# Visiting Black Patients: Racial Disparities in Security Standby Requests

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*Abstract: Background:* Structural inequalities exist within healthcare. Racial disparities in hospital security standby requests (SSRs) have not been previously explored. We speculated hospital SSRs varied based upon race with black patients and their visitors negatively impacted.

*Methods:* An 8-year retrospective study of hospital security dispatch information was performed. Data were analyzed to determine demographic information, and service location patterns for SSRs involving patients and their visitors. The race of the patient's visitors was imputed using the patient's race. The observed and expected (using hospital census data) number of patients impacted by SSRs was compared. Descriptive statistics were computed. Categorical data were analyzed using chi-square or Fisher exact test statistic. A $p < 0.05$ was statistically significant.

*Results:* The majority of the 1023 SSRs occurred for visitors of patients who were white (N = 642; 63%), female (56%), or < 21 years old (50.7%). However, SSRs differed significantly based upon the patient's race. Although Black patients represent 12% of the hospital population, they and their visitors were more than twice as likely ($p < 0.0001$) to have a SSR generated (N = 275; 27%) when compared to the visitors of both White and other (*i.e.,* race unknown) patients (N = 106; 10%) *combined* ($p < 0.0001$).

*Conclusion:* This study adds to the medical errors and healthcare disparities literature by being the first to describe racial disparities in SSRs for Black patients and their visitors. It also introduces the concept of "security intervention errors in healthcare environments." New metrics and continuous quality improvement initiatives are needed to understand and eliminate racial/ethnic based disparities in SSRs.

**Keywords**: Racial disparities and inequities■Health and healthcare disparities and inequities■Medical errors■Security intervention errors in healthcare environments

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## INTRODUCTION

Healthcare disparities remain a national priority and public health issue.[1] Present day Black−White disparities are a reflection of historic practices in the U.S. (*i.e.,* segregated and lower quality health resources) that have consistently resulted in lower quality healthcare and poorer health outcomes for Black patients.[1,2] Despite matching for socioeconomic and insurance status, abundant evidence indicates that Blacks have less access to quality healthcare, receive lesser quality healthcare, and have worse health outcomes than Whites for most diseases studied (*e.g.*, cancer, chronic pain, and heart disease).[1−4]

Across health sectors, several strategies have been proposed to address disparities by focusing on the preparation, recruitment, retention, and promotion of underrepresented racial/ethnic minority healthcare providers.[5,6] Unfortunately, at every stage of this process, the current pace of these initiatives lags behind comparable efforts for Whites, with little prospect of providing a timely response to reducing health and healthcare disparities.[7−9] Moreover, the role of institutional healthcare inequities, bias, prejudice, and stereotyping within healthcare systems remains largely unacknowledged and unaddressed. At a time when the U.S. is increasingly diverse, the racial/ethnic diversity of college campuses, health professional schools and healthcare systems have *not* kept pace; resulting in a failure to provide the needed excellence and diversity in the health professions to address persistent healthcare disparities.[10−12]

This article examines issues of race/ethnicity in relation to healthcare disparities and reports on a first-ever systematic study of race disparities in hospital security standby requests (SSRs) for patients and their visitors *i.e.,* security being called for a present, imminent, or perceived incident/threat. The following sections discuss issues of race/ethnicity in terms of the broader U.S. context, as well as within healthcare interactions and institutions. A case study and data analysis from a quartenary care Midwestern teaching hospital are presented demonstrating consistently higher rates of SSRs in response to Black patients and their visitors as compared to White patients and their visitors. Discussion of study findings highlight interpersonal and organizational factors operating within healthcare settings impacting patient and hospital employee interactions, including enhanced security and policing practices that characterize current hospital settings and the potential escalating role this may have in patient-employee encounters. The article concludes with recommendations for the training and education of hospital employees, description of study limitations, and call for further research efforts that expand the scope and depth of this first effort at examining an under-researched issue.

## RACE/ETHNICITY IN THE BROADER SOCIAL CONTEXT

Accumulated micro-aggressions and macro-aggressions, both within and outside of healthcare systems, over the

life course contribute to increased health and healthcare disparities for Blacks and other racial/ethnic minorities (*e.g.,* decreased quality of life, increased co-morbidities, and decreased life expectancy).[1,13,14] Specifically, racial/ethnic minorities are at increased risk for experiencing micro-aggressions, both explicit and implicit discrimination and racism, everyday discrimination and unfair treatment, as well as macro-aggressions such as physical, emotional, and social trauma.[14–16] Particularly troubling when viewed from a historical perspective and as an ongoing public health issue, are the number of documented macro-aggressions such as the recent killing of unarmed Black men, women, and children by police and security officers.[17–19] These deaths have generated important conversations on the role of race, systemic and systematic biases, as well as protests (and counter-protests) regarding the use of deadly police force in communities across the country.[14,20–23,40–43] Sadly, in 2017 these macro-aggressions, including the deaths of unarmed people, continue and are often accompanied by criminal and civil litigation.[43]

Persistent micro-aggressions and macro-aggressions directed at racial/ethnic minorities, have also heightened awareness about the negative impact of stereotyping, bias, and marginalization.[13–16,20] Beginning in the Fall of 2014, undergraduate and graduate students across U.S. college and university campuses engaged in non violent protests, medical students engaged in "White Coats for Black Lives die-ins," and many football players in the National Football League and other allies engaged in silent protests by taking a knee during the national anthem to raise awareness about racial discrimination, injustice, and inequality as well as the number of unarmed black people seriously harmed or killed by police.[14,20–23,44–46] Their activism yielded increased awareness about the role of Black race and premature mortality due to police. Unfortunately, the increased activism regarding micro-aggressions, discrimination, and racial hatred has also led to violent protests and bodily harm including a death in one university community, i.e., Charlottesville.[47,48]

Research on racial/ethnic differences in health and healthcare, as well as public awareness about the personal costs and social injustice of these disparities is growing. Health and healthcare disparities are associated with significant individual, social, and economic costs that are disproportionately borne by minorities, low income individuals, and marginalized populations. The literature identifies several critical factors including the operation of racial/ethnic based stereotypes, structural barriers in hospitals and healthcare settings, and variability in medical and administrative decision-making.[4,24,25] Further, conscious and unconscious bias operating systematically at individual, systemic, and institutional levels, lead to suboptimal healthcare access, quality, treatment, and outcomes.[4,24–26] Finally, variability in decision-making processes within the clinical encounter and healthcare enterprise is known to contribute to health and healthcare disparities.[4,24–26]

## CASE STUDY

In November 2013, a hospital chaplain practicing in a large teaching hospital, approached a senior administrator. The chaplain expressed concern that hospital security was being called to attend to patient encounters when the more appropriate referral would have been to contact spiritual care (Appendix A). More specifically, the chaplain observed security was called more for Black patients and their visitors than for White patients and their visitors than for white patients and their visitors.

Our research team was approached as an independent party to ascertain the veracity of the observations. We speculated that healthcare was not immune to larger societal problems regarding interracial social perceptions and interactions. The case represented a previously unexamined question in the healthcare disparities literature that deserved further scrutiny. That is, what are the social circumstances associated with hospital SSRs with patients and their visitors. Specifically, a retrospective study was designed to examine 1) whether hospital employee and patient characteristics influence decision-making with regard to SSRs and 2) whether there were racial differences in SSRs for patients and their visitors.

## METHODS

This research project design was submitted and approved by the Institutional Review Board. Written informed consent was waived. A secondary analysis of a unique hospital database containing security dispatch information (since inception in 2006 through June 30, 2014) was performed. The data were analyzed to determine the patterns, location, and types of SSRs generated for patients and their visitors. Using the patient's medical record number, limited patient demographic information (*i.e.,* age, gender, and race) was obtained and the associated medical record was cross-matched with the dispatch data. A detailed analysis examining patient service location (*e.g.,* emergency care, general care, and surgical and intensive care) for SSRs from early 2013 to June 30, 2014 was conducted.

Analyses were conducted in several stages and compared to the hospital census. Descriptive statistics were computed to establish sample demographic characteristics. Categorical data were analyzed using chi-square or Fisher exact test statistic. Statistical significance for all analyses were determined by using 2-tailed tests, with the probability of Type I error $p < 0.05$.