'I Don't Want *THAT* Doctor to See Me'

Responding to Bias and Racism from Patients

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On a rainy Thursday afternoon, a middle-aged man came to the hospital for his visit with a specialist. He had many routine procedures to treat his condition, but so far little progress had been made. He was growing tired, frustrated and worn down. That day, the patient became somewhat agitated as the specialist made his rounds through the room. The patient's attitude switched instantly from one of being tired but compliant to being hostile, angry and challenging. The shift in tone was noticeable to his care team, and they started inquiring about his behavior. Moments after his specialist left the room, the chaplain came to provide spiritual care. The chaplain noticed the man's shift in behavior and mood, so she asked him what he needed to feel more comfortable. The patient looked up at her and said, "I want you to get that Arab doctor off my care team!"

For some care providers, this scenario is far too common. People of color or whose first language isn't English, women and LGBTQ+ individuals often experience racist, xenophobic, sexist or homophobic comments regularly. In fact, such comments are increasing as people become more comfortable feeling empowered to express them. Acquiescing to such biased demands may impact underrepresented associates physically, psychologically, emotionally and even professionally.

At Bon Secours Mercy Health, our mission of extending the compassionate ministry of Jesus calls us to provide quality health care to all patients, regardless of race, gender, nationality, sexual orientation or personal beliefs. Even when a patient exhibits racist behaviors and attitudes, we are bound by the Hippocratic Oath to treat them. But are we obliged to meet their requests? And if not, how should we respond?

For our care providers, the frequency of such requests and behaviors has increased over the last few years, causing us to develop a response plan. Across our system, we have seen cases like this unfold, often with chaplains who are tasked with supporting our patients spiritually and emotionally. When patients feel comfortable making biased comments and requests, our chaplains immediately recognize a conflict with their own values. As chaplains have grappled with the issue, our Diversity and Inclusion team worked with them to identify a solution.

At Bon Secours Mercy Health, diversity and inclusion is a ministry-wide priority. As the nation's fifth largest Catholic health system, we serve more than two million patients a year across seven U.S. states and in Ireland. Our 60,000 associates provide health care to patients with a focus on serving the poor, dying and underserved. Based on our mission and core values of human dignity, integrity, compassion, service and stewardship, we see diversity and inclusion as the right thing to do from a mission perspective as well as a business one.

Our philosophy is that when we live our mis-

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sion in the way that we care for people and communities, we can also be an embodiment of inclusion. Jesus embraced all people regardless of their attributes, attitudes, status or behaviors. Our commitment as a ministry to our patients and associates is rooted in principles of inclusion, where we treat everyone with dignity and respect. Yet we know it can be challenging to help our associates stand on these principles when patients make racist, sexist or xenophobic requests or comments.

As we considered the issue of patient bias and racist comments, it was necessary to understand the pervasiveness of the problem from scientific and historical perspectives. The first step is to clarify the difference between bias and racism. Bias is a cognitive process that allows the brain to make shortcuts in its decision making about people, things and situations. Cognitive shortcuts evolved to help humans decipher between what is good or bad, safe or dangerous. Evolutionarily speaking, bias became an early defense mechanism to identify danger and make quick, life-saving decisions. Bias is influenced by stereotypes or negative portrayals of people based on certain attributes. Biases can be implicit, that is, occurring without conscious awareness, or explicit, occurring with conscious awareness.

Racism is a systemic structure of injustices that foster inequities for people based on their physical and cultural attributes. In the early parts of U.S. history, the notion of race was deployed to justify racial supremacy and support the enslavement of African people and the genocide of Native people. This was done by making racial distinctions between white, African and Native peoples where African and Native people were considered racially inferior. This framing was later applied to other groups that drew intellectual and behavioral distinctions based on race.[1] Human bias is influenced by such a racial paradigm because these constructs influence our perceptions of behavior from a perspective of race. This deeply rooted systemic structure still influences our social consciousness, which perpetuates social injustices and inequities toward people of color. The mechanism of socially engineering bias to leverage the fear and hatred of people of different races is as pervasive as ever.[2,3]

The history of systemic racism helps us understand what happens when individuals act in accordance with certain stereotypes about people of different racial and ethnic backgrounds. When a person is frightened, vulnerable or sick, bias mechanisms are heightened, so that they are more likely to display biased or racist beliefs and behaviors when in this state. It should not be sur-

prising, then, that patients who hold these biases are more likely to display them in states of duress.

The response to bias and racism in care settings should be met with the same complexity of thinking. Rather than simply putting together a programmatic response to such issues, we developed and deployed an integrated strategic approach to diversity and inclusion to ensure the advancement of equity for all Bon Secours Mercy Health associates, patients and communities.

Our priority was to establish a structure to support diversity and inclusion in our ministry. To do this, we deployed Leadership Councils for Diversity and Inclusion in each of our markets in 2019. These councils consist of cross-functional leaders who represent different levels in the organization and different attributes in terms of race, ethnicity, gender, sexual orientation, religion, age and ability. The Leadership Councils for Diversity and Inclusion develop strategic plans that support the five key areas of our ministry: a workforce that represents the communities we serve; a workplace culture where everyone is treated with dignity and respect; engagement with all the communities we serve; a patient experience where all patients receive equitable care; and a business strategy that leverages diversity and inclusion to grow the ministry. The Leadership Councils for Diversity and Inclusion develop market-level plans that they monitor, support and communicate to their market peers.

Additionally, we developed diversity and inclusion education and training that is deployed across the system in order to reduce the impact of bias in our care delivery, associate relations and community engagement. In 2019, for example, we were able to train almost 2,000 leaders in diversity and inclusion and 700 associates in bias reduction across the ministry. Our goal is to train all 60,000 associates in anti-racism and cultural sensitivity by the end of 2021.

When our mission leaders raised the issue of patients displaying bias towards our caregivers, we were able to build on our established foundation to provide a multi-faceted response. We started by redesigning our current bias training that only focused on reducing bias at the individual level. This four-hour training, entitled 3Rs: Bias Recognition, Bias Reflection and Bias Reduction, has five key modules aimed at reducing the impact of bias on one's behavior. A sixth element was added to address patient biases.

The first module focuses on building trust and comfort with the group. We have found in past trainings that people are more likely to fully engage in a training seminar when they have established trust in the presenters, as well as the other people in the room. Given the sensitive nature of the topic of bias, trust was crucial, because the participants are expected to open up about their experiences and analyze their own biases.

The second module is designed to help participants gain an understanding of the basics of diversity and inclusion. The Bon Secours Mercy Health understanding of diversity is rooted in the existence of the gifts, talents and attributes of people, processes and functions, characterized by both differences and similarities. This definition is designed to show that diversity is a fundamental part of who we are as people and that it exists in all of us. Inclusion is creating and fostering a trusting environment where all are included, respected and supported in their engagement with the acceleration of the mission, values and vision. Diversity is who we are. Inclusion is what we do. This becomes the focal point of ensuring that all members of our community feel engaged in our mission.

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The third module covers the importance of cognitive diversity, which is a person's individual thinking style preference. Using the Whole Brain Thinking model developed by Ned Herrmann, we showcase how different thinking styles influence how we are engaged, how we communicate, what information we see as important and what we focus on when we are thinking.[4] This portion of the training module is designed to give our participants a sense for how they think, how others think, and what they need to do when speaking

with someone who has a different thinking style preference.

The fourth module is focused especially on the 3Rs: bias recognition, reflection and reduction. In this portion of the training, we highlight how every person has bias, which is a cognitive process. Thus, intercepting bias and reducing the impact of bias on our behavior becomes the goal instead of ignoring our biases and pretending that they do not exist. Bias recognition is aimed at learning that everyone has biases and trying to determine how they occur in our interactions. The next step in the process is to reflect on the bias by determining the root and intention behind it. After reflecting on our bias, it is critical to take steps to reduce the impact of the bias on our behavior. We use multiple tools to help our participants do this, such as the equity lens. This tool helps a person check their own biases and remove such biases in their decision-making process to remain as objective as possible. It helps ensure that people are making decisions based on consistent criteria instead of bias.

The fifth part of the training module is aimed at putting the 3Rs to work through an application exercise. We divide the room into small groups of three or four people. Together they select a certain number of people out of a larger list of people to embark on a journey to a Brave New World. Each person on the list has different salient attributes, such as age, race, gender, occupation, parental status, educational background, criminal background and health status. The group establishes certain criteria for deciding who stays and who goes. After each group has determined their short list, they are required to justify their selections, using strict criteria about who they took and why. As facilitators, we challenge their selections and help pull out the implicit biases of the group. By the end of the module, we highlight how to apply the equity lens to change the influence of bias on their behavior going forward.

The last part of the training is focused on having difficult conversations. In this module, we start with the premise that what you permit you promote. That is, if you do not address biased behaviors directly, then you are complicit in their impact on other people. Second, we give a script-template that helps participants learn different responses when addressing requests from patients. With statements such as "I understand that you feel frustrated, but we do not make decisions based on a person's race or ethnicity," our participants have a standard reply that they are able to rely upon in difficult scenarios. The third portion of the module provides protocols to stand behind our mission, vision and values in response to these requests. For example, our participants were instructed to say "At Bon Secours Mercy Health, our mission is to live the compassionate healing ministry of Jesus every day, which requires us to support all of our patients, associates and community members by treating them with dignity and respect at all times. For that reason, I'm not willing or able to make that type of accommodation for you." These standardized responses create messaging that helps respond to these scenarios with integrity, allowing us to stay true to our mission, vision and values.

With the incorporation of cognitive diversity, we look deeper at how thinking influences interactions, perspectives and communication. This helps our participants see on a deeper level how people are similar to and different from one another.

In summary, the 3R training is designed to take our participants on a diversity and inclusion journey that engages them in the content, breaks down personal barriers and teaches on a deeper level how to mitigate the effects of bias on their behaviors and on others. By starting with trust building, we can help people have open discussions about their beliefs and views. Afterwards, we work to help everyone to see themselves in Bon Secours Mercy Health's definitions of diversity and inclusion. With the incorporation of cognitive diversity, we look deeper at how thinking influences interactions, perspectives and communication. This helps our participants see on a deeper level how people are similar to and different from one another. These first three modules prepare our participants to start looking at their own biases, which will help them more actively and openly reduce the impact of bias on their behavior. The final two modules reinforce their learning by giv-

ing them practice at examining their biases and addressing the biases of others.

CONCLUSION

The response to the training has been overwhelmingly positive. Participants feel empowered to address patient bias in real time, while also discovering they still have work to do on their own. In follow up debriefs, our chaplains said they were able to respond with integrity to challenging patients, and that has empowered the chaplains to stay true to our mission, vision and values in continuing the good work of extending the compassionate healing ministry of Jesus.

For diversity and inclusion, our work is far from done. We know that we must continue to develop ways for patients and associates to better understand our embrace of diversity and our practice of inclusion. With our ministry-wide commitment to infusing diversity and inclusion into everything we do, we know we can make real strides towards ending systemic structures of inequity that plague our associates, patients and communities, making us better able to support everyone in mind, body and spirt.

For Bon Secours Mercy Health, **NATHAN ZIEGLER** is vice president of culture and inclusion; **ODESA STAPLETON** is chief diversity and inclusion officer, and **MUZIET SHATA** is director of language services.

NOTES

1. Audrey Smedley and Brian Smedley, "Race as Biology Is Fiction, Racism as a Social Problem Is Real: Anthropological and Historical Perspectives on the Social Constructs of Race," *American Psychologist* 60, no. 1 (2005):16-26, doi: 10.1037/0003-066X.60.1.16.
2. Combating Bias and Stigma related to COVID-19," American Psychological Association, March 25, 2020, http://www.apa.org/topics/covid-19-bias.
3. Ying Liu and Brian Karl Finch, "Discrimination against Asian, Black Americans More Likely amid Coronavirus Pandemic," *The Evidence Base*, USC Schaeffer, March 23, 2020, https://healthpolicy.usc.edu/evidence-base/discrimination-against-asian-black-americans-more-likely-amid-coronavirus-pandemic/?utm_source=sfmc&utm_medium=email&utm_campaign=covidexternal&utm_content=newsletter.
4. Whole Brain Thinking website: https://www.herrmann.com.au/what-is-whole-brain-thinking/.

QUESTIONS FOR DISCUSSION

The decline in civil discourse and heightened levels of fear, anger and anxiety have resulted in situations of bias and racism directed at clinicians and other health care professionals. Bon Secours Mercy Health has developed a system-wide approach to dealing with bias and racism directly and consistently. Authors Nathan Ziegler, Odesa Stapleton and Muziet Shata describe the process they developed and the commitment that makes it work.

1. How has your ministry dealt with difficult patients who acted or spoke inappropriately in ways that express racist or other prejudicial biases? Since many of these instances happen in the ED or ICU, when anxiety is at its highest, what has been done to defuse and rectify the situation?

2. How can entire hospitals and long-term care facilities, much less large health systems, enact policies and procedures that carry out real diversity and inclusion? What has to become actionable? What needs to happen to make it a system-wide priority rather than a department with the right name?

3. How would you rate your organization's approach to diversity and inclusion? Does your ministry have a process in place to provide training and reflection opportunities for all associates whether in new associate orientation, formation experiences or other leadership development opportunities? Are the values of diversity and inclusion clearly articulated in your recruitment, retention and promotion practices? What work still needs to be done?

4. This article mentions the difficult role chaplains have in responding to racist situations or leading difficult conversations. What mechanism does your system have in place so that difficult conversations have all the right people at the table, from intake receptionist to board member? Do you have any suggestions for your ministry's approach to this subject?

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