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Patient perspectives on racial and ethnic implicit bias in clinical encounters: Implications for curriculum development

Cristina M. Gonzalez[a,*], Maria L. Deno[b], Emily Kintzer[c], Paul R. Marantz[d], Monica L. Lypson[e], M. Diane McKee[d]

[a] Albert Einstein College of Medicine & Montefiore Medical Center, Montefiore Medical Center- Weiler Division, Bronx, 10461, USA
[b] Albert Einstein College of Medicine & Universidad Iberoamericana, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Bronx, 10461, USA
[c] Montefiore Medical Center, Bronx, NY 10467, USA
[d] Albert Einstein College of Medicine, 1300 Morris Park Avenue, Bronx, 10461, USA
[e] George Washington University School of Medicine and Health Sciences, University of Michigan Medical School & Office of Academic Affiliations, Department of Veterans Affairs, 1500 E Medical Center Dr, Ann Arbor, MI, 48109, USA

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ABSTRACT

Objective: Patients describe feelings of bias and prejudice in clinical encounters; however, their perspectives on restoring the encounter once bias is perceived are not known. Implicit bias has emerged as a target for curricular interventions. In order to inform the design of novel patient-centered curricular interventions, this study explores patients' perceptions of bias, and suggestions for restoring relationships if bias is perceived.
Methods: The authors conducted bilingual focus groups with purposive sampling of self-identified Black and Latino community members in the US. Data were analyzed using grounded theory.
Results: Ten focus groups (in English (6) and Spanish (4)) with N = 74 participants occurred. Data analysis revealed multiple influences patients' perception of bias in their physician encounters. The theory emerging from the analysis suggests if bias is perceived, the outcome of the encounter can still be positive. A positive or negative outcome depends on whether the physician acknowledges this perceived bias or not, and his or her subsequent actions.
Conclusions: Participant lived experience and physician behaviors influence perceptions of bias, however clinical relationships can be restored following perceived bias.
Practice implications: Providers might benefit from skill development in the recognition and acknowledgement of perceived bias in order to restore patient-provider relationships.

1. Introduction

In North America, after several decades of focus on cultural competency instruction in medical education [1–3], health disparities persist [4,5] and racial and ethnic minority respondents are still more likely to perceive bias when seeking medical treatment than Whites [6]. Implicit bias refers to the unconscious and unintentional assumptions people make about each other. Evidence demonstrates this bias negatively impacts patient's perceptions of the clinical encounter [7–9] treatment recommendations [10], and trust [11–14]. Although studies from various countries have explored patients' perceptions of race and/or ethnicity and bias in medicine [6,12,14–25], patient perspectives on and suggestions for restoring the clinical and/or therapeutic relationship once bias is perceived are not known. Understanding these perspectives could inform the development of innovations in medical student education addressing implicit bias in clinical encounters.

Implicit bias contributes to health disparities through medical decision-making and interpersonal communication [26]: Evidence demonstrates the influence of physician implicit bias on patient perspectives of encounters [7–9], physician communication patterns [9,27], clinical outcomes [28], and clinical decision-making [29–33]. Implicit bias regarding race has been demonstrated in medical students [34,35]. In an effort to decrease physician contributions to health disparities, curricula have been developed to teach about implicit bias across the continuum from

* Corresponding author at: Montefiore Medical Center-Weiler Division, 1825 Eastchester Road, DOM 2-76, Bronx, NY, 10461, USA.
E-mail addresses: Crgonzal@montefiore.org (C.M. Gonzalez), mld92@cornell.edu (M.L. Deno), emkintze@montefiore.org (E. Kintzer), Paul.Marantz@einstein.yu.edu (P.R. Marantz), Monica.Lypson@va.gov (M.L. Lypson), Diane.Mckee@einstein.yu.edu (M. D. McKee).

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undergraduate to graduate and continuing medical education [36–43]. These curricular models have not explicitly provided instruction on detecting the perceptions of bias by patients during the patient-physician encounter, nor in skills to restore the encounter once bias is perceived. Our study addresses this gap in knowledge by exploring patients' perceptions of physician bias and their suggestions for restoring the relationship and the encounter once bias is perceived.

This study is part of a comprehensive needs assessment [44] to inform curriculum development for medical students in implicit bias recognition and management. Patients represent the intended beneficiaries of any successful future curricular interventions, therefore it is critical to maintain a patient-centered perspective [45] in the development of novel curricular interventions. To inform the design of future patient-centered curricular interventions in implicit bias recognition and management, the purpose of this study is to explore patients' perceptions of physician bias and their preferences and suggestions for restoring the relationship if they perceive bias.

2. Methods

Given that little is known about patient perspectives on implicit bias we conducted an exploratory focus group interview study using grounded theory, a systematic qualitative methodology involving the discovery of theory through the analysis of data [46]. Recruitment, data collection, and analysis were conducted iteratively to fully capture and explore variation in patients' perspectives. All aspects of the study were approved by the Institutional Review Board of the Albert Einstein College of Medicine.

2.1. Sample

Participants were selected through purposive sampling, a useful way to select study subjects that will ensure "information-rich cases for study in-depth [47]." To be eligible, community members spoke English or Spanish, were aged 18–90, had sought medical care for themselves or their child(ren) in the previous year, and lived or sought medical care in New York City, NY, USA. Two investigators recruited participants from community board meetings in Bronx, NY, USA, a borough of New York City. There are eleven community boards in the Bronx representing various neighborhoods. All residents represented by a given community board and who met our study inclusion criteria were eligible to attend. Investigators also pursued referrals from colleagues. Participants were selected to span the socioeconomic spectrum within the United States (US). We sampled for participants who self-identified as Black (African American, Caribbean, and African), and Latino (US-born and immigrants), or as both Black (race) and Latino (ethnicity).

2.2. Interview guide development

We developed the interview guide (Appendix 1) based on review of the literature related to racial discordance, trust, and discrimination in clinical encounters [6–25]. Questions focused on racial and ethnic bias, our construct of interest. It was supplemented by our clinical experiences (e.g. patient anecdotes of mistreatment perceived related to race/ethnicity). We revised items through discussion among the investigative team until all investigators agreed to the final questions.

In the US there have been historical differences in societal acceptance and social status between White and racial and ethnic minority populations. Therefore, our open-ended questions explored patient perspectives on how they were treated and/or judged by both individual providers and within the healthcare system, the consequences of those experiences, and their suggestions for actions physicians can take to restore the relationship if patients perceive bias. The questions served as a starting point for the discussion, and facilitators were able to probe unanticipated lines of discussion that occurred in the focus groups.

2.3. Data collection

Focus groups were conducted in English or Spanish with participants in community settings. The bilingual PI (CMG) followed a semi-structured interview guide and a bilingual research assistant (MLD) took field notes of nonverbal behaviors. Focus groups were digitally recorded and professionally transcribed. Spanish focus groups were professionally translated and transcribed. Investigators cross-referenced the transcripts to the audio to check for accuracy. Focus groups continued until data analysis demonstrated we had reached thematic saturation, i.e., no new concepts in subsequent focus groups emerged [48]. Participants received a meal and a $25 gift card. Written, informed consent was obtained.

2.4. Analysis

We conducted the data analysis in three phases [49]. The first phase was to develop the codebook. Three investigators (CMG, MLD, EK) independently read three transcripts each line-by-line to identify phrases that related to patient perspectives on implicit bias. These phrases were discussed and consensus reached on a list of codes and their definitions to create the preliminary codebook. This codebook was applied to three more transcripts and further refined after discussion. During the second phase, the codebook was used to code the remaining transcripts, which were coded independently by two investigators each. Using inductive reasoning, the investigators began with low inference codes, discussed their meaning, and developed conceptual themes. Finally, they met to discuss the relationships between themes and reach consensus on representative quotes. Once the final themes and their representative quotes were identified, these data were presented to select participants to ensure accurate representation of their perspectives, for member checking [50].

3. Results

We conducted ten focus groups, six in English and four in Spanish, with N = 74 participants. Demographic data demonstrated successful sampling across the socioeconomic spectrum of the US (Table 1). Our analysis identified four themes relating patient experiences with discrimination to perceptions of bias in their physician encounters, the outcomes of perceived bias, and suggestions for physician actions to restore the relationships within such encounters when bias is perceived.

3.1. Racism/discrimination is exhausting

Participants discussed their experiences with racism within society and the healthcare system and voiced frustration with the ubiquitous nature of bias. Previous experiences with both explicit racism and subtle slights were common to many of our participants.

One participant described an example of such a slight:

"In my profession it happens all the time because in New York City most attorneys aren't of color. So when you come into the court . . . they usually think that you're a litigant, not an attorney. That happens often." [Latino Man]

Patients may be experiencing subtle slights in the form of bias and discrimination in their day to day lives, potentially affecting

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