NCC Pediatrics Continuity Clinic
Curriculum: **Disparities in Health Care**

Goals & Objectives:

Upon completion of this module, the learner should be able to:

a. Understand the difference between health disparities and health equity, and the implications for both on research, policy and practice
b. Describe examples of health disparities within various populations
c. Discuss efforts and resources to address health inequities in pediatrics and/or the military population

Pre-Meeting Preparation:

Please read/review the following:

- "The Intersection of Race, Racism, and Child and Adolescent Health" *(PIR, 2022)*
- "The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It." Marcelin JR, Siraj DS, Victor R, Kotadia S, and Maldonado YA. *J Infect Dis* 2019;220:S62-S73.
- "Child Health Disparities: What Can a Clinician Do?" Cheng TL, Emmanuel MA, Levy DJ, and Jenkins RR. *Pediatrics* 2015;136;961.

Conference Agenda:

- Discuss cases
- Review "Being An Active Bystander" handout from The OSU Kirwan Institute for the Study of Race and Ethnicity
- Review quiz questions

Extra Credit:

- Take an Implicit Association Test
- Watch the "The Neuroscience of Decision-Making: Are We Foul or Fair?" TED Talk by Kimberly Papillion, Esq.
- Complete The OSU Kirwan Institute Implicit Bias Module Series
- Kaiser Family Foundation Racial Equity and Health Policy page
- 2023 Kids Count Data Book *(Annie E. Casey Foundation)*

- The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Deficit Hyperactivity Disorder, and Asthma *(Sabin JA and Greenwald AG. Am J Public Health 2012;102:988-995.)*
- The Impact of Racism on Child and Adolescent Health *(AAP Policy Statement, Pediatrics, 2019)*
- Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care *(National Academies, 2003)*

The Intersection of Race, Racism, and Child and Adolescent Health

Monique Jindal, MPH, MD,* Maria Trent, MPH, MD,[†‡] Kamila B. Mistry, MPH, PhD[§]

*Department of Medicine, University of Illinois Chicago, Chicago, IL

[†]Department of Population, Family, and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD

[‡]Division of Adolescent and Young Adult Medicine and [§]Division of General Pediatrics, Department of Pediatrics, Johns Hopkins University School of Medicine, Baltimore, MD

EDUCATION GAP

Although progress has been made in addressing racism as a critical determinant of health in pediatrics, (1) a 2016 study revealed that more than half of medical trainees in the study endorsed false myths about Black patients, including Black patients have thicker skin and, therefore, feel less pain than white patients. (2) Pediatric clinicians require foundational knowledge regarding race, racism, and their relation to health to learn strategies to mitigate the impact of racism on racial health disparities among children and adolescents.

OBJECTIVES *After completing this article, readers should be able to:*

1. Describe race, racial/ethnic health disparities, and health equity.

2. Understand how racism and race-based medicine are linked to adverse health and perpetuate racial health disparities.

3. Understand 3 key mechanisms underlying racial health disparities for children and adolescents: historical and present-day trauma, provider bias (implicit and explicit), and structural racism.

4. Consider strategies to address racism within the field of pediatrics.

ABSTRACT

There has been an increasing focus on the impact of racism both within pediatrics and throughout society as a whole. This focus has emerged as a result of the current sociopolitical climate in the United States coupled with the recent deaths of Black Americans by law enforcement and the maltreatment of Latina/o immigrants. In 2019, the American Academy of Pediatrics released the landmark policy statement "The Impact of Racism on Child and Adolescent Health," which describes the profound effects of racism on health, its function in perpetuating health disparities, and the potential role of child health professionals in addressing racism as a public health issue. (1) Foundational knowledge regarding race, racism, and

ABBREVIATIONS

AIAN American Indian/Alaskan Native
GFR glomerular filtration rate
UTI urinary tract infection

their relation to health are not consistently included in standard medical education curricula. This leaves providers, including pediatricians, with varying levels of understanding regarding these concepts. This article seeks to provide an overview of the intersection of race, racism, and child/adolescent health in an effort to reduce knowledge gaps among pediatric providers with the ultimate goal of attenuating racial health disparities among children and adolescents. Please reference the Table for additional resources to reinforce concepts described throughout this article.

DEFINITION OF RACE

Race is a socially constructed system that artificially divides people into distinct groups based on observable physical characteristics (phenotypes), particularly skin color. (3) There is no biological basis for racial categories. (4) Most physical variation, approximately 94%, lies within racial groups, which means there is greater variation within racial groups than between them. (5) Furthermore, the definition of race has been shown to change as political, economic, and historical contexts change. (6) The US Census highlights the inconsistency in classifying races over time and by location in the country. For example, Asian Indians, a category from the 1980 census, were considered "Hindu" from 1920 to 1940, "other" from 1950 to 1960, and "white" in 1970. Being "Black" has varied both throughout history and in different parts of the country as well. (5) Until the mid-20th century, if a person was white and any other race they could not be classified as white. Some may recall the "one drop rule" denoting that one drop of Black blood precludes one from being white and, therefore, from the rights and privileges of being white. (6) Race classification has also changed based on immigration policy. Jewish, Irish, Italian, and Slavic people were not always classified as completely white but were eventually categorized as white. (7)

Throughout history, race has been used to justify the subordination of different groups based on myths about their genetic or biological predispositions. (7) Superiority and inferiority based on race justified the poor treatment, displacement, and ultimate genocide of indigenous populations in the United States. (8) Racial categories were subsequently used during the American Revolution to create a hierarchy and to justify slavery. (9) Even after slavery was abolished, other policies, such as Jim Crow laws, were developed to systematically oppress Black Americans in the United States. (10) Such exclusion and oppression has been experienced by other populations in the United States as well, ranging from Japanese Americans placed in internment camps to attempts to limit Latina/o immigration (11) and more recently discrimination toward East Asian Americans amidst the coronavirus pandemic. (12)

RACIAL/ETHNIC HEALTH DISPARITIES AND HEALTH EQUITY

According to the US Department of Health and Human Services' Healthy People 2020, racial/ethnic health disparities are health differences that are closely linked to economic, social, or environmental disadvantages and adversely affect groups who have systemically experienced greater obstacles to health based on their racial or ethnic group. (13) Numerous studies indicate that race/ethnicity has strong associations with several health outcomes despite adjusting for measures of socioeconomic status such as education and income. Race/ethnicity instead is thought to determine access to crucial resources, including education and wealth but also prestige, power, and other resources that are often difficult to adequately measure. (14)(15) Such disparities have also been defined as health differences that are "avoidable, unnecessary, and unjust." Health equity, however, is the principle that underlies a commitment to reduce and eliminate disparities in health and give special attention to those at greatest risk based on social conditions. A reduction in health disparities is a marker of progress toward achieving health equity. (16)

Racial/ethnic health disparities among children and adolescents exist across many health outcomes, including but not limited to infant mortality, asthma prevalence, access to primary care, referrals to specialty care, timing of autism diagnosis, likelihood of being activated on a kidney transplant waiting list, time to surgery, lengths of stay, age at heart transplantation, and more. (17)(18)(19)(20)

DEFINITION OF RACISM

Racism is a root cause of racial/ethnic health disparities. (21) Racism is defined as a system of power that structures opportunity (eg, education, housing, jobs, justice) and assigns value (worthy or unworthy, full of potential or full of menace) based on the social interpretation of how one looks (which we call "race"). This system unfairly disadvantages some individuals and communities and unfairly advantages other individuals. Racism is passed on through generations and ultimately creates and maintains a social hierarchy. (22)

Table. Racism Resources

CATEGORY	RESOURCES
Definition of race	Readers may use this video as an introduction to understanding that race is a social construct: *The Myth of Race, Debunked in 3 Minutes*

Racial/ethnic health disparities and health equity	Readers may use the following readings to gain a general understanding of racial/ethnic disparities in health and health-care:
	   "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"
	   Reducing Racial Disparities in Health by Confronting Racism

Definition of racism	The following Ted Talk uses an allegory or story to describe race and racism, including the multiple levels of racism via Camara Jones' Gardeners Tale:
	   Camara Jones' Allegories on Race & Racism
	The link to the written version is provided as well:
	   A Gardener's Tale
	Dr Brene Brown and renowned author Ibram Kendi discuss Kendi's book *How to be an Antiracist*:
	   Unlocking Us with Brene Brown: Guest, Ibram Kendi

Racism and health	This Ted Talk, podcast, and collection of previous publications can be reviewed for an overview of racism's effect on health:
	   David Williams' *How Racism Makes Us Sick*
	   Social Distance Podcast: *How Racism Kills Black Americans*
	   American Academy of Pediatrics' *Pediatric Collection of Publications on Racism and Pediatric Health*

Race-based medicine and health	Law scholar Dorothy Roberts discusses how race is used as a medical shortcut and the potential for harm in her Ted Talk: Dorothy Roberts' *The Problem with Race-Based Medicine*

Historical trauma	The *New York Times Magazine* developed the 1619 project in an effort to reframe US history in the context of slavery and the contributions of Black Americans. Essays, poems, and podcasts can be accessed through the following link:
	   The 1619 Project Ibram Kendi writes about the roots of racism in historic policies and procedures through the following book:
	   Stamped from the Beginning
	Ta-Nehisi Coates writes an essay for *The Atlantic* highlighting the argument that Black Americans are owed compensation for their treatment in the United States:
	   The Case for Reparations

Implicit bias	Readers can take Harvard's implicit association test to interrogate their own implicit biases through the following website:
	   Project Implicit
	The following books explore hidden biases that all humans carry as well as their potential manifestations in health-care:
	   Banaji & Greenwald's *Blindspot*
	   Augustus White's *Seeing Patients: Unconscious Bias in Health Care*

Structural racism	The following website contains short clips describing aspects of structural racism, such as redlining and how the racial wealth gap was created:
	   Race: The Power of an Illusion
	The following book provides a deep dive into segregation and its impact in the United States:
	   Rothstein's *Color of Law*
	The following Ted Talks highlight the presence of structural racism within the criminal justice system:
	   Michelle Alexander's *The Future of Race in America*
	   Bryan Stevenson's *We Need to Talk About an Injustice*
	This *New England of Medicine* perspective piece discusses structural racism and health:
	   How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities

Intrapersonal context strategies	
Create a psychologically and culturally safe medical home	This toolkit can be used to ensure that ideas and decisions made within the medical home/clinical space foster racial equity: The Government Alliance on Race and Equity (GARE) Toolkit

Understand racial identity development and promote child exposure to diversity	The following resources can assist in discussing race and racism with youth:
	   NPR's Talking Race with Young Children
	   http://www.raceconscious.org
	   https://www.embracerace.org
	   Sesame Street's Racism Townhall
	Providers can watch the following video and use with their learners. This video is a replication of the Doll test referenced in the text:
	   Doll Test
	This organization's mission is to produce and promote literature that reflects the lives of all children and provides examples of potential books for clinical spaces or literacy programs such as Reach Out and Read:
	   We Need Diverse Books
	Clinicians can read the following book for a more detailed understanding of race, racism, and racial identity:
	   Tatum's *Why Are All the Black Kids Sitting Together in the Cafeteria?*

Table. Racism Resources (Continued)

CATEGORY	RESOURCES
Use the raising resisters approach	The following book is written by the psychologist who developed the raising resisters approach: Janie Ward's *The Skin We're In*
Interpersonal context strategies	
Mitigate bias	See above for the link to the implicit association test The below article further describes mitigating strategies discussed in the text: Dr Quinn Capers' *Everyday Solutions to Reduce Bias*
Institutional context strategies	
Create standardized curricula based on current evidence	MedEdPORTAL's Anti-Racism Collection Below is a link to *Academic Medicine's* recent special issue on "Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments": *Academic Medicine* December 2020 Volume 95 issue
Reevaluate institutional race-based medicine practices	The following report describes why biological race should be abolished in medicine: *Towards the Abolition of Biological Race in Medicine*
Optimize diversity of the medical workforce	The following 2 articles can be used as guides in how to perform antiracist recruitment and minimize bias: Dr Quinn Capers' "How Clinicians and Educators Can Mitigate Implicit Bias in Candidate Selection" "Developing an Anti-Racist Residency Recruitment Process"
Analyze quality of care with racial disparity lens	The following commentary discusses the importance of collecting data by race and going beyond documenting racial disparities toward interrogating the causal mechanisms: Dr Camara Jones' Invited Commentary: "Race," Racism, and the Practice of Epidemiology"
Critically appraise race in medical research	The following Health Affairs blog addresses standards for appraising race in research: On Racism: A New Standard for Publishing on Racial Health Inequities
Community and public policy context strategies	
Desegregate	This essay provides foundational knowledge in understanding the impact of segregation on health: *Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda*
Limit criminal justice involvement	The following writings discuss the impact of policing on child health and provide foundational knowledge to advocate for change, such as limiting police presence in schools: Dr Rhea Boyd's *Police, Equity and Child Health* "6 Things You Need to Know about School Policing" "De-Policing America's Youth: Disrupting Criminal Justice Policy Feedbacks That Distort Power and Derail Prospects"
Advocate within the educational system	The following organization provides free resources to educators to promote antibias education: Teaching Tolerance

Note: This table is not intended to be an exhaustive list of resources but rather a place to start in understanding the intersection of race, racism, and health.

Previous work by Jones (23) described 3 levels of racism: personally mediated, institutional, and internalized. *Personally mediated* racism is what most people think of when they hear the word *racism*. *Personally mediated* racism includes prejudice or assumptions about the abilities, motives, and intentions of others according to their race, as well as discrimination or actions toward others according to their race. These can be acts of commission or omission. Jones (23) describes *institutional* racism as differential access to goods, services, and opportunities by race. Although many use the terms *structural* and *institutional* racism interchangeably, there are distinct differences in these concepts. *Structural* racism refers to the "ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems ... (eg, in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc) that in turn reinforce discriminatory beliefs, values, and distribution of resources." (24) *Institutional* racism, however, lies within structural racism and refers specifically to "discriminatory policies and practices carried out ... [within and between individual] state or non-state institutions." (25) Although these policies may have explicitly named race in the past (eg, school segregation), many currently do not (eg, employer practices of screening applications based on zip code). *Internalized* racism is acceptance of negative messages about one's own intrinsic worth by members of a stigmatized race. For a comprehensive overview of the 3 levels of racism and an allegory that assists in explaining the levels, we recommend reading or watching the Gardener's Tale. (23)

Although children and adolescents may directly experience racism at each of these levels, children can also be indirectly impacted by racism as bystanders through *vicarious racism*. Vicarious racism is indirect exposure to prejudice or discrimination that is experienced by friends, families, and strangers. Data suggest that children and adolescents who are bystanders to experiences of racism have both physiologic and psychological responses and often are affected long after the initial encounter. (26)

RACISM AND HEALTH

Racism, not race, predicts health. (27) Racism's effect on health can be understood through Bronfenbrenner's socioecological model, which considers the influence of multiple environmental layers, including intrapersonal, interpersonal, institutional, community, and public policy, in producing overall health. (28) The levels of racism (internalized, interpersonal, institutional/structural) operate within each of these socioecological levels (Fig). (29) Additional research has highlighted the differential effect on child and adolescent health depending on the level of racism. More specifically, child and adolescent experiences of interpersonal racism have been linked to a multitude of pediatric health outcomes, including depression and anxiety, (30) as well as suicidal ideation. (31) Structural racism has been linked to adverse birth outcomes, including small for gestational age, increased risk of chronic disease, increased exposure to air pollution, racial disparities in police shootings of unarmed individuals, and more. (25)(32)(33) Internalized racism is associated with depression, psychological distress, and poor metabolic health. (34)(35) Last, as highlighted previously, children and adolescents who experience vicarious racism have bodily responses, with a negative effect on both socioemotional and mental health. (26)

There are several existing theories describing how racism is linked to adverse health. Weathering is a theory that proposes that the cumulative impact of stressors such as racism cause "wear and tear," which accelerates aging and explains the physical consequences of social inequities. (36) More recently, weathering has been tied to the theories of allostasis and epigenetics. Allostasis is the theory that chronic stress exposure (ie, experiences of racism) leads to increased allostatic load, or adaptive costs, resulting in alteration of brain structure, neuronal conne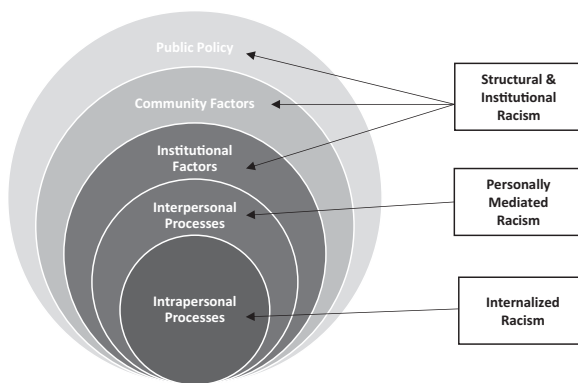ctivity, and premature aging. (37) When the body undergoes a social or physical stressor, the sympathetic nervous system and the hypothalamic-pituitary-adrenal axis are activated, leading to release of catecholamines and cortisol, respectively. Such hormone production stops once the stressor has subsided. However, if a body is chronically stressed, these response systems remain activated, resulting in high allostatic load, which has been linked to poor health outcomes. (36)(37) The field of epigenetics has also seen recent advances, with research showing the impact of racism on gene expression (eg, DNA methylation/shortening of telomeres). (38) Although some research has revealed the impact of historical trauma on gene alteration in subsequent generations, (39)(40) this remains an important area for future research. (41)

In addition, the life course perspective, which describes a multidisciplinary approach to understanding the mental, physical and social health of individuals, has implications for understanding the impact of racism on health. The life course approach examines human experiences throughout time as an individual is affected by the prenatal environment (eg, maternal experiences of racism linked to low birthweight), is born into a unique historical period (eg, decline in infant mortality after enactment of the Civil Rights Act), undergoes life events during critical or sensitive periods (eg, first experience of racism during early childhood), enters and exits social pathways and systems (eg, structural racism via education and employment), becomes interlinked with social networks (eg, impact of a friend's experience of racism), experiences stress proliferation, one stressor leading to another (eg, a Black adolescent male detained by police with subsequent effect on access to social goods), and more. (42)(43)

RACE-BASED MEDICINE AND HEALTH

Although it is well-known that social conditions have led to racial disparities, the medical field continues to focus on disparate outcomes by race as a basis for continued use of racial categories in medical diagnosis and treatment, a common practice that reinforces a damaging and scientifically flawed understanding of race. Similar to the concept of race, race-based medicine is rooted in the foundations of slavery and has been used as a means to systemically oppress certain groups. A prominent example of this is race-based guidelines for the diagnosis and treatment of hypertension. The underpinnings of such recommendations are based on the hypothesis that Black people tend to retain salt, and this is why they were able to survive the conditions during trans-Atlantic slave trade, which included but were not limited to intense heat and limited

Figure. Bronfenbrenner's socioecological model applied to the levels of racism.

water. (44) Although hypertension is not as common among children, there are several other examples of race-based medicine in pediatrics. Race-based corrections for lung capacity also have their basis in slavery. Dr Samuel Cartwright in the 1850s claimed that Black people have lower lung capacity than white people and for this reason slavery was beneficial for Black people and a way to "vitalize their blood." He helped develop the spirometer, which applies correction factors of 10% to 15% for individuals labeled as Black. (45) Although some scientists continue to cite literature that supports racial differences in lung capacity, a recent systematic review reveals that among these commonly cited studies, race/ethnicity is rarely defined and socioeconomic status is not examined. Indeed, few studies address the impact of environmental or social factors, such as exposure to toxins or experiencing the stress of ongoing racial discrimination. (46)

Similarly, the widely used Modification of Diet in Renal Disease equation for glomerular filtration rate (GFR) corrects for race, resulting in higher GFR values in Black people. Some claim that Black people have higher muscle mass and, therefore, release more creatinine, (47) and others largely dispute this. (48) The current race adjustments, which yield higher estimates of kidney function, may lead to delayed referral for both specialist care and transplantation, ultimately leading to worse outcomes. (49)

In addition to previously described measurements such as pulmonary function tests and GFR, diagnosis and treatment guidelines also reinforce race-based medicine. A 2011 American Academy of Pediatrics' guideline for the diagnosis and management of urinary tract infections (UTIs) in children with fever indicated that white or non-Black patients have a higher probability of UTI. (19) This may have contributed to the underdiagnosis of UTI in Black children. This guideline was reaffirmed in 2016 and subsequently retired in 2021, (50) when the validity of race-based guidelines started being called into question more consistently. (51)

Diseases have also been commonly taught as race-based, such as sarcoidosis and sickle cell anemia. (52) Although sickle cell anemia is often thought to be a disease of Black individuals, it can be found across populations in Africa and the Mediterranean. Sickle cell trait is protective against malaria, and for this reason the trait tends to persist in areas with endemic malaria, such as parts of Africa. (53) The racial distribution of patients with sickle cell anemia in the United States instead reflects the capture and transport of Africans from West Africa to the United States during the slave trade.

THE IMPACT OF HISTORICAL AND PRESENT-DAY TRAUMA WITHIN HEALTH-CARE, PROVIDER BIAS, AND STRUCTURAL RACISM

Historical and present-day trauma, provider biases, and the structural racism embedded in society are key drivers of racial/ethnic health disparities.

Historical and Present-day Trauma within Health-care

Discriminatory events (ie, poor treatment) within the medical system have contributed to widespread trauma in Black communities. (54) A commonly cited example is the Tuskegee syphilis study that occurred from 1932 to 1972 in which the natural progression of untreated syphilis was studied. Despite medical professionals' eventual access to effective antibiotic treatment, Black men continued to be studied while being denied treatment, which led to significant effects on their lives as well as the health of their wives and children. (55) Although this is the most often described example of exploitation of Black individuals in medical history, there are several others, such as experimentation on those enslaved to perfect ovarian tumor removal, testing of the smallpox vaccine, trials of general anesthesia, and more. (56) The case of Henrietta Lacks, a young Black woman who died of cervical cancer in 1951 and whose cells have been used to advance science without her or her family's consent or knowledge, is another important example of maltreatment within the medical system. (57)

The impact of historical trauma can be understood via Sotero's conceptual model that proposes that trauma begins with the subjugation of a group by the dominant culture via physical or psychological violence, segregation or displacement, economic deprivation, and cultural dispossession with an effect on primary, secondary, and subsequent victims. (58) The impact of racialized trauma can be seen with Black individuals' ongoing perceptions of discrimination within health-care. A recent study revealed that approximately 60% of Black individuals believed that the government was hiding information about the human immunodeficiency virus/AIDS epidemic or that human immunodeficiency virus derived from a man-made virus. (59) Other work reveals that Black individuals often avoid participation in research and organ donation due to medical mistrust. Patients cite their own perceptions of deception by providers, present-day experiences of racism from the medical field, and historical injustices against their communities within health-care as key drivers of their medical decision making. (60)(61) Trauma-related work

also suggests that contemporary experiences of racial trauma reinforce the negative effects of historical trauma. (62)

Although it is important for clinicians to understand the impact of trauma on their patients and their medical decision making, the impact of trauma should be considered within the greater context of racism as a whole. More recently, mistrust has dominated conversations surrounding the COVID-19 pandemic and vaccine uptake. However, focusing on mistrust is akin to patient blaming and has been described as a "scapegoat," a way to avoid addressing structural racism, which has affected factors such as vaccine distribution and access to trusted messengers and regular medical providers. Medical exploitation of Black communities, therefore, is ongoing and reflects a need for health-care systems and individuals to become more trustworthy. (63)

Provider Bias

In 2002, the Institute of Medicine's report "Unequal Treatment" highlighted the potential role of provider bias in perpetuating racial and ethnic health disparities. (64) Biases can be expressed implicitly or explicitly. Implicit bias or preference refers to automatic thoughts, feelings, and attitudes that often exist outside of conscious awareness. Explicit bias refers to conscious thoughts, feelings, and attitudes that one is aware of and can choose whether to reveal. (65) Racial bias is pervasive in the general population, with more than 70% of people showing implicit preference for white people compared with Black people. Although physicians generally report an explicit desire to provide equitable care, (66) physicians too have an overall preference for white patients consistent with that of the general population. (67) Although such evidence has often been built by using the implicit association test, a computer-based test that traditionally uses adult faces to assess racial bias, a recent study using children's faces demonstrated that pediatricians, no different than other physicians, show similar racial biases toward their patients. (68) A recent systematic review further indicates that most studies interrogating provider racial bias show that physicians consistently have anti-Black/pro-white bias. (69)

Provider bias affects care delivery. A meta-analysis of 155 studies revealed that implicit racial attitudes predicted prejudiced behavior more accurately than self-reported or explicit measures. (70) Implicit or unconscious bias among providers has also been implicated in the provision of health-care. One study suggests that physicians with pro-white implicit bias are more likely to treat white patients according to the professionally accepted standard of care for acute coronary symptoms compared with their treatment of Black patients. (67) This phenomenon is not restricted to adult care. Implicit bias has also been linked to the observed racial disparities in infant mortality, asthma, pain control, and obesity within pediatrics. (71) More specifically, pediatricians have been shown to provide racially disparate pain control for children with appendicitis, with Black children being less likely to receive any pain medication for moderate pain and less likely to receive opioids for severe pain compared with White children. (72) Similar trends have been shown for pain control for Black children with long bone fractures and was associated with the provider's levels of anti-Black bias. (73) Other examples include disproportionate screening of Black children for nonaccidental trauma and sexually transmitted infections. (74)(75)

Structural Racism

Although biases drive interpersonal racism within health-care and, therefore, contribute to health disparities, these interactions occur in the context of structural racism. Structural racism is defined as the systems that perpetuate and reinforce "race-based social ostracism, in which phenotypic or [perceived] cultural characteristics are used to target individuals for social exclusion, unfair treatment, and harassment." (76) Structural racism works through policies, laws, and regulations at local, state, and national levels that result in differential access to goods, services, and opportunities based on race. Even if interpersonal discrimination was completely eliminated, racial inequities would likely remain unchanged due to the persistence of structural racism. (23) Structural mechanisms such as these do not require the actions or intent of individuals to function or exert their effects on individuals. (77)

Although there are multiple forms of structural racism in society, we highlight the health effects of residential segregation and the criminal justice system. Residential segregation refers to physical separation of races by enforced residence in particular areas and is an example of structural racism with far-reaching impact across generations. Despite the absence of supportive legal statutes currently, residential segregation remains high and much of the current state of residential segregation in the United States is based on policies dating back hundreds of years. The Indian Removal Act of 1830 led to the displacement, destabilization, and destruction of Native American communities to areas west of the Mississippi. In 1862, the Homestead Act granted formerly American Indian

territory land to adult heads of families, excluding racial/ethnic minorities. Subsequently, in the 1930s, the Federal Housing Administration used redlining, or the designation of neighborhoods as "hazardous" based on racial demographics. Neighborhoods with higher populations of Black individuals or immigrants were consistently rated lower. Redlining affected the distribution of loans and low-cost mortgages to returning World War II veterans as a part of the GI Bill because the program adopted the biased Federal Housing Administration standards. Over time, this discrimination has resulted in systematic denial of capital investments to improve economic opportunities for all Americans and has resulted in downstream effects on access to services, including transportation, education, food security, and health-care. Beyond concentrating poverty and access to resources, residential segregation also concentrates environmental pollutants and infectious agents, affecting health outcomes such as asthma and cancer. (78)(79)(80) Specifically related to health-care services, segregated neighborhoods predominated by minority groups are more likely to have pharmacies with inadequate medication supplies, (81) hospitals with limited resources, (82) and lower-quality care provision. (83) For child health, residential segregation has been specifically linked to adverse birth outcomes. (84) Despite societal changes over time, the United States remains largely segregated, with continued residential isolation of Black individuals and consequent concentration of poverty. (85)

The criminal justice system via policing practices and the mass incarceration of Black Americans is another example of structural racism. Present-day policing practices can be traced back to slavery, when police forces, made up of white volunteers, were created in an effort to surveil and contain "runaway slaves." Once slave patrols were dissolved, Black codes came into existence that specified Black people's possible places of employment, wages, lack of voting rights, and housing restrictions. After these codes were made illegal, Jim Crow laws then came into effect mandating separate public spaces for Black individuals versus white individuals to reinforce racist practices. (86) Presently, Black Americans are more likely to be stopped by police, to have multiple contacts with police, and to experience threat or use of force compared with their white counterparts. (87) Similarly, 1 of every 3 Black boys can be expected to be sentenced to prison compared with 1 of every 17 white boys. (88) A recent study reveals that states with higher levels of racial disparities in segregation, incarceration, education, and economic status also have higher levels of unarmed Black individuals being killed by police, highlighting the impact of structural racism on health. (33) This phenomenon also extends to how children are disciplined in schools, with the tendency to criminalize youth-related behaviors of Black children, ultimately contributing to what is often called the school to prison pipeline. (89) Of note, contact with police has been associated with adverse health for Black children and adolescents across multiple domains including mental health, risk behaviors such as smoking and maltreatment. (90)

The effects of structural racism are not exclusive to Black Americans. Other racial/ethnic minorities, including but not limited to American Indian/Alaskan Native (AIAN) and Latina/o populations, similarly experience the detrimental results of structural racism. AIAN people were forcibly removed from their land and their children were sent to boarding schools, where students were prohibited from speaking their native language, given European names, and forced to have European haircuts in an effort to cleanse them of their culture and norms. Following the aforementioned Indian Removal Act in 1830, thousands of Native Americans died of hunger and disease, often referred to as a genocide. Decades later, communally held tribal lands were seized by the federal government and redistributed between Native American families and white Americans. The land given to Native families, however, was not suitable for farming. Many tribal nations were subsequently placed under state jurisdiction, contributing to not only loss of land but also loss of self-governance. Such policies, laws, and practices have led to AIAN people experiencing some of the highest levels of financial insecurity in the country as well as poor health. (91) AIAN children and adolescents experience higher rates of obesity, depression, substance abuse, and suicide compared with their white counterparts. Some of the many factors contributing to poor health in this racial/ethnic group are linked to structural racism's impact on access to healthy food, underfunded health-care and educational systems, geographic isolation, and more. (92)

STRATEGIES TO ADDRESS RACISM IN MEDICINE

As previously described, racism operates within the context of the socioecological model at the intrapersonal, interpersonal, institutional, community, and public policy levels (Fig). To address racism's effect on child and adolescent health, strategies that have been studied are described herein.

Intrapersonal Context

Internalized racism operates within the intrapersonal environment.

Create a Psychologically and Culturally Safe Medical Home. To address the potential impact of internalized racism on children, clinical settings can provide psychological safety for patients and use the tenets of trauma-informed care, which include screening, ensuring providers' understanding of their own history, engaging in interprofessional collaboration, understanding the health impact of trauma, and providing patient-centered communication and care. (93) Clinics can also provide appropriate mental health referrals for racialized trauma (94) as well as a mechanism for reporting experiences of discrimination within the health-care setting. (95)

Understand Racial Identity Development and Promote Child Exposure to Diversity. Providers can educate themselves on racial identity development and the importance of diversity for children of all backgrounds. Research shows that as early as age 3 to 6 months children notice differences in skin color, by age 3 to 4 years can express explicit forms of racism, and by age 10 to 12 years may become set in their beliefs. (96) Clinicians can use these stages of racial identity development to guide anticipatory guidance. Research also has shown that positive representation of minorities and exposure to diverse settings is beneficial to child development. Regardless of race, children exposed to diversity are more likely to enroll in college and to have higher test scores, improved self-confidence, and enhanced leadership skills. (97) One mechanism to achieve child exposure to diversity is through literacy promotion programs such as Reach Out and Read, which can infuse cultural diversity within clinics by promoting and providing books that tell diverse stories and are written and illustrated by diverse authors and illustrators. (1)

Use the Raising Resisters Approach. Providers can use the raising resisters strategy to assist patients and families in recognizing racism, differentiating racism from other forms of unfair treatment or developmental stressors, opposing negative messages or behaviors in a safe manner, and countering or replacing messages or experiences with something positive. (98) This strategy can be more simply described as "name it, read it, oppose it, replace it." Dr Janie Ward's book *The Skin We're In* further discusses this strategy as a method for assisting minority children in experiences of racism. (99)

Interpersonal Context

Personally mediated racism operates within the interpersonal environment.

Mitigate Bias. Although literature supporting the use of specific strategies to mitigate racial bias in health-care is limited, social psychology literature does support the use of empathy and perspective-taking, or the act of putting yourself in someone else's shoes. (100) One study found that nurses who initially exhibited pro-white bias in pain control reduced their bias after engaging in an empathy-inducing, perspective-taking exercise. Nurses first watched videos of real Black and white patients experiencing pain and subsequently provided pain treatment decisions, which revealed a wide racial disparity. Subsequently, nurses were asked to watch the same videos, but imagine how the pain affects the patient's life. This perspective-taking exercise attenuated the racial disparity in pain treatment by 55%. (101) Other strategies that have been studied include exposure to positive out-group examples, (102) exploring common identities, (103) and increased intergroup contact. (104) Each of these strategies require diversification of the pediatric workforce, which is discussed later herein.

Burnout has also been associated with medical professional explicit and implicit racial biases. (105) Burnout reduction strategies such as stress management and self-care training, mindfulness, small group discussion, and structural interventions such as duty hour requirements have all been shown to be effective (106) and can be prioritized in programs committed to racial bias mitigation. (107)(108)

Institutional Context

Institutional/structural racism operates within the institutional context as well as the community and public policy contexts.

Create Standardized Curricula Based on Current Evidence. Since the Institute of Medicine's report "Unequal Treatment," (64) there has been increasing attention to strategies that address physician biases, including the Liaison Committee on Medical Education's mandate for educational initiatives to address awareness of biases. However, there is a dearth of research evaluating any such curricula. (109) A survey of pediatric program directors showed that program directors believe this training could be helpful but are uncertain whether the current methods of training are impactful. (110)

Although teaching regarding social determinants of health and health disparities has become more common, few medical resources include discussions of race and racism. (111) MedEdPORTAL, an online journal of teaching and learning resources for health professions published by

the Association of American Medical Colleges, provides a bank of potential antiracism educational resources. (112) Many of the current offerings, however, solely focus on implicit bias and are offered as single sessions, which some research has shown to be ineffective. (109) Implicit bias teaching and encouraging reflection of personal biases can be coupled with historical trauma and structural racism teaching. (113) Approaches from other disciplines can also be adapted as the medical community continues to teach and evaluate the most effective practices for such education. Previous work in this area suggests that the often-used framework of cultural competency promotes stereotypes, reinforces reductive understandings of identity without consideration of context, and allows an individual to believe they can achieve competence in other life experiences. (114) A previous systematic review found that although cultural competency training may increase knowledge and awareness, it rarely improves outcomes. (115) Education efforts can shift to structural competency instead, which recognizes and emphasizes the complex contextual frames that drive racial health disparities. (116) Previous work also suggests the importance of follow-up sessions to allow for continued critical self-reflection as well as small group settings to encourage robust dialogue. (117)(118) Active learning strategies such as simulation and teaching of skills such as patient-centered communication can also prepare pediatric providers to serve a diverse patient population. (119)(120)

Reevaluate Institutional Race-Based Medicine Practices. Given continued conflation of biology and the social construct of race within medicine (eg, spirometry, estimated GFR), institutions can organize for change and advocate to have race corrections or race-based algorithms removed from clinical practice norms. (52) Mentioning race at the beginning of clinical presentations is often practiced and suggests that a patient's race may predict disease probability and drug response or even provide information about a patient's diet, education, or cultural norms. Some research has shown that race is more often specified in presentations of Black patients compared with white patients and furthermore that race specification of Black patients is associated with references to demeaning characteristics such as illiteracy, unemployment, and violence. (121) Clinicians can avoid the use of race in clinical presentations, which reifies the fallacy of biology and race, and ensure that race is not used as a proxy for genetic variation, social class, or other parts of the social history. (122) Institutions as well as national organizations can also evaluate their allocation of resources for diseases often misattributed to race, such as cystic fibrosis and sickle cell disease. Despite 3 times as many Americans experiencing sickle cell disease, cystic fibrosis is 8 times as likely to receive funding. (123)

Optimize Diversity of the Medical Workforce. Black, AIAN, and Latina/o individuals are underrepresented in pediatrics, promoted more slowly, and retained poorly, particularly within academics. (124) A 2006 review found that physician-patient race concordance increases patient satisfaction, patient comprehension, and continuity of care. (125) Furthermore, racially diverse teams outperform less diverse ones. (126) Institutions can use holistic recruitment processes to increase the racial diversity of the physician workforce. (127)(128) This can be coupled with retention efforts such as peer support, (129) career development and advancement opportunities, (130) and support in the development of mentorship or sponsorship teams. (68) Institutions can also consider reevaluating their promotion standards given that racial/ethnic minority pediatricians often carry an unfair burden of diversity efforts without compensation or promotion. (124)(131)

Analyze Quality of Care with a Racial Disparity Lens. Clinics, hospitals, organizations, and governing bodies can ensure that quality improvement programs and quality care assessments include data collection and analyses by race. (132) Once data are collected, observed race-associated differences can then be further interrogated, as described later herein. Although race is a social construct and there is some discussion regarding how collecting data by race may reify race as biology, (133) the racial categories to which one is assigned within a race-conscious society can dictate social experiences and the distribution of risk and opportunity. (134) As long as there are racial differences in health outcomes, it remains important to report, monitor, and interrogate these disparities in an effort to eliminate them.

Critically Appraise Race in Medical Research

Researchers can define race during the design of a study and specify the purpose of its use during the conception of the study. Researchers can also prioritize use of racially diverse samples to allow for comparisons across groups and sample races across various socioeconomic strata. (107) Researchers can include measures that interrogate racism, not race, as the critical driver of health inequities and name racism in their work. (108) When race is used to understand the impact of racism on an outcome, scholars can perform analyses with effect modification or racial stratification rather than using race as a covariate. Using race as a covariate adjusts for the potential confounding effect of race on the exposure and outcome being studied.

Race stratification is the practice of separating data by racial groups and then exploring what factors may contribute to racial differences observed. As Dr Jones explains regarding racial stratification, "This strategy treats race like the side of the city on which people live, as a marker for differential experiences and exposures rather than as a factor inherent to the person." Last, using race as an effect modifier explores how the relationship between an exposure and an outcome differs depending on race.

Community and Public Policy Contexts

Racial health equity cannot be achieved without addressing racism via multidisciplinary partnerships, including the community, the criminal justice system, and the educational system. This section provides some examples of how clinicians can partake in such advocacy work.

Desegregate. As previously mentioned, residential segregation has profound effects on health. (84) Providers can advocate for desegregation of cities and neighborhoods as well as fair housing practices. Relatedly, providers and institutions can engage with community leaders to ensure access to resources within their jurisdictions, such as safe outdoor areas, stores that carry healthy food options, and schools with high-quality education. (135)

Limit Criminal Justice Involvement. With Black children having disproportionate contact with police and the criminal justice system, (136) providers can advocate for policies and practices that limit child and adolescent contact with law enforcement as well as alternative strategies to youth incarceration. (137)

Advocate Within the Educational System

Similar to health-care, educational providers can benefit from implicit bias and antiracism curricula given the racial disparities in both academic outcomes and rates of suspension and expulsion that reflect systemic racism. (138) Providers and their institutions can advocate for policies that support such training as well as for increased access to mental health services within schools, which will assist with handling disruptive behavior in the school setting. (139)

Summary

Racism has detrimental effects on the health and well-being of all children and adolescents. As individuals, whether within our own personal networks, our clinical practices, our medical institutions, or our professional organizations, it is essential to keep the impact of racism in all forms in our constant view. Understanding the intersection of race, racism, and child health is essential to providing equitable care to our patients and families. By consensus:

- Race is a social construct without biological underpinnings.

- Racism is a system of power that structures opportunity and assigns value based on the social interpretation of how one looks.

- Racism, not race, is a root cause for racial health disparities.

- The use of race-based medicine is based on the biological fallacy of race and can be challenged.

- The understanding of concepts such as race, racism and its many forms, and the particular effects of historical and present-day trauma, provider bias, and structural racism on health can be taught.

- As racial disparities continue to persist, and in many cases grow, it is incumbent on us all to do our part by committing to lifelong learning, unlearning, and teaching regarding the intersection of race, racism, and health.

SUPPLEMENT ARTICLE

The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It

Jasmine R Marcelin,[1] Dawd S. Siraj,[2] Robert Victor,[3] Shaila Kotadia,[3] and Yvonne A Maldonado[3]

[1]University of Nebraska Medical Center, Omaha; [2]University of Wisconsin, Madison; and [3]Stanford University School of Medicine, California

The increasing diversity in the US population is reflected in the patients who healthcare professionals treat. Unfortunately, this diversity is not always represented by the demographic characteristics of healthcare professionals themselves. Patients from under-represented groups in the United States can experience the effects of unintentional cognitive (unconscious) biases that derive from cultural stereotypes in ways that perpetuate health inequities. Unconscious bias can also affect healthcare professionals in many ways, including patient-clinician interactions, hiring and promotion, and their own interprofessional interactions. The strategies described in this article can help us recognize and mitigate unconscious bias and can help create an equitable environment in healthcare, including the field of infectious diseases.

Keywords. Unconscious bias; diversity and inclusion; mitigating strategies.

There is compelling evidence that increasing diversity in the healthcare workforce improves healthcare delivery, especially to underrepresented segments of the population [1, 2]. Although we are familiar with the term "underrepresented minority" (URM), the Association of American Medical Colleges, has coined a similar term, which can be interchangeable: "Underrepresented in medicine means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population" [3]. However, this definition does not include other nonracial or ethnic groups that may be underrepresented in medicine, such as lesbian, gay, bisexual, transgender, or questioning/queer (LGBTQ) individuals or persons with disabilities. US census data estimate that the prevalence of African American and Hispanic individuals in the US population is 13% and 18%, respectively [4], while the prevalence of Americans identifying as LGBT was estimated by Gallup in 2017 to be about 4.5% [5]. Yet African American and Hispanic physicians account for a mere 6% and 5%, respectively, of medical school graduates, and account for 3% and 4%, respectively, of full-time medical school faculty [6]. As for LGBTQ medical graduates, the Association of American Medical Colleges does not report their prevalence [6]. Persons with disabilities are estimated to be 8.7% of the general population [4], while the prevalence of physicians with disabilities has been estimated to be a mere 2.7% [7].

Furthermore, although women currently outnumber men in first-year medical school classes [8], gender disparities still exist at higher ranks in women's medical careers [9–11].

Unconscious or implicit bias describes associations or attitudes that reflexively alter our perceptions, thereby affecting behavior, interactions, and decision-making [12–14]. The Institute of Medicine (now the National Academy of Medicine) notes that bias, stereotyping, and prejudice may play an important role in persisting healthcare disparities and that addressing these issues should include recruiting more medical professionals from underrepresented communities [1]. Bias may unconsciously influence the way information about an individual is processed, leading to unintended disparities that have real consequences in medical school admissions, patient care, faculty hiring, promotion, and opportunities for growth (Figure 1). Compared with heterosexual peers, LGBT populations experience disparities in physical and mental health outcomes [15, 16]. Stigma and bias (both conscious and unconscious) projected by medical professionals toward the LGBTQ population play a major role in perpetuating these disparities [17]. Interventions on how to mitigate this bias that draw roots from race/ethnicity or gender bias literature can also be applied to bias toward gender/sexual minorities and other underrepresented groups in medicine.

The specialty of infectious diseases is not free from disparities. Of >11 000 members of the Infectious Diseases Society of America (IDSA), 41% identify as women, 4% identify as African American, 8% identify as Hispanic, and <1% identify as Native American or Pacific Islander (personal communication, Chris Busky, IDSA chief executive officer, 2019). However, IDSA data on members who identify as LGBTQ and members with disabilities are not available.

Correspondence: J. R. Marcelin, MD, Division of Infectious Diseases, University of Nebraska Medical Center, 985400 Nebraska Medical Center, Omaha, NE 68198-5400 (jasmine.marcelin@unmc.edu).

Glossary of key terms used in discussion of unconscious bias

Active bystander—A person who witnesses a situation, acknowledges the potential problem, and speaks up about it [59]

Bias—Tendency to favor one group over another; biases can be favorable or unfavorable and can be unconscious (implicit or unintentional) or conscious (explicit or intentional) [14]

Cultural humility—Defined by its ongoing self-reflection: a lifelong commitment to continuously evaluate one's own behaviors, beliefs, and identities and determine how potential biases and assumptions may surface when collaborating with an individual of a different background [72]

Intent vs impact—Concept that the focus of behavioral change should consider the impact on the recipient regardless of the *intent* of the offending behavior (ie, whether a result of unconscious or conscious bias) [59]

Microaggression—"Brief and commonplace daily verbal/nonverbal behavioral, and environmental indignities whether intentional or unintentional that communicate hostile, derogatory or negative racial/ethnic, gender, sexual orientation, and religious slights and insults" [73], (p. 271); these can occur wherever people are perceived as "other"; some groups have a lifetime burden of microaggressions that can contribute to physical or psychological illness

Prejudice—Outward expressions of negative attitudes towards different social groups [20]

Stereotype—An oversimplified, fixed, and widely held belief about an entire group of people; stereotypes may not always be accurate, especially when they lead to judgments applied to individuals within that group [14]

Unconscious bias—Attitudes or stereotypes that unconsciously alter our perceptions or understanding of our experiences, thereby affecting behavior, interactions, and decision-making [12–14]

Underrepresented minority—Understood to mean either underrepresented minorities or underrepresented in medicine

Figure 1. Glossary of key terms.

The 2017 IDSA annual compensation survey reports that women earn a lower income than men [18], and a review of the full report demonstrates similar disparities among URM physicians, compared with their white peers [19]. While it may not be feasible to assign a direct causal relationship between unconscious bias and disparities within the infectious diseases specialty, it is reasonable and ethical to attempt to address any potential relationship between the two. In this article,

we define unconscious bias and describe its effect on healthcare professionals. We also provide strategies to identify and mitigate unconscious bias at an organizational and individual level, which can be applied in both academic and nonacademic settings.

UNCONSCIOUS BIAS—THE ROLE IT PLAYS AND HOW TO MEASURE IT

Even in 2019, overt racism, misogyny, and transphobia/homophobia continue to influence current events. However, in the decades since the healthcare community has moved toward becoming more egalitarian, overt discrimination in medicine based on gender, race, ethnicity, or other factors have become less conspicuous. Nevertheless, unconscious bias still influences all human interactions [13]. The ability to rapidly categorize every person or thing we encounter is thought to be an evolutionary development to ensure survival; early ancestors needed to decide quickly whether a person, animal, or situation they encountered was likely to be friendly or dangerous [20]. Centuries later, these innate tendencies to categorize everything we encounter is a shortcut that our brains still use.

Stereotypes also inadvertently play a significant role in medical education (Figure 1). Presentation of patients and clinical vignettes often begin with a patient's age, presumed gender, and presumed racial identity. Automatic associations and mnemonics help medical students remember that, on examination, a black child with bone pain may have sickle-cell disease or a white child with recurrent respiratory infections may have cystic fibrosis. These learning associations may be based on true prevalence rates but may not apply to individual patients. Using stereotypes in this fashion may lead to premature closure and missed diagnoses, when clinicians fail to see their patients as more than their perceived demographic characteristics. In the beginning of the human immunodeficiency virus (HIV) epidemic, the high prevalence of HIV among gay men led to initial beliefs that the disease could not be transmitted beyond the gay community. This association hampered the recognition of the disease in women, children, heterosexual men, and blood donor recipients. Furthermore, the fact that white gay men were overrepresented in early reported prevalence data likely led to lack of recognition of the epidemic in communities of color, a fact that is crucial to the demographic characteristics of today's epidemic. Today, there is still no clear solution to learning about the epidemiology of diseases without these imprecise associations, which can impact the rapidity of accurate diagnosis and therapy.

IMPACT OF BIAS ON HEALTHCARE DELIVERY

Unconscious bias describes associations or attitudes that unknowingly alter one's perceptions and therefore often go unrecognized by the individual, whereas conscious bias is an explicit form of bias that is based on one's discriminatory beliefs and

values and can be targeted in nature [14]. While neither form of bias belongs in the healthcare profession, conscious bias actively goes against the very ethos of medical professionals to serve all human beings regardless of identity. Conscious bias has manifested itself in severe forms of abuse within the medical profession. One notable historical example being the Tuskegee syphilis study, in which black men were targeted to determine the effects of untreated, latent syphilis. The Tuskegee study demonstrated how conscious bias, in this case manifested in the form of racism, led to the unethical treatment of black men that continues to have long-lasting effects on health equity and justice in today's society [21]. Given the intentional nature of conscious bias, a different set of tools and a greater length of time are likely required to change one's attitudes and actions. Tackling unconscious bias involves willingness to alter one's behaviors regardless of intent, when the impact of one's biases are uncovered and addressed [22]

There is still debate, however, about the degree to which unconscious bias affects clinician decision-making. In one systematic review on the impact of unconscious bias on healthcare delivery, there was strong evidence demonstrating the prevalence of unconscious bias (encompassing race/ethnicity, gender, socioeconomic status, age, weight, persons living with HIV, disability, and persons who inject drugs) affecting clinical judgment and the behavior of physicians and nurses toward patients [12]. However, another systematic review found only moderate-quality evidence that unconscious racial bias affects clinical decision-making [23]. A detailed discussion of the impact of unconscious bias on healthcare delivery is out of the scope of this article, which is focused on the impact of unconscious bias as it relates to healthcare professionals themselves. Nevertheless, strategies to mitigate the effects of unconscious bias (discussed later) can be applied to healthcare delivery and patient interactions.

MEASURING BIAS—THE IMPLICIT ASSOCIATION TEST (IAT)

While we know that unconscious bias is ubiquitous, it can be difficult to know how much it affects a person's daily interactions. In many cases, an individual's unconscious beliefs may differ from their explicit actions. For example, healthcare professionals, if asked, might say they try to treat all patients equally and may not believe they hold negative attitudes about patients. However, by definition, they may lack awareness of their own potential unconscious biases, and their actions may unknowingly suggest that these biases are active.

To measure unconscious bias, Drs Mahzarin Banaji and Anthony Greenwald developed the IAT in 1998 [24]. Many versions of the IAT are accessible online (available at: https://implicit.harvard.edu/implicit/), but one of the most studied is the Race IAT. The IAT has been extensively studied as an

inexpensive tool that provides feedback on an individual biases for self-reflection. The IAT calculates how quickly people associate different terms with each other. To determine unconscious race bias, the race IAT asks the subject to sort pictures (of white and black people) and words (good or bad) into pairs. For example, in one part of the Race IAT, participants must associate good words with white people and bad words with black people. In another part of the Race IAT, they must associate good words with black people and bad words with white people. Based on the reaction times needed to perform these tasks, the software calculates a bias score [20, 24]. Category pairs that are unconsciously preferred are easier to sort (and therefore take less time) than those that are not [24]. These unconscious associations can be identified even in individuals who outwardly express egalitarian beliefs [20, 24]. According to Project Implicit, the Race IAT has been taken >4 million times between 2002 and 2017, and 75% of test takers demonstrate an automatic white preference, meaning that most people (including a small group of black people) automatically associate white people with goodness and black people with badness [20]. Proponents of the IAT state that automatic preference for one group over another can signal potential discriminatory behavior even when the individuals with the automatic preference outwardly express egalitarian beliefs [20]. These preferences do not necessarily mean that an individual is prejudiced, which is associated with outward expressions of negative attitudes toward different social groups [20].

Many of the studies of unconscious bias described in this article use the IAT as the primary tool for measuring the phenomenon. Nevertheless, the degree to which the IAT predicts behavior is as of yet unclear, and it is important to recognize the limitations and criticisms of the IAT, as this is pertinent to its potential application in mitigating unconscious bias. Blanton et al reanalyzed data from 2 studies supporting the validity of the IAT, claiming that there is no evidence predicting individual behavior, with concerns for interjudge reliability and inclusion of outliers affecting results [25]. Response to this criticism by McConnell et al describes extensive training of test judges and evidence that the reanalysis was not a perfect replication of methods [26]. Blanton et al argue further in a different article that attempting to explain behavior on the basis of results of the IAT is problematic because the test relies on an arbitrary metric, leading to identified preferences when individuals are "behaviorally neutral" [27]. Notwithstanding the limitations of the IAT, none of its critics refute the existence of unconscious bias and that it can influence life experiences. The following sections review how unconscious bias affects different groups in the healthcare workforce.

Racial Bias

Medical school admissions committees serve as an important gatekeeper to address the significant disparities between racial

and ethnic minorities in healthcare as compared to the general population. Yet one study demonstrated that members of a medical school admissions committee displayed significant unconscious white preference (especially among men and faculty members) despite acknowledging almost zero explicit white preference [28]. An earlier study of unconscious racial and social bias in medical students found unconscious white and upper-class preference on the IAT but no obvious unconscious preferences in students' response to vignette-based patient assessments [29]. Unconscious bias affects the lived experiences of trainees, can potentially influence decisions to pursue certain specialties, and may lead to isolation. A recent study by Osseo-Asare et al described African American residents' experiences of being only "one of a few" minority physicians; some major themes included discrimination, the presence of daily microaggressions, and the burden of being tasked as race/ethnic "ambassadors," expected to speak on behalf of their demographic group [30].

Gender Bias

Gender bias in medical education and leadership development has been well documented [11, 31]. Medical student evaluations vary depending on the gender of the student and even the evaluator [31]. Similar studies have demonstrated gender bias in qualitative evaluations of residents and letters of recommendations, with a more positive tone and use of agentic descriptors in evaluations of male residents as compared to female residents [11]. Studies evaluating inclusion of women as speakers have also demonstrated gender bias, with fewer women invited to speak at grand rounds [9] and differences in the formal introductions of female speakers as compared to male speakers [32, 33], with men more likely referred to by their official titles than women.

Sexual and Gender Minority Bias

Sexual and gender minority groups are underrepresented in medicine and experience bias and microaggressions similar to those experience by racial and ethnic minorities. Experiences with or perceptions of bias lead to junior physicians not disclosing their sexual identity on the personal statement part of their residency applications for fear of application rejection or not disclosing that they are gay to colleagues and supervisors for fear of rejection or poor evaluations [34]. In one study, some physician survey respondents indicated some level of discomfort about people who are gay, transgender, or living with HIV being admitted to medical school. These respondents were less likely to refer patients to physician colleagues who were gay, transgender, or living with HIV [35]. These explicit biases were significantly reduced, compared with those revealed in prior surveys done in 1982 and 1999; opposition to gay medical school applicants went from 30% in 1982 to 0.4% in 2017, and discomfort with referring patients to gay physicians went from 46% in 1982 to 2% in 2017 [35]. The 2017 survey did not measure levels of unconscious bias, which is likely to still be pervasive despite decreased explicit bias. As with other types of bias, these data reveal that explicit bias against gay physicians has decreased over time; the degree of unconscious bias, however, likely persists. While this is encouraging to some degree, unconscious bias may be much more challenging to confront than explicit bias. Thus, members of underrepresented groups may be left wondering about the intentions of others and being labeled as "too sensitive."

Studies including the perspectives of LGBTQ healthcare professionals demonstrate that major challenges to their academic careers persist to this day. These include lack of LGBTQ mentorship, poor recognition of scholarship opportunities, and noninclusive or even hostile institutional climates [36]. Phelan et al studied changes in biased attitudes toward sexual and gender minorities during medical school and found that reduced unconscious and explicit bias was associated with more-frequent and favorable interactions with LGBTQ students, faculty, residents, and patients [37].

Disability Bias

Physicians with disabilities constitute another minority group that may experience bias in medicine, and the degree to which they experience this may vary, depending on whether disabilities may be visible or invisible. One study estimated the prevalence of self-disclosed disability in US medical students to be 2.7% [7]. Medical schools are charged with complying with the Americans With Disabilities Act, but only a minority of schools support the full spectrum of accommodations for students with disabilities [38]. Many schools do not include a specific curriculum for disability awareness [39]. Physicians with disabilities have felt compelled to work twice as hard as their able-bodied peers for acceptance, struggled with stigma and microaggressions, and encountered institutional climates where they generally felt like they did not belong [40]. These are themes that are shared by individuals from racial and ethnic minorities.

MITIGATING UNCONSCIOUS BIAS

A strategy to counter unconscious bias requires an intentional multidimensional approach and usually operates in tandem with strategies to increase diversity, inclusion, and equity [41, 42]. This is becoming increasingly important in training programs in the various specialties, including infectious diseases. The Accreditation Council for Graduate Medical Education recently updated their common program requirements for fellowship programs and has stipulated that, effective July 2019, "[t]he program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce" [43]. The implication of this requirement is that recognition

and mitigation of potential biases that may influence retention of a diverse workforce will ultimately be evaluated (directly or indirectly).

Mitigating unconscious bias and improving inclusivity is a long-term goal requiring constant attention and repetition and a combination of general strategies that can have a positive influence across all groups of people affected by bias [44]. These strategies can be implemented at organizational and individual levels and, in some cases, can overlap between the 2 domains (Figure 2). In this section, we review how infectious diseases clinicians and organizations like IDSA and hospitals can use some of these strategies to address and mitigate implicit bias in our specialty.

Organizational Strategies

Commitment to a Culture of Inclusion: More Than Just Diversity Training or Cultural Competency

Creating change requires more than just a climate survey, a vision statement, or creation of a diversity committee [45]. Organizations must commit to a culture shift by building institutional capacity for change [41, 46]. This involves reaffirming the need not only for the recruitment of a critical mass of underrepresented individuals, but equally importantly, the recruitment of critical actor leaders who take the role of change agents and have the power to create equitable environments [41, 47–49]. These change agents need not themselves be underrepresented; indeed, the success of culture change requires the involvement of allies within the majority group (eg, men, white people, and cis-gender heterosexual individuals). IDSA has demonstrated a commitment to this type of culture change with recent changes in leadership structure and with intentional

recruitment of individuals invested in diversity and inclusion; however, there is always room for reevaluation of other areas where diversity is desired.

Committing to a culture of inclusion at the academic-institution level involves creating a deliberate strategy for medical trainee admission and evaluation and faculty hiring, promotion, and retention. Capers et al describe strategies for achieving diversity through medical school admissions, many of which can also be applied to faculty hiring and promotion [49]. Notable strategies they suggest include having admissions (or hiring) committee members take the IAT and reflect on their own potential biases before they review applications or interview candidates [49]. They also recommend appointing women, minorities, and junior medical professionals (students or junior faculty) to admissions committees, emphasizing the importance of different perspectives and backgrounds [49]. Organizations can also survey employee perception of inclusivity. These assessments include questions on the degree to which an individual feels a sense of belonging within an institution, alongside questions pertaining to experiences of bias on the grounds of cultural or demographic factors [50]. Conducting regular assessments and analysis of survey results, particularly on how individuals of diverse backgrounds feel they can exist within the organization and their culture simultaneously, allows organizations to ensure that their trainings on unconscious bias and promotion of cultural humility lead to long-term positive change. Furthermore, realizing that different demographic groups may feel less respected than others provides information on areas of focus for consequent refresher seminars on combating unconscious bias in conjunction with cultural humility.
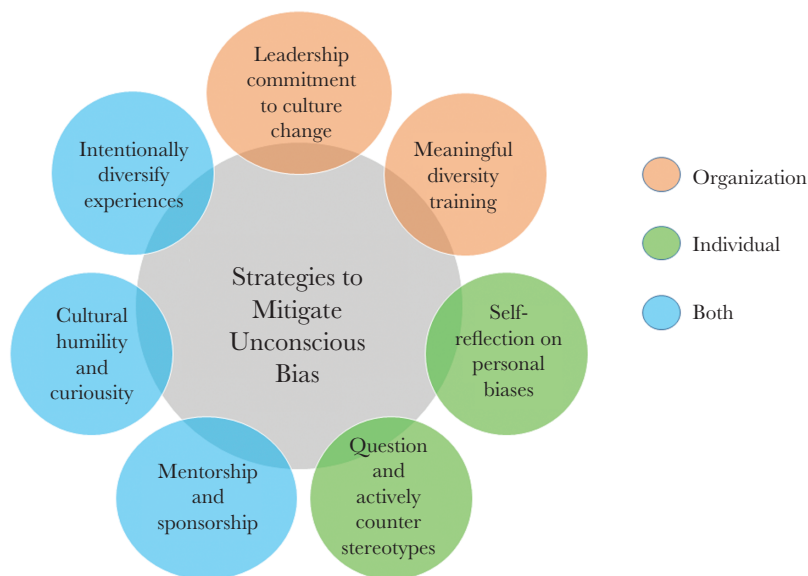

Figure 2. Organization-level and personal-level strategies to mitigate unconscious bias. Orange circles indicate organization-specific strategies, green circles indicate individual-level strategies, and blue circles represent strategies that can be emphasized on both organizational and individual levels to mitigate implicit bias.

Meaningful Diversity Training and the Usefulness of the IAT

Notwithstanding potential criticisms of the IAT with respect to prediction of discriminatory behavior, this can be a useful tool within a comprehensive organizational training seminar directed toward understanding and addressing individual unconscious bias. In the study by Capers et al, over two thirds of admissions committee members who took the IAT and responded to the post-IAT survey felt positive about the potential value of this tool in reducing their unconscious bias [28]. Additionally, almost half were cognizant of their IAT results when interviewing for the next admissions cycle, and 21% maintained that knowledge of this bias affected their decisions in the next admissions cycle [28]. Perhaps this knowledge led to conscious changes in committee member behavior because, in the following year, the matriculating class was the most diverse in that institution's history [28, 49]. A similar bias education intervention coupled with the IAT led to a decreased unconscious gender leadership bias in one academic center [48]. IDSA and infectious diseases practices (or academic divisions) could consider ways to incorporate this into already established training for those in leadership roles or on leadership search committees.

Of course, the potential applicability of the IAT can be overstated—at best, several meta-analyses have demonstrated that there may only be a weak correlation between IAT scores and individual behavior [51–53], and several criticisms of the IAT have already been discussed here. Additionally, while important to acknowledge that bias is pervasive, care must be taken to avoid normalizing bias and stereotypes because this may have the unintended consequence of reinforcing them [54]. Important points that should be emphasized when using the IAT as part of diversity training include that (1) people should be aware of their own biases and reflect on their behaviors individually; (2) the IAT can suggest generally how groups of people with certain results may behave, rather than how each individual will behave; and (3) on its own, the IAT is not a sufficient tool to mitigate the effects of bias, because if there is to be any chance of success, an active cultural/behavioral change must be engaged in tandem with bias awareness and diversity training [55].

Individual Strategies

Deliberative Reflection

Before encounters that are likely to be affected by bias (such as trainee evaluations, letters of recommendation, feedback, interviews, committee decisions, and patient encounters), deliberative reflection can help an individual recognize their own potential for bias and correct for this [56]. It is also a good time to consider the perspective of the individual whom they will be evaluating or interacting with and the potential impact of their biases on that individual. Participants can be encouraged to evaluate how their own experiences and identities influence their interactions. Including data on lapses in proper care due to provider bias also proves helpful in giving workers real-life examples of the consequences of not being vigilant for bias [51, 57]. This motivated self-regulation based on reflections of individual biases has been shown to reduce stereotype activation and application [44, 58]. If one unintentionally behaves in a discriminatory manner, self-reflection and open discussion can help to repair relationships (Figure 3).

Question and Actively Counter Stereotypes

Individuals may question how they can actively counter stereotypes and bias in observed interactions. The

Addressing Personal Bias (Before It Occurs)

We all have bias …
While you cannot control another's actions, you can be an example to others with your own:

Be Aware
Of your biases and how such biases appear as "intuition"

Be Systematic
By using concrete guidelines or checklists, be transparent in decision-making

Be Open
To new experiences and to learning about different identities

Addressing Personal Bias (After It Occurs

What if I unintentionally commit a microaggression?

Intent vs Impact
• Remember that intent and impact are distinct
• Consider other's past experiences

Own Your Actions
• Acknowledge that your actions were biased
• Own the consequences

Reinforcea and Repair
• Reach out and rebuild trust
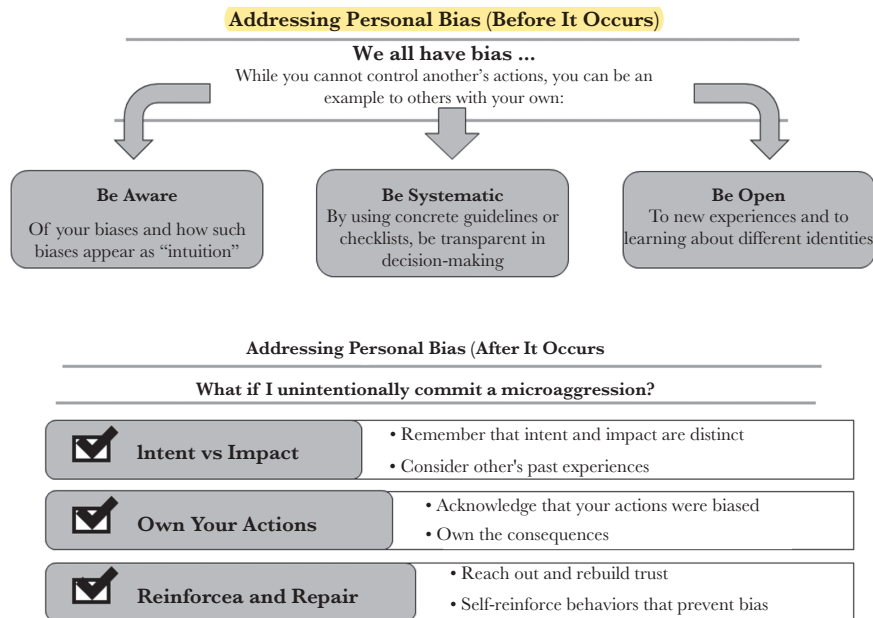• Self-reinforce behaviors that prevent bias

Figure 3. Strategies to address personal bias before and after it occurs.

active-bystander approach adapted from the Kirwan Institute [59] can provide insight into appropriate responses in these situations (Figure 4).

Strategies That Apply to Both Organizations and Individuals

Cultural Competency and Beyond: Cultural Humility

Healthcare organizations seeking to develop providers who can work seamlessly with colleagues and more effectively treat patients from all cultural backgrounds have been conducting trainings in cultural competency [60]. The term "cultural competency" implies that one has achieved a static goal of championing inclusivity. This approach imparts a false sense of confidence in leaders and healthcare professionals and fails to recognize that our understanding of cultural barriers is continually growing and evolving [61]. Cultural humility has been proposed as an alternate approach, subsuming the teachings of cultural competency while steering participants toward a continuous path of discovery and respect during interactions with colleagues and patients of different cultural backgrounds [62]. Other synonymous terms include "cultural sensitivity" and "cultural curiosity." Rather than checking a box for training, cultural humility focuses on the individual and teaches that developing one's self-awareness is a critical step in achieving mindfulness for others [63]. Cultural humility emphasizes that individuals must acknowledge the experiential lens through which they view the world and that their view is not nearly as extensive, open, or dynamic as they might perceive [61]. By training leaders and healthcare professionals that they do not need to be and ultimately cannot be experts in all the intersecting cultures that they encounter, healthcare professionals can focus on a readiness to learn that can translate to greater confidence and willingness in caring for patients of varying backgrounds [61].

As cultural humility is important to recognizing and mitigating conscious and unconscious biases, patient simulations and diversity-related trainings should be augmented with discussions about cultural humility.

By integrating cultural humility into healthcare training procedures, organizations can strive to eliminate the perceived unease healthcare professionals might experience when interacting with individuals from backgrounds or cultures unfamiliar to them. Cultural humility starts from a condition of empathy and proceeds through the asking of open questions in each interaction (Figure 1). Instilling elements of cultural humility training within simulation-based learning provides participants with experience in treating a wide array of patients while providing low-risk, feedback-based learning opportunities [22, 64].

Diversify Experiences to Provide Counterstereotypical Interactions

Exposing individuals to counterstereotypical experiences can have a positive impact on unconscious bias [10, 44, 55]. Therefore, intentional efforts to include faculty from underrepresented groups as preceptors, educators, and invited speakers can help reduce the unconscious associations of these responsibilities as unattainable. Capers et al suggest that including students, women, and African Americans and other racial and ethnic minorities on admissions committees may be part of a strategy to reduce unconscious bias in medical school admissions [49]. If institutions, organizations, and conference program committees are aware of their own metrics in this respect, following this information with deliberate choices to remedy inequities can have a profound impact on increasing diversity [65]. Furthermore, in medical training, while deliberate curricula involving disparities and care of underrepresented individuals are beneficial, educators must be aware of the impact of the hidden curriculum on their trainees. The term "hidden curriculum" refers to the aspects of medicine that are learned by trainees outside the traditional classroom/didactic instruction environment. It encompasses observed interactions, behaviors, and experiences often driven by unconscious and explicit bias and institutional climate [66–68]. Students can be taught to actively seek out the hidden curriculum in their training

---

Step 1: Acknowledge the bias in the interaction

Step 2: Make a conscious decision to address the bias

Step 3: Utilize one of the following action strategies to counter the bias

Humor[a]	"English is my first language, what's yours?" (eg, In response to "your English is so good!")
Reject the stereotype outright	"I don't get the joke"
Ask questions	"What did you mean when you said ___?"
Acknowledge discomfort	"What you just said makes me very uncomfortable. Please don't speak like that around me anymore."
Be direct	"I know you didn't intend for your words to be interpreted as a stereotype, but as your friend, I wanted to be honest with you that that's how it came across."

Step 4: Continue the conversion beyond the interaction

Adapted with permission from Tenney [59].

[a]Humor is potentially culturally based, and may not always work

Figure 4. Kirwan Institute approach to countering unconscious bias as an active bystander.

environment, reflect on the lessons, and use this reflection to inform their own behaviors [67]. Individuals can intentionally diversify their own circles, connecting with people from different backgrounds and experiences. This can include the occasionally awkward and uncomfortable introductions at professional meetings or at community events, making an effort to read books by diverse authors, or trying new foods with a colleague. These are small behavioral changes that, with time, can help to retrain our brain to classify people as "same" instead of "other."

Mentorship and Sponsorship

Mentors can, at any stage in one's career, provide advice and career assistance with collaborations, but sponsors are typically more senior individuals who can curate high-profile opportunities to support a junior person, often with potential personal or professional risk if that person does not meet expectations. URMs and women physicians tend not to have as much support with mentoring and sponsorship as the majority group, white men. Qualitative studies of URM physician perspectives typically reveal themes of isolation and lack of mentorship, regardless of the URM group being studied [30, 36, 69]. Possible reasons include lack of mentors from similar backgrounds or ineffective mentoring in discordant mentor-mentee relationships. Mentor-training workshops that intentionally include unconscious bias training can enhance the effectiveness of mentors working with diverse trainees and junior faculty and address this potential barrier to URM success [70]. Providing mentorship within an individual department, as well as support for participating in external mentorship and career development programs, can help create sponsorship opportunities that eventually influence career advancement [41]. Many professional societies such as IDSA provide mentorship opportunities, and these can be enhanced by encouraging more sponsorship of junior clinicians for opportunities such as podium lectures, moderating at conferences, writing editorials, or committee positions.

SUMMARY

In the years since the IAT was first described, researchers have published countless data on the impact of unconscious bias. Fortunately, explicit and implicit attitudes toward many disenfranchised groups of people have regressed to a more neutral position over time [71], but this does not mean that unconscious bias has disappeared. Just as healthcare providers are required to stay up to date on medical techniques and procedures to best serve their patients, we propose that trainings involving the social aspects of medicine be treated similarly. Cultural humility is characterized by lifelong learning and is a key aspect of a successful provider-patient relationship. Thus, it is imperative that healthcare organizations and professional medical societies such as IDSA continually provide healthcare professionals with learning opportunities to enhance their interactions with individuals different from themselves. Effectively addressing unconscious bias and subsequent disparities in IDSA will need comprehensive, multifaceted, and evidence-based interventions (Figure 5).

CALL TO ACTION

IDSA has demonstrated a commitment to diversifying its society leadership by commissioning the Gender Disparities Task Force and the Inclusion, Diversity, Access & Equity Task Force, reconfiguring existing committees, developing new committees (eg, the Leadership Development Committee), and creating new opportunities, such as the IDSA Leadership Institute. While these are important and impactful actions, we propose the following

---

Unconscious Bias Highlights

1. Unconscious biases are attitudes or stereotypes that unknowingly alter our perceptions or understanding of our experiences, thereby affecting behavior interactions and decision-making.
2. Unconscious bias can influence behaviors, but the exact extent to which it does so is unclear.
3. Women and individuals underrepresented in medicine can have different experiences with recruitment, hiring, promotion, and compensation (among others) due to unconscious bias, as compared to their majority peers (white men).
4. Strategies to mitigate unconscious bias are multifactorial but involve bias awareness, culture change, countering stereotypes, and intentional group diversification.
5. The extent to which unconscious bias plays a role in diversity challenges within the specialty of infectious diseases is unknown.

The Infectious Diseases Society of America can play a role in mitigating unconscious bias by:

a. Incorporating measurable evidence-based bias reduction strategies into infectious diseases training programs and membership at large
b. Enhancing mentorship programs to intentionally seek equitable inclusion of those traditionally underrepresented in leadership
c. Incorporating principles of cultural humility into leadership development
d. Supporting infectious diseases divisions and fellowship programs with their group efforts to create a more diverse environment

Figure 5. Unconscious bias highlights.

additional steps to address the role of unconscious bias in various settings. First, develop an IDSA-sponsored climate survey to assess perceptions of inclusion and belonging within the Society, and repeat this climate assessment after implementing bias reduction strategies. Second, provide IDSA-sponsored education/training on unconscious bias reduction strategies and cultural humility to academic infectious disease divisions and fellowship programs to support the recruitment and retention of a diverse infectious diseases physician workforce. Third, develop benchmarks for excellence in infectious diseases divisions and fellowship training programs to evaluate these bias reduction strategies. Fourth, provide education/training on unconscious bias–reduction strategies and cultural humility to leadership and membership within IDSA. Specifically, the board of directors, the Leadership Development Committee, the Awards Committee, and others involved in electing, nominating, or honoring members should consider including incorporating the IAT and bias-reduction education for their committee members. After implementing such strategies, IDSA should reevaluate metrics of awardees, committee chairs, and leadership to determine whether these strategies made an impact. Fifth, cultivate existing mentorship programs within IDSA, with the added focus of intentional mentoring and sponsorship of groups traditionally underrepresented in leadership. Sixth, commit to consistent review and revision of infectious diseases recruitment messaging, ensuring that materials and media counter harmful stereotypes and represent true diversity. Seventh, collect, review, and publish metrics of diversity in all facets of the membership, including IDWeek speaker demographic characteristics, IDSA journal editor/reviewers, guideline authorship, and committee membership, with intentional response strategies to change these demographic characteristics to a more diverse distribution. Eighth, be transparent about reporting of metrics, with clear accountability and flexibility to adjust initiatives based on results.

NOTE

Although there are numerous data describing the impact of unconscious bias on healthcare delivery, clinician-patient interactions, and patient outcomes, discussion of these aspects is out of the scope of this article, which focuses on the impact of unconscious bias on healthcare professionals. Additionally, the majority of data on unconscious bias presented in this article relates to general academic training and career development, as data in the infectious diseases practice community is limited. This represents an area of need for evaluation within the specialty of infectious diseases, since a vast majority of members are in clinical practice and may experience bias in varying degrees. While it is important to support trainees who may experience unconscious bias, it is also critical to provide support for infectious diseases clinicians further along in their careers, as a means to maintain retention in the specialty. Finally, some individuals may prefer person-first language, while others may

prefer identity-first language when referring to disabilities. We consistently used person-first language throughout this manuscript based on the recommendation by the Centers for Disease Control & Prevention (https://www.cdc.gov/ncbddd/disabilityandhealth/pdf/disabilityposter_photos.pdf).

Notes

References

1. Institute of Medicine (US) Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce. In the nation's compelling interest: ensuring diversity in the health-care workforce. Smedley BD, Stith Butler A, Bristow LR, eds. Washington, DC: National Academies Press (US), **2004**.
2. American College of Physicians. Racial and ethnic disparities in health care, updated 2010. https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/racial_disparities.pdf. Accessed 25 January 2019.
3. Association of American Medical Colleges. Underrepresented in medicine definition. https://www.aamc.org/initiatives/urm/. Accessed 19 January 2019.
4. United States Census Bureau. US Census Bureau QuickFacts. https://www.census.gov/quickfacts/fact/table/US#. Accessed 2 January 2019.
5. Newport F. In U.S., estimate of LGBT population rises to 4.5%. https://news.gallup.com/poll/234863/

estimate-lgbt-population-rises.aspx. Accessed 25 January 2019.

6. Association of American Medical Colleges (AAMC). AAMC facts & figures 2016; diversity in medical education. http://www.aamcdiversityfactsandfigures2016.org/index.html. Accessed 25 January 2019.

7. Meeks LM, Herzer KR. Prevalence of self-disclosed disability among medical students in US allopathic medical schools. JAMA 2016; 316:2271–2.

8. Association of American Medical Colleges. U.S. medical school applications and matriculants by school, state of legal residence, and sex, 2018–2019. https://www.aamc.org/download/321442/data/factstablea1.pdf. Accessed 4 January 2019.

9. Boiko JR, Anderson AJM, Gordon RA. Representation of women among academic grand rounds speakers. JAMA Intern Med 2017; 177:722–4.

10. Carnes M, Bartels CM, Kaatz A, Kolehmainen C. Why is John more likely to become department chair than Jennifer? Trans Am Clin Climatol Assoc 2015; 126:197–214.

11. Gerull KM, Loe M, Seiler K, McAllister J, Salles A. Assessing gender bias in qualitative evaluations of surgical residents. Am J Surg 2019; 217:306–13.

12. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics 2017; 18.

13. Staats C, Dandar V, St Cloud T, Wright R. How the prejudices we don't know we have affect medical education, medical careers, and patient health. In: Darcy Lewis and Emily Paulsen, eds. Proceedings of the 2014 diversity and inclusion innovation forum: unconscious bias in academic medicine. Association of American Medical Colleges. Association of American Medical Colleges and the Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University, USA 2017;1–93.

14. Staats C, Patton C. State of the science: implicit bias review: the Ohio State University Kirwan Instiute for the study of race and ethnicity. OH: The Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University, 2013; 1–102.

15. Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. Washington, DC: The National Academies Press, 2011.

16. Gonzales G, Przedworski J, Henning-Smith C. Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the united states: results from the national health interview survey. JAMA Intern Med 2016; 176:1344–51.

17. Valdiserri RO, Holtgrave DR, Poteat TC, Beyrer C. Unraveling health disparities among sexual and gender minorities: a commentary on the persistent impact of stigma. J Homosex 2019; 66:571–89.

18. Trotman R, Kim AI, MacIntyre AT, Ritter JT, Malani AN. 2017 infectious diseases society of america physician compensation survey: results and analysis. Open Forum Infect Dis 2018; 5:ofy309.

19. Marcelin JR, Bares SH, Fadul N. Improved infectious diseases physician compensation but continued disparities for women and underrepresented minorities. Open Forum Infect Dis 2019; 6:ofz042.

20. Banaji MR, Greenwald AG. Blindspot: hidden biases of good people. 1st ed. USA: Delacorte Press, 2013.

21. Francis CK. Medical ethos and social responsibility in clinical medicine. J Urban Health 2001; 78:29–45.

22. Teal CR, Gill AC, Green AR, Crandall S. Helping medical learners recognise and manage unconscious bias toward certain patient groups. Med Educ 2012; 46:80–8.

23. Dehon E, Weiss N, Jones J, Faulconer W, Hinton E, Sterling S. A systematic review of the impact of physician implicit racial bias on clinical decision making. Acad Emerg Med 2017; 24:895–904.

24. Greenwald AG, McGhee DE, Schwartz JL. Measuring individual differences in implicit cognition: the implicit association test. J Pers Soc Psychol 1998; 74:1464–80.

25. Blanton H, Jaccard J, Klick J, Mellers B, Mitchell G, Tetlock PE. Strong claims and weak evidence: reassessing the predictive validity of the IAT. J Appl Psychol 2009; 94:567–82; discussion 583–603.

26. McConnell AR, Leibold JM. Weak criticisms and selective evidence: Reply to Blanton et al. (2009). J Appl Psychol, 2009;94, 583-9. doi:10.1037/a0014649

27. Blanton H, Jaccard J, Strauts E, Mitchell G, Tetlock PE. Toward a meaningful metric of implicit prejudice. J Appl Psychol 2015; 100:1468–81.

28. Capers Q 4th, Clinchot D, McDougle L, Greenwald AG. Implicit racial bias in medical school admissions. Acad Med 2017; 92:365–9.

29. Haider AH, Sexton J, Sriram N, et al. Association of unconscious race and social class bias with vignette-based clinical assessments by medical students. JAMA 2011; 306:942–51.

30. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority resident physicians' views on the role of race/ethnicity in their training experiences in the workplace. JAMA Netw Open 2018; 1:e182723.

31. Riese A, Rappaport L, Alverson B, Park S, Rockney RM. Clinical performance evaluations of third-year medical students and association with student and evaluator gender. Acad Med 2017; 92:835–40.

32. Files JA, Mayer AP, Ko MG, et al. Speaker introductions at internal medicine grand rounds: forms of address reveal gender bias. J Womens Health (Larchmt) 2017; 26:413–9.

33. Mehta S, Rose L, Cook D, Herridge M, Owais S, Metaxa V. The speaker gender gap at critical care conferences. Crit Care Med **2018**; 46:991–996.

34. Lee KP, Kelz RR, Dubé B, Morris JB. Attitude and perceptions of the other underrepresented minority in surgery. J Surg Educ **2014**; 71:e47–52.

35. Marlin R, Kadakia A, Ethridge B, Mathews WC. Physician attitudes toward homosexuality and HIV: the PATHH-III survey. LGBT Health **2018**; 5:431–42.

36. Sánchez NF, Rankin S, Callahan E, et al. LGBT trainee and health professional perspectives on academic careers–facilitators and challenges. LGBT Health **2015**; 2:346–56.

37. Phelan SM, Burke SE, Hardeman RR, et al. Medical school factors associated with changes in implicit and explicit bias against gay and lesbian people among 3492 graduating medical students. J Gen Intern Med **2017**; 32:1193–201.

38. Zazove P, Case B, Moreland C, et al. U.S. medical schools' compliance with the americans with disabilities act: findings from a national study. Acad Med **2016**; 91:979–86.

39. Seidel E, Crowe S. The state of disability awareness in american medical schools. Am J Phys Med Rehabil **2017**; 96:673–6.

40. Meeks LM, Herzer K, Jain NR. Removing barriers and facilitating access: increasing the number of physicians with disabilities. Acad Med **2018**; 93:540–3.

41. DiBrito SR, Lopez CM, Jones C, Mathur A. Reducing implicit bias: association of women surgeons #HeForShe task force best practice recommendations. J Am Coll Surg **2019**; 228:303–9.

42. South-Paul JE, Roth L, Davis PK, et al. Building diversity in a complex academic health center. Acad Med **2013**; 88:1259–64.

43. Accreditation Council for Graduate Medical Education. Common program requirements (fellowship). https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRFellowship2019.pdf. Accessed 19 January 2019.

44. Devine PG, Forscher PS, Austin AJ, Cox WT. Long-term reduction in implicit race bias: a prejudice habit-breaking intervention. J Exp Soc Psychol **2012**; 48:1267–78.

45. Carnes M, Fine E, Sheridan J. Promises and pitfalls of diversity statements: proceed with caution. Acad Med **2019**; 94:20–4.

46. Smith DG. Building institutional capacity for diversity and inclusion in academic medicine. Acad Med **2012**; 87:1511–5.

47. Helitzer DL, Newbill SL, Cardinali G, Morahan PS, Chang S, Magrane D. Changing the culture of academic medicine: critical mass or critical actors? J Womens Health (Larchmt) **2017**; 26:540–8.

48. Girod S, Fassiotto M, Grewal D, et al. Reducing implicit gender leadership bias in academic medicine with an educational intervention. Acad Med **2016**; 91:1143–50.

49. Capers Q, McDougle L, Clinchot DM. Strategies for achieving diversity through medical school admissions. J Health Care Poor Underserved **2018**; 29:9–18.

50. Person SD, Jordan CG, Allison JJ, et al. Measuring diversity and inclusion in academic medicine: the diversity engagement survey. Acad Med **2015**; 90:1675–83.

51. Greenwald AG, Banaji MR, Nosek BA. Statistically small effects of the implicit association test can have societally large effects. J Pers Soc Psychol **2015**; 108:553–61.

52. Oswald FL, Mitchell G, Blanton H, Jaccard J, Tetlock PE. Predicting ethnic and racial discrimination: a meta-analysis of IAT criterion studies. J Pers Soc Psychol **2013**; 105:171–92.

53. Oswald FL, Mitchell G, Blanton H, Jaccard J, Tetlock PE. Using the IAT to predict ethnic and racial discrimination: small effect sizes of unknown societal significance. J Pers Soc Psychol **2015**; 108:562–71.

54. Duguid MM, Thomas-Hunt MC. Condoning stereotyping? How awareness of stereotyping prevalence impacts expression of stereotypes. J Appl Psychol **2015**; 100:343–59.

55. Dasgupta N. Chapter five—implicit attitudes and beliefs adapt to situations: a decade of research on the malleability of implicit prejudice, stereotypes, and the self-concept. In: Devine P, Plant A, eds. Advances in experimental social psychology. Vol. 47. USA: Academic Press, **2013**:233–79.

56. Phillips NA, Tannan SC, Kalliainen LK. Understanding and overcoming implicit gender bias in plastic surgery. Plast Reconstr Surg **2016**; 138:1111–6.

57. Nelson SC, Prasad S, Hackman HW. Training providers on issues of race and racism improve health care equity. Pediatr Blood Cancer **2015**; 62:915–7.

58. Burns MD, Monteith MJ, Parker LR. Training away bias: the differential effects of counterstereotype training and self-regulation on stereotype activation and application. J Exp Soc Psychol **2017**; 73:97–110.

59. Tenney L. Being an active bystander: strategies for challenging the emergence of bias. Columbus, OH: Ohio State University Kirwan Institute for the Study of Race and Ethnicity, **2017**.

60. Harrison G, Turner R. Being a 'culturally competent' social worker: making sense of a murky concept in practice. Br J Soc Work **2010**; 41:333–350.

61. Juarez JA, Marvel K, Brezinski KL, Glazner C, Towbin MM, Lawton S. Bridging the gap: a curriculum to teach residents cultural humility. Fam Med **2006**; 38:97–102.

62. Chang ES, Simon M, Dong X. Integrating cultural humility into health care professional education and training. Adv Health Sci Educ Theory Pract **2012**; 17:269–78.

63. Kumagai AK, Lypson ML. Beyond cultural competence: critical consciousness, social justice, and multicultural education. Acad Med **2009**; 84:782–7.

64. Beauchamp GA, McGregor AJ, Choo EK, Safdar B, Rayl Greenberg M. Incorporating sex and gender into

culturally competent simulation in medical education. J Womens Health (Larchmt) **2019**. doi:10.1089/jwh.2018.7271

65. van Ryn M, Hardeman R, Phelan SM, et al. Medical school experiences associated with change in implicit racial bias among 3547 students: a medical student CHANGES study report. J Gen Intern Med **2015**; 30:1748–56.

66. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. Acad Med **1998**; 73:403–7.

67. Neve H, Collett T. Empowering students with the hidden curriculum. Clin Teach **2018**; 15:494–9.

68. Fallin-Bennett K. Implicit bias against sexual minorities in medicine: cycles of professional influence and the role of the hidden curriculum. Acad Med **2015**; 90:549–52.

69. Liebschutz JM, Darko GO, Finley EP, Cawse JM, Bharel M, Orlander JD. In the minority: black physicians in residency and their experiences. J Natl Med Assoc **2006**; 98:1441–8.

70. Gandhi M, Fernandez A, Stoff DM, et al. Development and implementation of a workshop to enhance the effectiveness of mentors working with diverse mentees in HIV research. AIDS Res Hum Retroviruses **2014**; 30:730–7.

71. Charlesworth TES, Banaji MR. Patterns of implicit and explicit attitudes: I. Long-Term change and stability from 2007 to 2016. Psychol Sci **2019**; 30:174–92.

72. Yeager KA, Bauer-Wu S. Cultural humility: essential foundation for clinical researchers. Appl Nurs Res **2013**; 26:251–6.

73. Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. Am Psychol **2007**; 62:271–86.

POVERTY AND CHILD HEALTH DISPARITIES

Child Health Disparities: What Can a Clinician Do?

Tina L. Cheng, MD, MPH[a,b], Mickey A. Emmanuel, BS[c], Daniel J. Levy, MD[d], Renee R. Jenkins, MD[e]

abstract

Pediatric primary and specialty practice has changed, with more to do, more regulation, and more family needs than in the past. Similarly, the needs of patients have changed, with more demographic diversity, family stress, and continued health disparities by race, ethnicity, and socioeconomic status. How can clinicians continue their dedicated service to children and ensure health equity in the face of these changes? This article outlines specific, practical, actionable, and evidence-based activities to help clinicians assess and address health disparities in practice. These tools may also support patient-centered medical home recognition, national and state cultural and linguistic competency standards, and quality benchmarks that are increasingly tied to payment. Clinicians can play a critical role in (1) diagnosing disparities in one's community and practice, (2) innovating new models to address social determinants of health, (3) addressing health literacy of families, (4) ensuring cultural competence and a culture of workplace equity, and (5) advocating for issues that address the root causes of health disparities. Culturally competent care that is sensitive to the needs, health literacy, and health beliefs of families can increase satisfaction, improve quality of care, and increase patient safety. Clinical care approaches to address social determinants of health and interrupting the intergenerational cycle of disadvantage include (1) screening for new health "vital signs" and connecting families to resources, (2) enhancing the comprehensiveness of services, (3) addressing family health in pediatric encounters, and (4) moving care outside the office into the community. Health system investment is required to support clinicians and practice innovation to ensure equity.

[a]Department of Pediatrics, Johns Hopkins School of Medicine, Baltimore, Maryland; [b]Department of Population, Family, and Reproductive Health, Bloomberg School of Public Health, Baltimore, Maryland; [c]University of Florida College of Medicine, Gainesville, Florida; [d]Child and Teen Wellness Center, Owings Mill, Maryland; and [e]Department of Pediatrics and Child Health, Howard University, Washington, District of Columbia

Child health and health care disparities by race, ethnicity, and socioeconomic status (SES) are persistent and pervasive. Children of color and in low-income families continue to fall behind their more affluent and majority peers in health status.[1,2] Disparities that originate in childhood have been linked to adult chronic illness.[3] Although disparities must be addressed on the population and policy level, and issues such as poverty, discrimination, or environmental exposures may feel overwhelming, clinicians have a critical role in promoting health equity. The intimate clinician-patient relationship provides an opportunity to uncover and address the root causes of poor health. Culturally competent care that is sensitive to the needs, health literacy, and health beliefs of patients and families can increase quality of care and patient safety.[4] Health disparities are a health care quality and safety issue. When differential treatment or outcomes related to patient characteristics exist, quality improvement (QI) approaches are imperative.

Health inequality refers to differences in the health of individuals or populations, whereas health inequity or disparity refers to inequalities thought to be unfair, unjust, and

STATE-OF-THE-ART REVIEW ARTICLE

avoidable.[5] Almost all U.S. children have had a well-child visit in the past year,[6] making primary care an ideal location to ensure that children have the support necessary for optimal development and that adversities are buffered. The family contact that both primary and specialty clinicians have in outpatient and inpatient settings can promote health equity and improve health outcomes. Patient-centered medical home recognition[7] and quality benchmarks tied to payment recognize the importance of culturally competent care. National standards for culturally and linguistically appropriate services (CLAS) in health care by the Office of Minority Health have been increasingly embraced by state agencies and legislation. This article outlines specific, practical, actionable, and evidence-based activities that help clinicians assess and address health disparities related to race/ethnicity and SES (Table 1).

"DIAGNOSE DISPARITIES" IN ONE'S COMMUNITY AND PRACTICE

In the 1940s, Sidney Kark conceptualized "community-oriented primary care"[8]; later, the Folsom Commission report, "Health Is a Community Affair," emphasized the importance of knowing one's community and improving health on the local level.[9,10] Today, these ideas continue to resonate. Because communities are constantly changing, CLAS standards emphasize the importance of conducting "regular assessments of community health assets and needs and using the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area."[11] Free and easy-to-navigate websites provide city, district, county, state, and national data as well as maps on child and family demographics, health status, and well-being by race/ethnicity and poverty status, with comparisons to others and targets for improvement (Table 1). By periodically reviewing

these data, clinicians can keep tabs on the challenges their patients may face and can identify opportunities to help. For instance, if data show changing demographics with a growing immigrant community, assessing linguistic competency, health literacy, and cultural norms may be necessary, with implications for educational efforts, materials, and staffing.

In addition to reviewing population data, examining one's practice performance data stratified by insurance status, race/ethnicity, language, and SES as outlined in the Affordable Care Act (ACA) is critical to understanding areas for improvement. In this era of clinician accountability and performance measures, the QI and health disparities fields must join forces. There is evidence that culturally tailored or targeted QI approaches may have more promise than generic efforts.[12,13]

Finally, families must be involved. Conducting a community needs assessment and including families in improvement approaches can be powerful. For instance, an assessment of community needs identified poor oral health and difficulty finding pediatric dentists who accepted Medicaid. Identifying dentists and disseminating this information improved access and provided a patient voice in advocacy efforts to increase capacity.

Many practices and hospitals have initiated family advisory boards to provide feedback on care systems. Families can provide valuable insight about screening and referral efforts, development of community partnerships, and prioritization of resources and interventions. The National Initiative for Children's Healthcare Quality's toolkit, "Creating a Patient and Family Advisory Council," provides a step-by-step approach to assess practice readiness, recruit members, and involve, evaluate, and sustain an advisory council.[14] The Robert Wood Johnson Foundation has a compendium of useful tools to

engage patients in improving ambulatory care (Table 1).[15] Partnering with the community is the focus of research efforts by the Patient-Centered Outcomes Research Institute established in the ACA.

"DIAGNOSE DISPARITIES" IN CLINICAL ENCOUNTERS AND INNOVATE NEW PRACTICE MODELS

To prevent or buffer adversities that children and families may encounter, new delivery approaches and payment models are needed. The Maternal and Child Health Bureau encourages a "whole-person, whole-family, whole-community systems approach" that addresses upstream social determinants of health.[16] Clinical approaches include (1) diagnosing disparities by universal screening and connecting families to resources, (2) enhancing the comprehensiveness of services to address social determinants, (3) addressing family health in pediatric encounters, and (4) moving care outside the office into the community (eg, home, school, daycare) (Fig 1).

The first approach is to diagnose disparities through universal screening for new health vital signs. The American Academy of Pediatrics (AAP) Policy on Health Equity emphasizes that clinic visits are opportunities to screen and address the social, economic, educational, environmental, and person-capital needs of children and families.[17] Whereas clinical vital signs include temperature, heart rate, respiratory rate, blood pressure, and growth parameters, the Robert Wood Johnson Foundation Commission to Build a Healthier America strongly recommended that "new health vital signs" reflecting the root causes of health disparities be included, such as food security, educational progress, family employment, health literacy, neighborhood safety, and adequate housing.[18] For instance, poor housing is linked to health status.[19–21] A child

CHENG et al

TABLE 1 Free Web Resources to Assist Clinicians in Assessing and Addressing Health Disparities in Practice

Topic	Resource	Organization	URL
Obtaining Community Statistics (City, Metropolitan Area, District, County, State and National Data)	America's Children: Key National Features of Well-Being	Federal Interagency Forum on Child and Family Statistics	www.childstats.gov
	County Health Rankings & Roadmaps Program	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute	www.countyhealthrankings.org
	Diversitydatakids.org	Brandeis University	diversitydatakids.org
	KIDS COUNT	Annie E. Casey Foundation	datacenter.kidscount.org
	Agenda for Children 2014–2015	American Academy of Pediatrics Division of State Government Affairs	www.aap.org/en-us/advocacy-and-policy/state-advocacy/Pages/Poverty%20and%20Child%20Health%20State%20Advocacy%20Resources.aspx
	State Health Facts	Henry J. Kaiser Family Foundation	kff.org/statedata
Engaging Patients and Families to Improve Practice	Creating a Patient and Family Advisory Council: A Toolkit for Pediatric Practices	National Institute for Children's Health Quality	www.nichq.org/resources/PFAC-toolkit-landingpage.html
	Engaging Patients in Improving Ambulatory Care: A Compendium of Tools	Robert Wood Johnson Foundation	www.rwjf.org/en/research-publications/find-rwjf-research/2013/03/engaging-patients-in-improving-ambulatory-care.html
Health Literacy Toolkits	Health Literacy Universal Precautions Toolkit	Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf
	Health Literacy and Patient Safety: Help Patients Understand Kit and Manual for Clinicians	American Medical Association	med.fsu.edu/userFiles/file/ahec_health_clinicians_manual.pdf
	Teach-Back Training	Always Use Teachback! Toolkit	www.teachbacktraining.org
	Health Literacy Video	North Carolina Program on Health Literacy	http://nchealthliteracy.org/teachingaids.html
	See AHRQ Toolkit above for section on teach-back		
Testing for Unconscious Bias	Implicit Association Test	Project Implicit, Harvard University	implicit.harvard.edu/implicit/education.html
Cultural Competence Toolkits	AAP Culturally Effective Care Toolkit	American Academy of Pediatrics	www.aap.org/en-us/professional-resources/practice-support/Patient-Management/Pages/Culturally-Effective-Care-Toolkit.aspx
	National Center for Cultural Competence Self Assessments	National Center for Cultural Competence, Georgetown University	nccc.georgetown.edu/resources/assessments.html

with asthma living in housing with a cockroach infestation or mold will require assistance from social workers, legal advocates, and housing organizations to reduce allergen exposure and improve health.

Addressing these vital signs will require research on effective screeners and interventions, partnerships with community organizations, and appropriate payment for screening and management.

Although the clinician's office is often considered a safe environment in which to address family psychosocial problems, many clinicians fail to monitor these new vital signs and subsequently miss the opportunity to
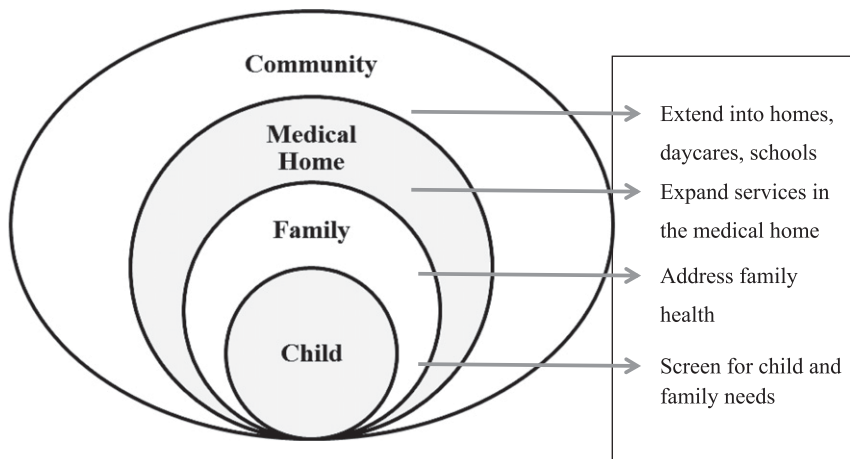
FIGURE 1
Four approaches to address health disparities in clinical practice.

help.[22] The WE CARE 10-item family psychosocial screening instrument was developed to assess family employment, education, housing, or food needs. A study using this screener with referral to community resources was found to be feasible in primary care, adding <2 minutes to the visit and leading to greater discussion of topics and referral completion.[23,24] Screening can be completed before or during a visit using the Internet, smart phones, kiosks, or paper and pencil. The iScreen study compared a screener for social determinants of health on a computer tablet or face-to-face in a pediatric emergency department, finding greater disclosure in electronic format.[25] Screening for adverse childhood experiences has also been proposed to identify and address trauma.

Some clinicians have avoided this type of screening because of limited resources. However, clinician acknowledgment, support, and referrals can be therapeutic, and educational resources are available. For instance, the smokefree.gov website from the National Cancer Institute provides a free quit line or instant messaging support, and all states have quit lines listed. If screening suggests depression, acknowledgment of the concern and referral to clinicians and crisis

management hotlines are critical first steps. New models connecting patients to community resources have been developed. The national Health Leads program uses a Family Help Desk staffed by undergraduate volunteers who connect families to community services.[26–28] The CAP4Kids Web site (cap4kids.org/whatiscap4kids.html) provides up-to-date information on community resources in certain cities.[29] New web-based products for sale are being developed and disseminated.

Increasing the comprehensiveness of services in primary or specialty care can provide one-stop shopping to address the new vital signs. Integrating services such as mental health can increase utilization and improve health outcomes.[30] The Healthy Steps model incorporates a child psychologist or developmentalist into pediatric practices, demonstrating greater parent satisfaction[31] and improvement in timely well-child care, immunization and breastfeeding rates, and discipline strategies.[32–34]

Other "wraparound" services could include social work, case management, nutritionists, lactation consultants, health educators, substance use counselors, legal advocates, and career counselors. Reach Out and Read family literacy

programs in primary care have demonstrated effectiveness in increasing parental support and how much parents read to their children.[35–37] Medical-legal partnerships integrate pro bono legal services into care teams to address issues such as public benefits, housing, and special education.[38] The Johns Hopkins Children's Center Harriet Lane Clinic is an example of a medical home that has incorporated many of the above services through partnerships with community organizations, optimized billing, and leveraged funds from health plans and private foundations.[30] With the current emphasis on population health and quality measures, payers have greater interest in investing in these services to improve practice and community health outcomes.

The third approach pertains to family health. Pediatric professionals recognize that child and family health are intertwined.[39] The AAP Task Force on the Family states that "families are the most central and enduring influence in children's lives" and coined the term "family pediatrics," which extends pediatrics to include screening, assessment, and referral of parents regarding their health issues.[40] Pediatrics offers an opportunity to facilitate access for families. The AAP recommends screening for parental smoking, maternal depression, and intimate partner violence to improve health for both parents and children.[41–44]

Addressing preconception women's health in pediatric practice is another family care opportunity. Although U.S. infant mortality rates have decreased over time, racial disparities persist. Prenatal interventions have been emphasized, but there is growing attention to preconception women's health. Addressing women's access to care, reproductive planning, nutrition, substance use, and mental health can improve health of future pregnancies and family health.[45,46] Pediatric

　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　CHENG et al

practice is an opportune location of contact, as clinicians see all preconceptional adolescents as well as mothers who are inter-conceptional before their next child. Demonstration of cost-effectiveness and payment models for implementation are needed.

A fourth approach is to move care outside the office and into the community where children are: in the home, daycare, or school. Whereas the medical approach is to ask families to come to offices, population health approaches suggest place-based initiatives and outreach to the child's natural environment. With growing emphasis on population health, prevention of readmissions, and quality measures, insurers and hospitals have become interested. Health reform has augmented home visitation programs. Integration with the medical home could reduce duplication of services and fragmentation while synergizing positive outcomes.[47]

School health, another area of ACA emphasis, has the potential to improve Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, such as the well-adolescent visit rate, by accessing youth in schools. Integrated school health can improve immunization rates, augment chronic disease management, enhance student health education, and improve school outcomes.[48]

BECOME LITERATE ON HEALTH LITERACY

Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[49] Some studies report that health literacy may be a stronger predictor of health than race/ethnicity, income, employment, and education level.[50] Addressing health literacy is critical for patient-centered, equitable, and safe care and involves improving patient and parent communication with clinicians, increasing knowledge

about the health care system, reducing language barriers, and understanding health beliefs.[1]

The Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit[51] and the American Medical Association's Health Literacy and Patient Safety Kit[49] (Table 1) include instructional videos and a variety of tools to assess clinician communication skills with low-literacy patients and assess patient-friendly office processes. AHRQ discusses 4 areas: spoken communication, written com-munication, patient self-management and empowerment, and supportive systems.[49] Checklists assess each of these areas and the toolkits offer practical strategies.

Recommendations to improve communication include slowing down, avoiding jargon, and using the "teach-back" technique. Teach-back is a method for clinicians to check whether they have adequately explained information in a manner that the patient understands. This method is 1 of the top 11 evidence-based patient safety practices identified by AHRQ,[52] and research demonstrates that teach-back can improve retention of information, communication, and patient health outcomes.[53–55] It involves asking, "I want to be sure I explained everything clearly. Can you explain it back to me so I can be sure I did?" or "We've gone over a lot of information. In your own words, please review with me what we talked about."[56] Training videos and assessment tools can be found online (Table 1; www.teachbacktraining.org).

DELVE INTO YOUR UNCONSCIOUS BIASES

A study performed using the Implicit Association Test (IAT), a measure of implicit social cognition, found that unconscious preferences and stereotypes are commonplace.[57] Acknowledging that everyone has preferences and conscious or

unconscious biases, it is important for clinicians to assess their implicit biases and explore how they affect behavior and treatment of patients. The free IAT assesses unconscious biases on a variety of characteristics such as race/ethnicity, gender, age, and weight status (https://implicit.harvard.edu/implicit).[58] The literature has found an association between clinician race/ethnicity IAT results and their patient care decisions.[59–61]

ENSURE A CULTURE OF EQUITY IN THE WORKPLACE

The AAP policy on "Enhancing the Pediatric Workforce Diversity and Providing Culturally Effective Pediatric Care" discusses the value of regular clinician self-reflection, self-knowledge, and self-critique to ensure cultural competence. For quality and safety, linguistic competency must also be ensured.[62,63] The AAP Culturally Effective Toolkit[64] is a practical, hands-on resource to assist clinicians and their office staff, including tips for busy practices: (1) have staff reflect the diversity of the patient population, (2) know community resources available for racial/ethnic or immigrant groups, (3) ask about nontraditional treatments, (4) consider group visits for families with limited English proficiency, and (5) plan extra time for patients requiring interpreters.

ADVOCATE FOR EFFORTS THAT ADDRESS ROOT CAUSES OF HEALTH DISPARITIES

Health disparities are rooted in social and environmental conditions outside of the health care system. Clinicians must add their voice to child advocacy efforts ensuring affordable, quality health care, child care, education, housing, nutritious food, family supports, and guarantees of a living wage. The AAP tracks state legislative actions on many poverty-related policies and lists state commissions and potential coalition partners (Table 1). Child advocacy or medical associations, community

organizations, and AAP chapters can be powerful agents of change.

SUMMARY

Clinicians play a critical role in diagnosing, addressing, and eliminating the conditions that cause health disparities. Clinician and staff provision of culturally effective care requires periodic assessment. Evidence-based practices can guide improvements. Health system investment in practice approaches to address social determinants of health offer promise to improve population health and ensure health equity.

ABBREVIATIONS

AAP: American Academy of Pediatrics
ACA: Affordable Care Act
AHRQ: Agency for Healthcare Research and Quality
CLAS: culturally and linguistically appropriate services
IAT: Implicit Association Test
QI: quality improvement
SES: socioeconomic status

REFERENCES

1. Cheng TL, Dreyer BP, Jenkins RR. Introduction: child health disparities and health literacy. *Pediatrics*. 2009;124 (suppl 3):S161–S162

2. Flores G; Committee On Pediatric Research. Technical report—racial and ethnic disparities in the health and health care of children. *Pediatrics*. 2010; 125(4). Available at: www.pediatrics.org/ cgi/content/full/125/4/e979 doi:10.1542/ peds.2010-0188

3. Braveman P, Barclay C. Health disparities beginning in childhood: a life-course perspective. *Pediatrics*. 2009;124(suppl 3): S163–S175

4. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Serv Res*. 2014;14:99

5. Kawachi I, Subramanian SV, Almeida-Filho N. A glossary for health inequalities. *J Epidemiol Community Health*. 2002;56(9):647–652

6. Bloom B, Cohen RA, Freeman G. Summary health statistics for U.S. children: National Health Interview Survey, 2010. National Center for Health Statistics. *Vital Health Stat*. 2011;10(250)

7. NCQA Patient-Centered Medical Home. Washington, DC: National Committee for Quality Assurance; 2014. Available at www.ncqa.org/Portals/0/Programs/ Recognition/PCMH/PCMH-2014_Brochure-web-1.pdf. Accessed May 1, 2015

8. Tollman S. Community oriented primary care: origins, evolution, applications. *Soc Sci Med*. 1991;32(6):633–642

9. National Commission on Community Health Services. *Health Is a Community Affair: Report of the National Commission on Community Health Services (NCCHS)*. Cambridge, MA: Harvard University Press; 1967

10. Folsom Group. Communities of solution: the Folsom Report revisited. *Ann Fam Med*. 2012;10(3):250–260

11. National Cultural and Linguistic Competency Standards. Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health; 2013. Available at www.thinkculturalhealth.hhs. gov/Content/clas.asp. Accessed May 1, 2015

12. Chin MH, Alexander-Young M, Burnet DL. Health care quality-improvement approaches to reducing child health disparities. *Pediatrics*. 2009;124(suppl 3): S224–S236

13. Quality Improvement Interventions to Address Health Disparities. Rockville, MD: Agency for Healthcare Research and Quality; 2014. www.ahrq.gov/research/ findings/evidence-based-reports/ gapdisptp.html. Accessed May 1, 2015

14. Creating a patient and family advisory council: a toolkit for pediatric practices. Boston, MA: National Initiative for Children's Healthcare Quality; 2012. Available at: www.nichq.org/resources/ PFAC-toolkit-landingpage.html. Accessed November 30, 2014

15. Aligning Forces for Quality. Engaging patients in improving ambulatory care: a compendium of tools from Maine, Oregon, and Humboldt County, California. Princeton, NJ: Robert Wood Johnson Foundation; 2013. Available at: www.rwjf. org/en/research-publications/find-rwjf-research/2013/03/engaging-patients-in-improving-ambulatory-care.html. Accessed November 30, 2014

16. Fine A, Kotelchuck M. Rethinking maternal child health: the Maternal Child Health life course model as an organizing framework. Washington, DC: Maternal and Child Health Bureau; 2010. Available at: mchb.hrsa.gov/lifecourse/ rethinkingmchlifecourse.pdf. Accessed November 30, 2014

17. Council on Community Pediatrics and Committee on Native American Child Health. Policy statement—health equity and children's rights. *Pediatrics*. 2010; 125(4):838–849. Available at: www. pediatrics.org/cgi/content/full/125/4/e838

18. Robert Wood Johnson Foundation Commission to Build a Healthier America. Time to Act: Investing in the Health of Our Children and Communities. Princeton, NJ: Robert Wood Johnson Foundation. Available at: www.rwjf.org/ commission. Accessed November 30, 2014

19. Hood E. Dwelling disparities: how poor housing leads to poor health. *Environ Health Perspect*. 2005;113(5):A310–A317

20. Krieger J, Higgins DL. Housing and health: time again for public health action. *Am J Public Health*. 2002;92(5): 758–768

21. Kersten EE, LeWinn KZ, Gottlieb L, Jutte DP, Adler NE. San Francisco children living in redeveloped public housing used acute services less than children in older public housing. *Health Aff (Millwood)*. 2014;33(12): 2230–2237

22. Fleegler EW, Lieu TA, Wise PH, Muret-Wagstaff S. Families' health-related social problems and missed referral opportunities. *Pediatrics*. 2007;119(6). Available at: www.pediatrics.org/cgi/ content/full/119/6/e1332

23. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE Project. *Pediatrics*. 2007;120(3):547–558. Available at: www.pediatrics.org/cgi/ content/full/120/3/e547

24. Garg A, Butz AM, Dworkin PH, Lewis RA, Serwint JR. Screening for basic social needs at a medical home for low-income children. *Clin Pediatr (Phila)*. 2009;48(1): 32–36

25. Gottlieb L, Hessler D, Long D, Amaya A, Adler N. A randomized trial on screening for social determinants of health: the iScreen Study. *Pediatrics* 2014;134(6). Available at: www.pediatrics.org/cgi/content/full/134/6/e1611

26. Garg A, Marino M, Vikani AR, Solomon BS. Addressing families' unmet social needs within pediatric primary care: the health leads model. *Clin Pediatr (Phila)*. 2012; 51(12):1191–1193

27. Garg A, Sarkar S, Marino M, Onie R, Solomon BS. Linking urban families to community resources in the context of pediatric primary care. *Patient Educ Couns*. 2010;79(2):251–254

28. Health Leads. Boston, MA: Health Leads. Available at: www.healthleadsusa.org. Accessed November 14, 2011

29. CAP4Kids: The Children's Advocacy Project of America. 2005. Available at: cap4kids.org/whatiscap4kids.html. Accessed November 30, 2014

30. Cheng TL, Solomon BS. Translating life course theory to clinical practice to address health disparities. *Matern Child Health J*. 2014;18(2):389–395

31. Minkovitz C, Strobino D, Hughart N, Scharfstein D, Guyer B; Healthy Steps Evaluation Team. Early effects of the healthy steps for young children program. *Arch Pediatr Adolesc Med*. 2001;155(4):470–479

32. Johnston BD, Huebner CE, Anderson ML, Tyll LT, Thompson RS. Healthy steps in an integrated delivery system: child and parent outcomes at 30 months. *Arch Pediatr Adolesc Med*. 2006;160(8): 793–800

33. Minkovitz CS, Hughart N, Strobino D, et al. A practice-based intervention to enhance quality of care in the first 3 years of life: the Healthy Steps for Young Children Program. *JAMA*. 2003;290(23): 3081–3091

34. Johnston BD, Huebner CE, Tyll LT, Barlow WE, Thompson RS. Expanding developmental and behavioral services for newborns in primary care; effects on parental well-being, practice, and satisfaction. *Am J Prev Med*. 2004;26(4): 356–366

35. Mendelsohn AL, Mogilner LN, Dreyer BP, et al. The impact of a clinic-based literacy intervention on language development in inner-city preschool

children. *Pediatrics*. 2001;107(1). Available at: www.pediatrics.org/cgi/content/full/107/1/e130

36. High PC, LaGasse L, Becker S, Ahlgren I, Gardner A. Literacy promotion in primary care pediatrics: can we make a difference? *Pediatrics*. 2000;105(4 pt 2 suppl3):927–934

37. Golova N, Alario AJ, Vivier PM, Rodriguez M, High PC. Literacy promotion for Hispanic families in a primary care setting: a randomized, controlled trial. *Pediatrics*. 1999;103(5 Pt 1):993–997

38. National Center for Medical Legal Partnership. Washington, DC. Available at: http://medical-legalpartnership.org. Accessed November 30, 2014

39. Fiese BH, Rhodes HG, Beardslee WR. Rapid changes in American family life: consequences for child health and pediatric practice. *Pediatrics*. 2013; 132(3). Available at: www.pediatrics.org/cgi/content/full/132/3/e552

40. Schor EL; American Academy of Pediatrics Task Force on the Family. Family pediatrics: report of the Task Force on the Family. *Pediatrics*. 2003; 111(6 Pt 2):1541–1571

41. Hagan JF, Shaw JS, Duncan PM, Eds. Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents. 3rd Ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008

42. Committee on Environmental HealthHealth; Committee on Substance Abuse; Committee on Adolescence; Committee on Native American Child. From the American Academy of Pediatrics: Policy statement—Tobacco use: a pediatric disease. *Pediatrics*. 2009; 124(5). Available at: www.pediatrics.org/cgi/content/full/124/5/e1474

43. Earls MF; Committee on Psychosocial Aspects of Child and Family Health American Academy of Pediatrics. Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics*. 2010;126(5). Available at: www.pediatrics.org/cgi/content/full/126/5/e1032

44. Thackeray JD, Hibbard R, Dowd MD; Committee on Child Abuse and Neglect; Committee on Injury, Violence, and Poison Prevention. Intimate partner violence: the role of the pediatrician. *Pediatrics*. 2010;125(5). Available at:

www.pediatrics.org/cgi/content/full/125/5/e1094

45. Johnson K, Posner SF, Biermann J, et al; CDC/ATSDR Preconception Care Work Group; Select Panel on Preconception Care. Recommendations to improve preconception health and health care—United States: a report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. *MMWR Recomm Rep*. 2006;55(RR-6):1–23

46. Cheng TL, Kotelchuck M, Guyer B. Preconception women's health and pediatrics: an opportunity to address infant mortality and family health. *Acad Pediatr*. 2012;12(5):357–359

47. Tschudy MM, Toomey SL, Cheng TL. Merging systems: integrating home visitation and the family-centered medical home. *Pediatrics*. 2013;132(suppl 2):S74–S81

48. Knopf J. School-Based Health Centers for the Improvement of Health Equity: A Community Guide Systematic Review, Centers for Disease Control and Prevention. Available at: www.sbh4all.org/session-materials/#sthash.23D47eQa.dpuf. Accessed August 20, 2015

49. Institute of Medicine. *Health Literacy: A Prescription to End Confusion*. Washington, DC: National Academies Press; 2004

50. Weiss BD. Health literacy and patient safety: Help patients understand manual for clinicians, 2nd Ed. American Medical Association Foundation and American Medical Association; 2007. Available at: med.fsu.edu/userFiles/file/ahec_health_clinicians_manual.pdf. Accessed November 16, 2014

51. DeWalt DA, Callahan LF, Hawk VH, et al. Health Literacy Universal Precautions Toolkit. North Carolina Network Consortium, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, under contract no. HHSA290200710014. AHRQ Publication 10-0046-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2010

52. Making Health Care Safer: An Updated Critical Analysis of the Evidence for Patient Safety Practices. Rockville, MD: Agency for Healthcare Research and Quality Report. Available at: www.ahrq.gov/research/findings/evidence-based-reports/ptsafetyuptp.html. Accessed November 30, 2014

53. White M, Garbez R, Carroll M, Brinker E, Howie-Esquivel J. Is "teach-back" associated with knowledge retention and hospital readmission in hospitalized heart failure patients? *J Cardiovasc Nurs*. 2013;28(2):137–146

54. Kornburger C, Gibson C, Sadowski S, Maletta K, Klingbeil C. Using "teach-back" to promote a safe transition from hospital to home: an evidence-based approach to improving the discharge process. *J Pediatr Nurs*. 2013;28(3):282–291

55. Schillinger D, Piette J, Grumbach K, et al. Closing the loop: physician communication with diabetic patients who have low health literacy. *Arch Intern Med*. 2003;163(1):83–90

56. Always Use Teach-back! Teach-Back Training. Available at: www.teachbacktraining.org. Accessed November 30, 2014

57. Nosek BA, Smyth FL, Hansen JJ, et al. Pervasiveness and correlates of implicit attitudes and stereotypes. *Eur Rev Soc Psychol*. 2007;18(1):36–88

58. Project Implicit. Cambridge, MA: 2011. Available at: implicit.harvard.edu/implicit/index.jsp. Accessed November 30, 2014

59. Cooper LA, Roter DL, Carson KA, et al. The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health*. 2012;102(5):979–987

60. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med*. 2013;28(11):1504–1510

61. Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med*. 2007;22(9):1231–1238

62. Flores G, Abreu M, Olivar MA, Kastner B. Access barriers to health care for Latino children. *Arch Pediatr Adolesc Med*. 1998;152(11):1119–1125

63. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003;111(1):6–14. Available at: www.pediatrics.org/cgi/content/full/111/1/e6

64. Cora-Bramble D, Schaefer DM. Culturally Effective Care Toolkit. Elk Grove Village, IL: American Academy of Pediatrics; 2011. Available at: www.aap.org/en-us/professional-resources/practice-support/Patient-Management/Pages/Culturally-Effective-Care-Toolkit.aspx. Accessed November 30, 2014

Disparities in Health Care Cases

A day in continuity clinic…
You are reviewing your schedule for the afternoon and you notice that your 1300 routine well visit has not checked in yet. The patient, Tai, is a 6-year-old with poorly controlled eczema and moderate persistent asthma who was last seen in clinic approximately one year ago for a well-child check. The family was listed as a 'no show' for their follow-up appointment, which was scheduled to further discuss their asthma action plan. Upon further chart review, you notice that there have been several missed visits in the past for asthma and eczema follow-up and that the patient's medications have not been refilled in several months. You proceed with the rest of your clinic, and while you are finishing up with your 1400 patient, you realize that this patient was just checked in.
What are your initial thoughts when preparing to see this family?

The patient is finally screened and brought into the room at 1450 and you notice that they are accompanied by a parent and 2 younger siblings. The screener reports that the family was unable to complete the screening questionnaires due to tardiness.

Do you have any thoughts about what race or nationality this family might be?

What about their socioeconomic status?

What is the parent's gender?

How is the parent dressed?

What does the parent sound like?

What aspects of what you think and how you feel about this family have the potential to positively or negatively impact the care you provide them?

What social determinants of health may positively or adversely impact their ability to "comply" with their health management plan?

Your next patient, Rosa, scheduled for 1500, is a 14yo here with their retired O6 sponsor. They come annually for visits, but this is your first time seeing them and they need sports physical forms signed. You read that the patient is a freshman in high school, plays soccer, and was reportedly considering a career in medicine per their last visit one year ago.

What are your initial thoughts when preparing to see this family?

- Discuss biases about children of officer sponsors.
- Any thoughts about the patient's activities or preferred career path?

You apologize for the wait and begin your clinic visit. The parent is very friendly, complimenting you on your excellent choices to become a physician AND serve your country. The child has no significant past medical history, negative ROS on the intake form, normal vitals, and normal growth curves. You perform a routine physical exam, clear them for sports, and tell them you look forward to seeing them in a year.

What is the patient's gender?

What is the patient's body habitus?

Do you have any thoughts about what race or nationality this family might be?

What is the parent's gender?

How is the parent dressed?

What does the parent sound like?

Should you have done a HEADSSS exam?

Would your race and/or gender affect how you perceive the parent's compliment?
- *If you were of the same race vs a different race*
- *If you were of the same gender vs a different gender*

BEING AN ACTIVE BYSTANDER

STRATEGIES FOR CHALLENGING THE EMERGENCE OF BIAS

THE KIRWAN INSTITUTE FOR THE STUDY OF RACE & ETHNICITY | AUTHOR: LENA TENNEY

"When we speak we are afraid our words will not be heard or welcomed. But when we are silent, we are still afraid. So it is better to speak." *–Audre Lorde*

Thank you for your commitment to challenging explicit and implicit bias. It can be difficult to know what to say when a family member, friend, colleague, acquaintance, or stranger makes problematic comments. However, we will only be able to dismantle oppression in its overt forms if we are brave enough to challenge bias in even its most common forms. The Kirwan Institute invites you to utilize these strategies to empower yourself to speak out in response to bias.

Individuals can be active bystanders when faced with the emergence of bias in interpersonal interactions. These suggestions encompass a variety of approaches to opening a conversation about bias. There is not a one-size-fits-all solution to challenging every manifestation of bias. Consider which strategy or strategies might be most effective based upon situational context, as well as your own strengths.

There is a difference between calling someone in (inviting continued discussion and learning) and calling someone out (shutting down the conversation). Both approaches are valid, yet might be more or less effective in various circumstances. The goals of these strategies are to educate people and invite them to do better, rather than to criticize or ostracize them, thereby addressing the situation while avoiding making the person defensive.

Strategies for Speaking Out

- **Use humor.**
  - "What are you?" "Human! How about you?"
  - "Your English is so good!" "I should hope so since it's the language I've been speaking my entire life!"
- **Be literal or refuse to rely on the assumption being made.**
  - "Let's powwow!" "I don't think we have time to plan a whole powwow, but I'm willing to have a quick meeting."
  - "That's just the way those people are, you know?" "Actually I don't know what you mean by that. I've met a lot of people in that group and they're all unique individuals."
  - "I don't get the joke. Can you explain it to me?"
- **Ask questions that invite discussion.**
  - "What do you mean when you say that?"

THE OHIO STATE UNIVERSITY
KIRWAN INSTITUTE FOR THE
STUDY OF RACE AND ETHNICITY

33 West 11th Avenue, Suite 115
Columbus, OH 43201
Phone 614.247.1633 | Fax: 614.688.5592

- o "Do you know what that phrase actually means and where it came from? Most people have no idea that it actually has an offensive origin/meaning."
- o "Can you explain your thought process to me? I want to be sure I understand how we reached such different conclusions."
- **State that you are uncomfortable.**
  - o "That phrase makes me uncomfortable. Could you please not use it around me?"
  - o "Assumptions about an entire group of people make me uncomfortable. I don't think that we can take that assumption for granted or make our decisions based off of it."
- **Create a conversation speedbump.**
  - o "I'm not an expert, but my understanding is that that language is outdated. Does anyone know what might be a better way to phrase that? If not, I'll try to Google it."
  - o "I'm not sure what I think about that. I'm going to have to think about that more."
  - o "I don't know how I feel about that…"
  - o "Ouch!" "Whoa!" "Excuse me?!" or "Seriously?!"
- **Use direct communication.**
  - o "That kind of language is not appropriate in the workplace."
  - o "When we say that people who are nearing retirement shouldn't be promoted to this position because they might not be as dedicated at this point in their career, I worry we aren't being fair to older employees. That assumption doesn't take into account every individual's circumstances and work ethic, so can we please make sure we aren't relying on it when deciding who to consider for the position?"
  - o "I know you aren't intending to stereotype anyone, but as your friend I wanted to let you know that what you said could easily be interpreted that way. Since I know you're a good person who cares about others, I would hate for you to accidentally say it again without realizing how it can come across."
- **Remind people of personal and/or institutional values.**
  - o "I know you want to be an ally, and that's exactly why I wanted to check in about your comment. I know I would want someone to tell me if I accidentally messed up."
  - o "You're new so maybe you haven't been told yet, but we don't talk about women like that here."
  - o "Clearly we have different personal opinions about this topic. Regardless, the handbook/code of conduct/non-discrimination policy does say that we do not discriminate/treat people differently/talk like that."
- **Remove yourself from the conversation.**
  - o "This conversation is no longer productive, so I am ending it."
  - o "We have this same fight every holiday gathering. Clearly we're not going to change each other's minds. I won't agree to disagree because people's humanity is too important for that, but I will ask that we not have this fight right now. Can we please enjoy family time together instead?"

Additional Resources
- Engage with the virtual training, "Did They Really Just Say That?! Being an Active Bystander"
  - o http://kirwaninstitute.osu.edu/active-bystander-training/

Disparities in Health Care Quiz

1. What is meant by health equity?
   a. All patients, regardless of their race or ethnicity, receive the same care.
   b. Health care is delivered in a way to guarantees equal outcomes for each patient.
   c. All patients, regardless of their race or ethnicity, receive the highest-quality care.
   d. All patients receive health care from culturally competent providers.

2. Health disparity refers to inequalities thought to be unfair, unjust, and avoidable. Which of the following factors can contribute to health disparities?
   a. Universal access to care
   b. Diversity among healthcare providers
   c. Social determinants of health
   d. Cultural humility

3. Which of the following terms refers to the tendency to favor one group over another?
   a. Prejudice
   b. Stereotype
   c. Bias
   d. Microaggression

4. Some automatic associations and illness scripts (such as a 16yo Black female presenting to the ER with abdominal pain) taught in medical training are examples of which of the following?
   a. Prejudice
   b. Stereotype
   c. Bias
   d. Microaggression

5. Which of the following is NOT an example of implicit bias?
   a. An automatic preference
   b. A negative belief that is suppressible
   c. A positive or negative unconscious attitude
   d. A bias that is acknowledged by the individual

6. What is the main difference between implicit and explicit biases?
   a. Implicit biases are more likely to be negative.
   b. Explicit bias is more harmful.
   c. Implicit preferences tend to engage automatic processing (fast thinking) while explicit preferences are more deliberate (slow thinking).
   d. People can recognize when someone is acting on explicit bias, but actions based on implicit bias are too subtle to notice.