medical care provider trainees to recognize the disparities in healthcare created by bias, and to assist in efforts to minimize gender bias for patients, are other ways to reduce inequities and disparities that result from discriminatory and biased care for women and which are detrimental.²³

8.2 Bias Against Women Knowledge Check

Complete the following knowledge check to see how women in healthcare experience unconscious bias.

[Diving Deeper with Bias Against Women Knowledge Check](#)

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Chapter 9 – Sexual Orientation and Gender Identity

9.0 Sexual Orientation and Gender Identity

Camilla Curren MD

Bias Toward Lesbian, Gay, Bisexual and Transgender (LGBT) Individuals in the Medical Setting



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Learning Objectives

At the conclusion of this chapter, the reader should be able to:

1. Identify bias in the medical community in interprofessional relationships involving LGBT providers.
2. Identify LGBT bias in physician/patient relationships.
3. Describe techniques to neutralize the effects of bias or ameliorate its severity when LGBT persons are involved.
4. Describe the negative effects of bias and discrimination against LGBT individuals in medical settings when it is not recognized or addressed based on the perspectives of the interviewees.

Self-Exploration:

Prior to reading the Sexual Orientation and Gender Identity Chapter, you will be asked to take a self-test.

1. Read the **Preliminary Information** and **disclaimer**, then click on “**I wish to proceed**” to take the test. [Click to complete the Sexuality-IAT, located in Harvard University’s Project Implicit website.](#)
2. After taking the test(s) read the next section to read perspectives on sexual and gender identity bias in health care.
3. You will then have the opportunity to complete a knowledge check to see if you gained a heightened understanding of sexual and gender bias in health care.
4. Use this opportunity to learn more about conscious and unconscious bias in health care, to retake the IAT test(s) and to reflect on how you can apply what you’ve learned in this chapter.

9.1 Acknowledging Bias Against Sexual Orientation and Gender

Camilla Curren MD

Bias Toward Sexual and Gender Minorities and the Hidden Curriculum

In 2014, a study of lesbian, gay, bisexual or transgender (LGBT) general surgery residents determined that one-half of them actively concealed their sexual orientation or gender identity from colleagues due to fear of discrimination or reprisal in the workplace.^{1,2} In another study, 82% of heterosexual first-year medical students held at least some degree of implicit bias against gay and lesbian students.³ In the study on surgery residents, none of the trainees who experienced overt homophobic remarks or slurs reported these incidents; one of the reasons cited was the feeling that nothing would be done about it if the event is reported.²

Bias against LGBT persons can be embedded in the hidden curriculum of an academic institution.^{1,4} Hidden curriculum has been defined as “the attitudes and values conveyed, most often in an implicit and tacit fashion, sometimes unintentionally, via the educational structures, practices, and culture of an educational institution”⁵ and as the combination of implicit and explicit biases, institutional climate, and usual behaviors at an academic medical center.¹ Discrimination and bias support ongoing identity concealment among sexual minorities, which in turn deprives others of LGBT faculty and peer role models. This leads to an institutional atmosphere that accepts or does not recognize biases and the need to reform attitudes toward LGBT learners, faculty, and patients.¹

Effects of Professional Bias Toward LGBT Health Providers

John Davis, PhD MD, former Associate Dean for Medical Education at OSU College of Medicine and national expert on LGBT issues, now Associate Dean of Curriculum at the University of California at San Francisco, notes that he witnessed derogatory references to sexual minorities during his years in training. However, Davis feels that it did not hold him back in his career. In fact, he encountered mainly supportive behavior when he came out as a medical student (he was the only openly gay student in his medical school class). Davis adds that he did, however, choose a specialty (infectious diseases) and work environments that were supportive of rather than hostile toward LGBT physicians.

In contrast, a Columbus, Ohio primary care physician in private practice, who retracted permission to use his name after being interviewed for this publication, still is not open about his sexual orientation and fears that some of his patients might leave his practice were they to discover that he is gay. Now middle-aged, he notes that, although he never experienced explicit bias in medical training, he felt lonely and isolated as a medical student and resident, and afraid to share his sexual minority identity with peers or attending physicians at OSU Wexner Medical Center. Eventually, he did, however, find some support among faculty at Nationwide Children's Hospital, which he believes had a more inclusive environment at the time.

Evidence of increased stress and burnout exists when health care providers experience discrimination or social bias in the workplace.^{1,6} In a 2011 study of self-identified LGBT physicians, 10% were denied referrals from heterosexual colleagues, 15% reported harassment by a peer, 22% experienced feeling socially ostracized, 65% witnessed derogatory comments about LGBT individuals, and 27% knew of discriminatory treatment of an LGBT coworker.⁶

[Julia Applegate, Director of Center for LGBTQ Health Equity, Equitas Health Director of Center for LGBT Health Equity for Equitas Health, on "Sexual Minority Health Providers and Bias in Medicine" – YouTube Video](#)



John Davis, PhD MD, Associate Dean for Medical Education at OSUCOM and national expert on LGBT issues. A.J Zanyk Photography 2013

Effects of Sexual Minority and Gender Identity Bias in Physician/Patient Relationships

“Our relationship to medicine and health is one that is tension-filled,” opines Julia Applegate, Director of LGBTQ Health Equity for Equitas Health Care in Columbus, Ohio. Applegate describes a difficult road of 37 years duration as a lesbian patient seeking comfortable and appropriate health care services. Having originally held a variety of jobs which occasionally required her to go back into the closet to avoid discrimination, Applegate finally arrived at a professional position working with the state and city on HIV prevention in an accepting and affirming environment, before progressing to her current post.

Applegate notes that health providers do not ask enough specific questions when interviewing LGBT patients, and that unnecessary lectures on topics like birth control and pregnancy prevention, for example, interfere with an accurate discussion of sexual practices. In addition, such conversations make lesbian patients feel “invisible” and interfere with the perception of the medical office as a safe space in which to discuss, for example, sexual orientation and its relationship to fertility concerns—so these and other aspects of a healthy life and applicable preventive care may never be addressed. Some studies indicate that the majority of physicians rarely elicit sexual information from their patients and would feel uncomfortable attempting to meet the healthcare needs of a lesbian or gay patient.⁶

[Julia Applegate on Provider Behaviors that are Welcoming to LGBTQ – YouTube Video](#)

Data compiled by the Fenway Institute suggests that incidences like those described by Applegate lead to internalized homophobia and negative expectations of the health care system by LGBT patients, resulting in a 40% reduction in the seeking of necessary preventive and urgent care by transgender patients. This reaction, in turn, increases the many health disparities that are known to so seriously affect LGBT patients,^{7,8} a group which comprises an estimated 3.8% of adults in the United States or about 9 million Americans.^{9,10}

Whereas lesbian, gay and bisexual patients are less likely than their heterosexual counterparts to receive preventive sexually transmitted infection (STI, including HIV) and cancer screenings, and are more likely to have substance abuse and mental health issues, often related to discriminatory behavior,¹⁰ transgender patients now frequently bear the brunt of discrimination in medical care.¹¹ This includes overt provider refusal of care (19% of respondents to the 2011 National Transgender Discrimination Survey) based solely on transgender status.¹¹ Many survey respondents reported postponing sick care due to worries about discrimination (28%¹¹ to 29.9%¹²). Race, poverty, and other social determinants of health additionally detracted disproportionately from the quality of life and accessibility of care for this cohort of persons.¹¹

According to Ramona Peel, MA, Trans-patient Navigator at Equitas Institute for LGBTQ Health Equity, common fears of transgender patients include being asked to educate health care providers on transgender health issues (even if the healthcare problem for which care is sought has nothing to do with being transgender), called by inaccurate pronouns (“he” for a transwoman), and being “dead-named”, or called by their no-longer-accurate birth name, usually specific to a gender with which the patient no longer identifies. She believes that cisgender persons do not realize how bad the discrimination is, or how high the rates of sexual assault are for transmen and transwomen. Combined with the personal chaos that can ensue when a person comes out as transgender, Peel states, this type of treatment demoralizes and damages the mental health of transgender patients. It may add to the statistics which tell us that LGBT patients are 2-3 times more likely to commit suicide than are heterosexual counterparts¹⁰. Barriers to mental and physical healthcare for sexual minority or gender nonconforming patients include feeling unwelcome or not safe in the healthcare environment, often based on provider and staff interactions. In fact, an independent study has corroborated that transgender patients who need to educate their provider on transgender health issues are four times more likely to avoid medical care in the future.¹²

[Affirming & Welcoming Transgender & Gender Nonconforming Patients w/ Ramona Peel & Dr. Cami Curren – YouTube Video](#)

Reducing Bias Against LGBT Persons in Healthcare Settings

In recent years, several position papers and statements from major medical organizations have called for an end to differential care and to the stigma against LGBT patients, as well as for the implementation of specific guidelines and procedures that will help ensure uniform care.^{10,13,14} In addition, methods and concept outlines for teaching communication techniques and specifics needed to provide competent LGBT healthcare have been deemed necessary and have been implemented in some medical training systems.^{10,15}

Julia Applegate agrees that these measures are helpful for reducing implicit bias and healthcare inequities. “LGBT patients have unique differences as do any marginalized group,” she emphasizes, and learning to address these differences in clinical encounters with patients across the lifespan will increase provider confidence and will thus decrease attitudinal biases that dissuade patients from accessing care. Currently, four or fewer hours of medical school training are typically devoted to LGBT patient care.¹⁰ Evidence exists that increased provider training will increase competence in providing LGBT specific care, and will help with bias reduction and, hopefully, with resolution of care inequities.^{15,16}

Additionally, Applegate notes, consistent training on providing an accepting atmosphere, as well as on cultural humility, has been shown to have a positive effect on bias reduction. Dr. Davis agrees and notes that those health providers with stature and power in a given situation may help colleagues to be more sensitive and supportive by communicating respectfully regarding the erosive nature of offhand remarks and other microaggressions toward LGBT colleagues. Providing positive LGBT role models can additionally modify the hidden curriculum and has been shown to normalize the acceptance of LGBT peers in medical environments.¹

Davis notes that failure to address disparities in healthcare toward any minority simply perpetuates the problem and reinforces biases toward all minorities; it is, therefore, the key to recognizing that there are still inequities in

LGBT healthcare and in acceptance in the health setting despite early attempts to address these problems. And Applegate worries that reduced emphasis on gaining acceptance for LGBT patients and providers will be a “weird consequence” of early success in this area. In fact, it may be hard to gauge the successes made due to poor data collection over time, which is likely to leave the extent of this problem poorly-estimated, Davis acknowledges.

[Healthcare Discrimination & Disparities Affecting Transgender Persons w/ Ramona Peel & Dr. Cami Curren – YouTube Video](#)

9.2 Sexual Orientation and Gender Identity Knowledge Check

Complete the following knowledge check to understand Sexual Orientation and Gender Identity bias.

[Diving Deeper with Sexual Orientation and Gender Identity Knowledge Check](#)

9.3 Bias Against Sexual Orientation and Gender Identity

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