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Case Example #5 — Part 1

Health inequity and implicit bias

CASE EXAMPLE

An African American man with a history of diabetes, hypertension, stroke, and a recent fall at home presented to the emergency room early one evening. He had a cursory evaluation at triage and was provided a wheelchair to sit in as he waited to be seen. After an hour of waiting, he was given a container to collect urine. Despite limited mobility, he walked himself to the restroom without assistance, collected the urine, and found his way back to the wheelchair where he waited. Hours passed; other patients with apparent less acute presentations were walked back and seen as he sat in his wheelchair; no one checked on him. Eventually, despite feeling reluctant to speak up for fear of displeasing the nurse and receiving hostility, he tried to get the attention of the desk nurse to determine when he'd be seen and asked for pain medication for a growing headache. The nurse spoke in an uncaring and loud voice, telling him that the ER was too busy to deal with this and that he needed to wait for his turn. She added that he was fine and didn't need pain medication. He asked if they could call his son and ask him to pick him up, but the nurse walked away without responding.

After several more hours of sitting and not being cared for, he felt unsafe and asked if he could call his son to pick him up. The nurse told him that there was nothing wrong with him and if he wanted to call to be picked up, that was up to him.

Eight hours later, the first and only call that was placed to the son was from his father. Through slurred and weakened speech, his father asked to be picked up. When the son arrived, his father was outside sitting at the curb unattended and in a wheelchair. He was confused, weak and crying. They left for home, discouraged and distrustful of whether quality care would be received.

Early the next morning, hours after leaving the ER, the father appeared by ambulance at the ER, once again, after having suffered a severe stroke.

The uncaring disregard with which the nurse engaged the patient illustrates how unconscious stereotypes or attitudes about a person, **implicit bias**, can be expressed in active disparity in the provision of care. Implicit bias is defined as “the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner.”³

Research has shown this can lead to differential treatment of patients by race, gender identity, weight, age, language, sexual orientation, income, and insurance status.³

Ignoring, disbelieving, or having contempt for the patient's experience of pain is a known manifestation of implicit bias towards patients of color, which can result in fear and reluctance to speak up when needs are not met.

After the long wait time, cursory assessment, poor communication and other failures in patient-centered care, the patient lost confidence in the ability to receive beneficial care and treatment and made the decision to disengage from seeking care despite worsening symptoms.

Research has shown that implicit or subconscious bias can negatively affect whether patients will subsequently return for services at the organization – with potentially detrimental consequences in terms of health outcomes.⁴

The mistrust and lost confidence that can occur when a caregiver does not believe the symptoms and complaints of patients of color can lead to worsening symptoms and ultimately poorer outcomes – further widening the disparity gap.¹

As other patients were seen, the patient languished in the emergency room without further assessment, interaction, communication, or care.

Disproportionately long waiting time for people of color is one way in which **institutional racism** can manifest in an organization's structures, rules and norms.¹ Institutional racism has been defined as “differential access to the goods, services, and opportunities of society by race... It is structural, having been codified in our institutions of custom, practice, and law...”²

This can have a negative impact on provision of care and health outcomes for patients.

The dismissing, disrespectful, disbelieving behavior of the nurse can foster further reluctance to speak up and overall doubt that quality care will be received, widening the gap in which health care may be distrusted and not sought by patients of color.¹

The lack of confidence built upon experiences of this kind or previous interactions can be perpetuated and affect a patient's willingness to seek health care in the future – leading to further widening of disparities in care.¹

Disclaimer: This case example is aggregated and is not representative of a single report or incident. Any likeness to an actual event is purely coincidental.

Case Example #5 — Part 2

Safety Strategies

Health inequity and implicit bias

A look at safety strategies

SAFETY STRATEGIES

An African American man with a history of diabetes, hypertension, stroke, and a recent fall at home presented to the emergency room early one evening. He had a cursory evaluation at triage and was provided a wheelchair to sit in as he waited to be seen. After an hour of waiting, he was given a container to collect urine. Despite limited mobility, he walked himself to the restroom without assistance, collected the urine, and found his way back to the wheelchair where he waited. Hours passed; other patients with apparent less acute presentations were walked back and seen as he sat in his wheelchair; no one checked on him. Eventually, despite feeling reluctant to speak up for fear of displeasing the nurse and receiving hostility, he tried to get the attention of the desk nurse to determine when he'd be seen and asked for pain medication for a growing headache. The nurse spoke in an uncaring and loud voice, telling him that the ER was too busy to deal with this and that he needed to wait for his turn. She added that he was fine and didn't need pain medication. He asked if they could call his son and ask him to pick him up, but the nurse walked away without responding. After several more hours of sitting and not being cared for, he felt unsafe and asked if he could call his son to pick him up. The nurse told him that there was nothing wrong with him and if he wanted to call to be picked up, that was up to him. Eight hours later, the first and only call that was placed to the son was from his father. Through slurred and weakened speech, his father asked to be picked up. When the son arrived, his father was outside sitting at the curb unattended and in a wheelchair. He was confused, weak and crying. They left for home, discouraged and distrustful of whether quality care would be received. Early the next morning, hours after leaving the ER, the father appeared by ambulance at the ER, once again, after having suffered a severe stroke.

The organization implemented mandatory annual training to develop cultural competencies regarding equitable, respectful, and caring engagement of all patients, families, and care partners. It also incorporated training for individuals to self-assess their own bias (implicit bias) to recognize and incorporate strategies and skills (such as perspective-taking) to mitigate its effects.^{1,3,5}

The organization improved its incident reporting capabilities to adequately capture incidents regarding health inequity, disparity, and/or racism whether subtle or overt, and to establish targeted solutions for remediation and improvement for areas of concern.⁶

Recognizing a significant need to transform its approach to health equity, the organization made health equity a strategic priority at a system-level and identified eliminating racism and decreasing health disparity as core values.

The organization performed a self-assessment to understand its current racial climate and focus on health equity, cultural competence, and patient-centered care. Using the IHI Health Equity Self-Assessment Tool for Health Care Organizations, the organization evaluated and developed improvement strategies around 5 strategic components:¹⁻⁵

1. Make health equity a strategic priority.
2. Develop structure and processes to support health equity work.
3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact, such as health care services, socioeconomic status, physical environment, and healthy behaviors.
4. Decrease institutional racism within the organization.
5. Develop partnerships with community organizations to improve health and equity.

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Case Example #5 — Resources

Health inequity and implicit bias

RESOURCES

1. Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. Available at ihi.org.
2. Jones CP. Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*. 2000;90(8):1212-1215.
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4. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health*. 2015;105(12):e60-e76.
5. National Steering Committee for Patient Safety. Implementation Resource Guide: A National Action Plan to Advance Patient Safety. Boston, Massachusetts: Institute for Healthcare Improvement. 2020. Available at www.ihi.org/SafetyActionPlan.
6. van Ryn M, et al. The impact of racism on clinician cognition, behavior, and clinical decision making. *Du Bois Review*. 8:1(2011):199-218.

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