Can Provider Bias Impact Patient Treatment Outcomes: A Qualitative Analysis

Tracey Davis Moore

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CAN PROVIDER BIAS IMPACT PATIENT TREATMENT OUTCOMES: A QUALITATIVE ANALYSIS

by

Tracey Davis Moore


The University of Memphis August 2023
Dedication

This dissertation is a tribute to my wonderful family and how you have helped me succeed academically and in life. I owe my success to your unending faith in me, and for that, I am eternally grateful. From the beginning of my education, my Mommy and Daddy fostered an atmosphere in which my natural curiosity and knowledge were valued. Your selflessness in prioritizing my brother, sister, and my education and providing the resources necessary for our intellectual growth has paved the way for this accomplishment. You are more than just my parents; you are my heroes and role models.

To my exceptional husband, your unwavering patience and understanding during the challenging moments of this endeavor have been my guiding light. Your constant encouragement, kind words, and faith in me have inspired me to surpass my expectations. Even when I doubted myself, your untiring strength gave me the courage to endure. You are my best friend, boyfriend, lover, husband, and the only man I ever wanted to be, my “Baby Daddy!”

My heart is full of gratitude for my super smart, intelligent, brilliant, grounded, handsome, and ever-talented son. I dedicate this dissertation to you and our family. You have a work ethic and drive to deliver one hundred percent, every time and at every turn, that should be bottled and given to those who need a JDM in their lives. Being your mother continues to be the best job I have ever had, and I thank you for being such an incredible young man. We are so proud of the man you are blossoming into and cannot wait to see how you will continue to improve this world we all share.

The study participants’ candid interviews made this dissertation possible. Their time, experiences, and honest, unbiased views have tremendously strengthened our research, revealing vital insights for clinicians and patients. I appreciate their contributions to this vital study.
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Abstract

Research has shown that social determinants of health, healthcare disparities, and historical trauma have contributed to inferior health outcomes for minority groups in the United States compared to their White counterparts. This qualitative research explored how healthcare providers perceive their own unconscious or implicit biases, which could potentially impact patient treatment outcomes. Bias was defined as a lack of objectivity combined with a preference for a particular person, group, or item. Data were collected using a multidisciplinary sample of healthcare treatment providers who participated in semistructured individual interviews with me. Twenty-six participants were interviewed with the same questions and in similar settings using narrative and critical race theories and CDA conceptual framework. Content analysis indicated emerging themes that affected the participants’ unconscious or implicit biases, including the environment in which participants were raised, a sense of commitment to community and educational achievement, and reverse bias. Research using self-assessments has consistently revealed that providers have an exaggeratedly positive appraisal of their personal self-awareness and response to bias. Participants in this study tended to underestimate their biases and overestimate their ability to treat patients free of prejudices. Health providers’ attitudes and perceptions in various healthcare settings have substantial implications for the experiences of patients who pursue preventative care vs. emergent care. Results suggest that training providers on culturally responsive patient care approach and increased community engagement will enable them to better understand implicit and explicit biases and thus more effectively meet their patients’ healthcare needs.

Keywords: bias, treatment, providers, healthcare, patients, psychiatry, values, prejudice in healthcare
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Can Provider Bias Impact Patient Treatment Outcomes?

Chapter I: Introduction

Inequalities at the systemic and structural levels in society are a significant source of bias in healthcare. These inequalities exist in sectors such as education, housing, and work, resulting in differences in health between populations. Implicit or unconscious bias also contributes to prejudice in healthcare. These forms of bias may be impacted by people’s exposure to societal norms and stereotypes, which can affect their ideas and preconceptions about particular groups of people and can exacerbate inequities in healthcare access, quality, and the usefulness of medical interventions.

Bias is defined by the Cambridge English Dictionary as the act of unfairly supporting or opposing a particular person or thing due to having allowed personal opinions to influence one’s judgment (Cambridge Dictionary, 2023). An unfair and unjustified distortion of judgment in favor of or against a person or thing is conveyed by the term bias. Healthcare provider bias occurs when the beliefs and actions of clinicians determine an ill-fated course of treatment for patients, albeit inadvertently. In addition, bias can arise when negative stereotypes become normalized in a practice or facility (Snowden, 2003). Due to implicit or explicit prejudices, healthcare provider bias occurs when the attitudes and behaviors of doctors influence an unfavorable course of treatment for patients, whether it is unintentional (Acosta & Skorton, 2021).

Practitioners and treatment institutions, such as hospitals, rehabilitation centers, and nursing homes, are further susceptible to prejudice in healthcare. A lack of cultural competency and comprehension of the varied requirements of patients can result in misunderstanding and substandard care. Additionally, healthcare providers may carry conscious prejudices against
specific communities, leading to discriminatory behaviors and poor health results. These conscious prejudices are evident in recent legislation passed by several states limiting or eliminating medical access and treatment specifically against women and transgender individuals (Kindy, 2023). For example, since 2015, the state of Tennessee has enacted 13 laws that restrict or eliminate the rights of LGBTQ citizens (Human Rights Staff, 2023a, 2023b; Kindy, 2023). Therefore, increasing awareness of these challenges and developing solutions that promote fairness and inclusion in healthcare systems to combat societal prejudice is vital. Kindy (2023) noted,

This week alone [April 7, 2023], Kansas lawmakers overrode the Democratic governor’s veto to ban transgender women and girls from sports teams; North Dakota Republicans approved a package of eight bills that would severely restrict transgender residents and ban drag shows, and Idaho’s governor signed a ban on gender-affirming health care for transgender youth.

It is essential to be aware that discrimination is not limited to racial classifications. Partiality can occur regarding gender, socioeconomic status (classism), educational prejudice, religious affiliation, sexual orientation, and a throng of other -isms in American culture (Farr, 2020). The possibilities are vast. However, little is known of the extent providers are aware of their own biases and how such biases impact the care they provide to patients. Provider bias can also contribute to healthcare disparities. Provider bias can arise from a range of factors, including cultural stereotypes, prior experiences, and a lack of cultural competence (Cohen & Jones, 2019). Are patients or providers aware of a provider’s bias, and how does that affect treatment outcomes and success? This research used qualitative interviews to assess the biases of treatment providers
who work in a state psychiatric inpatient hospital and other community healthcare settings in Memphis, Tennessee.

**Healthcare Disparity**

Paramount to the experience of provider bias is the overall public health crisis of healthcare disparities. Healthcare disparities are gaps in access to medical facilities and services, as well as disease and disability rates, across groups of individuals depending on socioeconomic criteria such as age, race, income, or gender and where they live (Agency for Healthcare Research and Quality., 2022). Additionally, fundamental to the disparity issues in healthcare are the consequences of historical trauma specific to minority racial groups (Gone et al., 2019). Similarly, historical trauma has been described as intergenerational trauma inflicted on individuals with a common identity or allegiance, including their psychological and sociocultural responses to the traumatic event (Subica & Link, 2022).

Fullilove (1999), a social psychiatrist, asserted that the 1949 U.S. Urban Renewal Act, which took away the land of many thriving Black communities, made existing health disparities worse by causing long-term stress, grief, and trauma-related symptoms in displaced residents. In addition, residents of Black communities affected by this act were displaced to regions of concentrated poverty with limited access to available resources, demanding they use their remaining life savings funds to resettle and start over at a deficit. Consequently, future generations were placed in an economic dilemma and started life at a disadvantage (Subica & Link, 2022).

Betancourt and Maina (2004) suggested that the challenges of addressing healthcare disparity are multifaceted and multidimensional. They noted that research has demonstrated that social determinants of health, such as lower educational levels, socioeconomic status, unsafe and
inadequate housing, racism, and living in the vicinity of environmental hazards, all unreasonably affect minority communities’ health outcomes. In addition, they noted that three out of five of the nation’s major landfills are housed in Black and Latino areas, which is further evidence of disparity.

**Hospital Closures**

These factors contribute to the increasing inequalities in healthcare delivery and outcomes for minorities in urban areas and socioeconomically challenged nonminority rural areas. Further compounding the disparity challenges is the growing decrease in hospital bed availability due to hospital closures. According to a North Carolina Rural Health Research Program, Copper Basin is one of 83 rural hospitals closed from 2010 to 2017. With eight medical centers closing since 2012 and another half dozen having severe financial difficulties, Tennessee is only second to Texas in terms of the number of rural hospital closures (Livingston, 2018).

Kilaru and Mahoney (2020) argued that a shared responsibility exists in society and communities when a hospital closes. They suggested that in this shared responsibility for the aftermath of closures, a historical bias that is correlated with social determinants of health must be investigated and develop a plan of preventative care (Kilaru and Mahoney, 2020). Furthermore, Kilaru and Mahoney pointed to the need to be proactive, rather than reactive, in evaluating those factors that may identify which facilities are at risk for closing in high-risk neighborhoods and then “do something about it.” In affected communities, addressing the social determinants of health is a longer-term prophylactic strategy. Among a variety of health-related social needs, hospitals are not solutions for housing and food insecurity, violence and injury prevention, prejudice and residential segregation, or education and health literacy. However,
hospitals and the healthcare apparatus can advocate for and assist in organizing services that address these fundamental issues (Kilaru & Mahoney, 2020, p. 707).

Although this study does not purport to be the “something” that would change the course of healthcare bias, it provides a unique perspective on patient care delivery from those charged with delivering said care. It is an opportunity to analyze the role of the healthcare professional at the leading edge of patient care in either increasing healthcare disparities due to personal bias or establishing a platform that could ultimately transform how care is delivered and what community hospitals become targeted for strategic closures.

**Mental Health Disparity**

To understand the mental health experience, it is necessary to review the history of the decline in psychiatric beds. Acute psychiatric hospitalization length of stay has decreased since community-based care’s inception in 1963 (Erickson, 2021). On October 31, 1963, President John F. Kennedy signed the Community Mental Health Act, which ignited the deinstitutionalization movement. It allowed for the development of community-based mental health care, enabling patients in psychiatric hospitals to be reintegrated into the community. Evidentiary data indicated that mental ailments could be treated better and more economically in community settings rather than in conventional psychiatric facilities (Substance Abuse and Mental Health Services Administration, 2021).

Viewed in the context of deinstitutionalization, the laws enacted by the federal government enacted and reinforced by the judicial system encouraged states to limit institutional care (Lutterman et al., 2017). Further, Lutterman et al. (2017) noted that in the 1960s, the Medicaid Institutions for Mental Disease developed policies and procedures restricting the use of Mental Health Block Grants from covering the cost of inpatient care in any setting, which
encouraged the use of community-based care over inpatient stays for Medicaid patients (Erickson, 2021). The factors mentioned above continue to influence the delivery and financing of care for mental health, which has contributed considerably to healthcare disparities. For example, Lutterman et al. noted that inpatient and other 24-hour residential treatment settings for adults aged 22 to 64 are not eligible for federal Medicaid matching payments, nor are facilities with more than 16 beds where more than half of the patients have a mental illness (p. 12).

A 2015 evaluation of state mental health agencies found that 35 of the 46 states evaluated—or 76% —had a significant shortage of psychiatric hospital beds (Lutterman et al., 2017). Whereas 17 states reported a lack of short-term beds in state mental institutions, 20 reported inadequate crisis beds in private psychiatric and general hospitals. Shockingly, three of the largest mental health centers in the United States are jails: Los Angeles County (California), Cook County (Chicago, Illinois), and New York City’s Rikers Island jail (Das, 2020).

**Jails and Prisons: The Nation’s Largest Providers of Mental Health Services**

It would appear that a decline in bed availability or community-based hospital closures has more profoundly impacted the mental health population than physical health. Patients experiencing a mental health emergency are more likely to be incarcerated than those experiencing a physical health emergency (Das, 2020; Lamb & Weinberger, 1998; Lutterman et al., 2017; Roth, 2020). As a result of the criminalization of mental health symptoms, as manifested by police and community response to concerning behaviors, people with these symptoms now become inmates or receive felony charges and become ensnared in the criminal justice system. Unfortunately, their mental illnesses remain untreated (Roth, 2020). The Los Angeles County Jail is one of the largest providers serving individuals with mental illness in the forensic system. Roth (2020) noted that Los Angeles County jail may have as many as 16,000
inmates on any given day and has been known to be as high as 20,000. It is conservatively estimated that as many as 31% of the inmate population is mentally ill at any given time. And because some mental illness symptoms may be perceived as insolence or violence, many inmates are placed in solitary confinement for 23 hours daily (Das, 2020; Lamb & Weinberger, 1998).

**Psychiatric Inpatient Bed Reduction**

Ono et al. (2021) found that a reduction in in-house mental health (for medical–surgical hospitals) services was related to an increase in emergency room duration of stay, psychiatric hospital transfers, and a decline in discharges directly to their home. They found that extended preadmission and emergency department lengths of stay correlate with high levels of provider stress, an increased risk of complications, decreased patient satisfaction, and a higher likelihood of poor outcomes. In addition, they found that these results demonstrate the importance of community or hospital-based psychiatric support when treating suicidal patients in acute care hospitals.

However, psychiatric hospitals designed for short-term acute care have seen increased readmission rates over the past four decades. Machado et al. (2012) characterized readmission occurrences as a reinvented category of institutionalization. In 1955 state hospitals had 558,922 inpatient psychiatric beds. By 2014, including private psychiatric facilities, general hospitals, and Veterans hospitals, total beds were reduced to 101,351, a rate of 29.7 beds per 100,000 people (Pinals & Fuller, 2020). This reduction of more than 81% of psychiatric beds dramatically impacted hospitals’ size and the communities tasked with caring for the mentally ill. However, psychiatric bed reduction has not led to an increase in community-based intervention services. Lutterman et al. (2017) noted that since 1970 there had been a 63% decrease in the number of patients receiving psychiatric or residential (subacute) care, and most of this decrease was due to
state and county psychiatric hospital closures, reducing patient census by 89% and 86% in Veterans Affairs medical centers.

As a result of the decline of inpatient beds and the absence of community-based treatment following deinstitutionalization, disparities in overall healthcare and nurtured population-specific biased care have expanded (Konstanzer, 2017; Lutterman et al., 2017). Population growth in the United States since 1970 has resulted in a more significant loss in psychiatric bed capacity as a proportion of patients per 100,000 people (Lutterman et al., 2017). This bed loss was more significant than the decline in the total number of patients. From 1970 to 2014, the number of patients in psychiatric beds fell from 236.8 per 100,000 to 53.8 per 100,000. This more than 76% decrease culminated in an average yearly capacity loss of 3.3% (Lutterman et al., 2017). The objective of community-based treatment is twofold: decreasing expenses and greatly enhancing the individual’s quality of life (Grob, 1994; Mechanic, 1989). Therefore, on both objectives, there was a crucial interest in minimizing the quantity and length of mental and physical health hospitalizations (Song et al., 1998).

The closures of hospitals and decreased number of available beds call for a closer examination of the bias involved in deciding which hospitals would be closed and where they were located (Ramesh & Tsai, 2022). Indeed, the closure of psychiatric hospitals impacts a vulnerable population during the period of rapid deinstitutionalization purported to benefit patients (Erickson, 2021). Individuals with serious mental illness also have higher rates of infectious diseases, noninsulin-dependent diabetes, respiratory disease, and certain forms of cancer than the general population (Dixon et al., 1999). The intersection of mental and physical illness is evident in the increased physical health needs of the mentally ill that require clinical intervention that often go unrecognized and untreated (De Hert et al., 2011).
The connection between social determinants of health and healthcare disparities should not be underestimated in the context of mental health services, accessibility, and available resources (Hacker et al., 2022). Though the intent of bed reduction may have been to provide more community-based care without the mental health centers and providers to support such a transition, the risk of patients not receiving adequate care has become more evident, particularly when seen in the context of inadequate social determinants of health (Lutterman et al., 2017). Social determinants of health underscore the importance of a comprehensive approach to healthcare service delivery and addressing bias. Reducing the number of available psychiatric beds should have been accompanied by adequate investment in community resources, which could involve a range of strategies, including increasing funding for community health programs, improving access to education and employment opportunities, and providing cultural competence training for healthcare providers (Marcelin et al., 2019).

**Social Determinants of Health**

Social determinants of health, including a range of factors can cause healthcare disparities. Healthy People 2030 (2020) defined *social determinants of health* as the environmental conditions under which individuals are born, live, and work that affect various health conditions and functions, as well as those overall quality of life. These determinants include factors such as socioeconomic status, education, employment, housing, and access to healthcare. Further, these environmental conditions place individuals at a greater risk of experiencing and dying from chronic yet treatable health issues, such as diabetes, heart disease, and high blood pressure (Centers for Disease Control and Prevention, 2022; Healthy People 2030, 2020).
Social determinants of health can contribute to healthcare disparities and provider bias in several ways. Individuals from low-income or marginalized communities may be less likely to have access to quality healthcare, which can contribute to healthcare disparities. Providers may have biases or hold stereotypes about specific patient populations, which can negatively impact the quality of care. Healthcare disparities are differences in health outcomes or access to healthcare between different population groups. To address healthcare disparities and provider bias, it is essential to address social determinants of health and promote equity in access to healthcare.

Social determinants of health such as poverty, education, and substandard housing can gravely impact a person’s health. Healthcare disparities are one of the most harmful connections to social determinants of health—inequalities in health outcomes or access to healthcare between different demographic groups. In addition to working with individuals and communities to enhance access to resources (such as employment opportunities) and services that support good health, social workers are taught to recognize and address these social determinants of health. Healthcare disparities may be exacerbated by lower levels of access to high-quality medical care that people from low-income or marginalized groups often have.

**Relevance of Healthcare Bias to Social Work Practice**

Social determinants of health, healthcare disparities, and provider bias are interconnected and important focus areas for social work. The relevance of social determinants of health to this study can be found in the National Association of Social Workers (2021b) Code of Ethics and the history of advocacy that guides the profession. Social workers are at the forefront of advocacy, intervention, service, and social justice. Since its establishment, this profession has been tasked with finding and using resources to mitigate the negative impact of social
determinants of health on individuals and their broader communities, social workers have proactively confronted healthcare inequality and the profession has been a forerunner in public health (Noel et al., 2022).

Provider bias can also contribute to healthcare disparities and negatively impact the quality of care provided to specific patient populations. Social workers can address provider bias by promoting cultural competency and diversity training for healthcare providers, advocating for policies that promote equity in healthcare, and working with healthcare organizations to encourage antibias policies and practices (Parker-Oliver & Demiris, 2006).

Overall, social work plays a critical role in addressing social determinants of health, healthcare disparities, and provider bias as it intersects with the profession’s commitment to social justice. For example, social workers may work with individuals experiencing homelessness to secure stable housing because inadequate housing can significantly impact a person’s health. Social workers work with individuals and communities to address such issues and promote equity in healthcare access and outcomes. By addressing these interconnected issues, social workers can help to improve the health and well-being of individuals, families, and communities (Parker-Oliver & Demiris, 2006; Sherman, 2016). In addition, social workers play key roles in advocating for policy changes that can address social determinants of health on a broader scale. Social workers may advocate for policies promoting affordable housing, increasing healthcare access, or improving educational opportunities (Agency for Healthcare Research and Quality, 2022).

Policymakers at the state and federal levels play a pivotal role in advancing programs that enable families, communities, and residents to participate fully in society and reach their full potential (Lombardi et al., 2021; Tropman et al., 2021). In its policy agenda, the National
Association of Social Workers (2021a) outlined the organization’s top legislative concerns, which included social determinants of health in the context of ensuring access to quality healthcare and addressing systemic economic inequities, all of which affect bias in healthcare.

Several ongoing endeavors are aimed at addressing healthcare disparities and promoting health equity and intersects with social work. Noteworthy among these are the Patient Protection and Affordable Care Act, Healthy People 2030, a comprehensive study conducted by the National Academies of Science, and the release of the *Integrated Social Care Report* by the National Academies of Sciences, Engineering, and Medicine. These initiatives have been accompanied by the identification of Social Work Grand Challenges (Johnstone, 2021; Lombardi et al., 2021; Noel et al., 2022; Obinna, 2021) as crucial areas for social workers to tackle.

Because social workers are advocates and social work is a key discipline in social services delivery caring for some of the most vulnerable members of society, it is crucial for social workers to contribute to the research on providers’ first-person accounting of healthcare bias, as this information may be beneficial in intervention and prevention activities for improved patient care (Johnstone, 2021; Lombardi et al., 2021; Robbins et al., 1999). Further, the social work profession is well suited to accommodate the wide range of expertise needed by interprofessional and interdisciplinary care teams, a necessity for comprehensive healthcare delivery that is vital for reducing health inequalities (Johnstone, 2021; Lombardi et al., 2021). Social workers are crucial to reducing inequalities by pushing for policies and programs that improve access to healthcare and other services. By advocating for these causes, they promote health equity and contribute to improving the health of individuals and communities.
Historical Trauma

Historical trauma results from historical oppression, cultural repression, colonialism of large populations, and the resulting accumulated injuries and injustices that continue throughout a person’s lifetime and through multiple generations (Lee & Johnstone, 2021). The impact of historical trauma on healthcare cannot be overstated or underestimated. The colonization and enslavement of the Americas and African indigenous people play a crucial role in ongoing disparities (Gone et al., 2019; Johnstone, 2021; Lee & Johnstone, 2021; Subica & Link, 2022).

A historical exploration of systemic social, racial, and economic challenges may shed further light on geographic regions and ethnicities most likely to be impacted by social determinants of health and medical biases. Understanding the consequences of hospital closures in communities requires identifying economic and social factors (e.g., rates of unemployment, high school graduation, poverty levels, crime rates, incidents of infectious disease rates) that impact such closures and biases implicit in the closures (Crouse et al., 2022). Hospital closures starting in the late 1990s have challenged minority and poor communities and widened the divide between healthcare disparities and healthcare bias (Malone et al., 2022; Subica & Link, 2022). Urban and rural areas have experienced some of the most dramatic decreases in community-based medical–surgery hospital resources (Livingston, 2018). In tandem with historical trauma, the areas most impacted by closures are more likely to be areas where individuals with histories of oppression and reduced access to resources live (Gone et al., 2019; Subica & Link, 2022).

Gone et al. (2019) pointed out that the impact of historical trauma varies among cultures, races, and indigenous people. Colonialism’s accumulated effects on indigenous communities in Canada and the United States have left them more vulnerable than their noncolonized counterparts and have contributed to low health outcomes over generations (Gone et al., 2019).
Clouston and Link (2021) reported that the enduring rise of health inequalities across periods in history indicates that the associations (the link between race, culture, education, and economic conditions) in question persist without regard to the types of diseases and their associated risk and protective factors vary from places and over historical times.

**Fundamental Cause Theory**

According to Clouston and Link (2021), fundamental cause theory was proposed to explain why socioeconomic status persists in being associated with mortality and morbidity in healthcare. Although the diseases affecting the population and the risk and protective factors affecting those diseases have changed significantly over time and across geographic locations, substantial disparities in health persist (Clouston & Link, 2021). According to the fundamental cause theory, health disparities persist as a result of underlying social forces that disadvantage some groups when it comes to accessing resources for maintaining good health and preventing disease (Subica & Link, 2022).

The link between fundamental cause theory and provider bias lies in the unequal distribution of resources and opportunities associated with socioeconomic status. Individuals with lower socioeconomic status often face structural barriers that limit their access to quality healthcare, including biases in the healthcare system. Provider bias may arise from implicit biases, stereotyping, or systemic factors in healthcare settings, all of which exist in areas of accepted social norms. Furthermore, fundamental cause theory suggests provider bias can perpetuate existing health inequalities and contribute to poorer health outcomes for marginalized groups. It can also lead to mistrust and dissatisfaction with the healthcare system, further limiting access to care and exacerbating disparities.
Associations between socioeconomic status and disease continue because risk and protective variables connecting socioeconomic status to health in one context have been replaced by systemic processes regardless of location and time, which continue to impact these poor health outcomes associated with historical racism and trauma (Clouston & Link, 2021, p. 132). A strength of fundamental cause theory is its capacity to determine if numerous avoidable illnesses are susceptible to various pathways contributing to health inequity and outcomes for different groups (Clouston & Link, 2021). As new illnesses emerge and new risk and protective variables become recognized, fundamental cause theory predicts that a fundamental cause will manifest, which has been demonstrated by the COVID-19 pandemic, which affected those most vulnerable to health disparities and social determinants of health (Clouston & Link, 2021).

Understanding the relationship between fundamental cause theory and provider bias could shed light on the complex interplay between social determinants of health and healthcare delivery. Efforts to address health disparities should not only focus on improving access to healthcare but also involve interventions that target the underlying social and economic factors that perpetuate inequities. Additionally, healthcare systems need to implement strategies to reduce provider bias through training, awareness, and systemic changes to ensure equitable care for all patients, regardless of socioeconomic status.

**African Americans Distrust of the Medical Establishment**

Paramount to historical trauma and the perpetuation of mistrust of the medical establishment is a history of medically abusive experiments on enslaved Africans and their descendants in the United States (Gamble, 1997; Jones & Reverby, 2022; Ojanuga, 1993). James Marion Sims, one of the most famous surgeons of the 19th century and exclaimed as the “father of modern gynecology,” was a prolific abuser of medical ethics who experimented on enslaved
women the without the benefit of anesthesia or similar measures to mitigate pain (Ojanuga, 1993; Wall, 2006). Although the horrors of medical experimentation on African Americans have long been understood and discussed, including experiments within living memory (e.g., Tuskegee Syphilis Study, 1932–1972; Centers for Disease Control and Prevention, 2021), Sims’ experiments on African slave women continue to be defended (Petros et al., 2018; Wall, 2020).

Although technology has become an effective tool in addressing some of the access challenges to medical care for disadvantaged communities, healthcare disparities still exist, the roots of which can be found in a historical bias. Twenty hospitals have closed in New York City over the past quarter century, resulting in a loss of approximately 5,800 beds (Kaufman, 2022). Twelve of these hospitals were in neighborhoods where the majority of residents were people of color and with a high prevalence of poverty. Six districts in the city, including four with a majority black and brown residents, have no hospitals whatsoever (Kaufman, 2022).

Though many factors have contributed to the perpetuation of healthcare biases, the history of enslaved people is just one portion of the complexities of social strata and economic distress (Gamble, 1997). The mistrust of the medical establishment lingers because of ongoing fears borne out of a disproportionate number of African Americans, Latinas, and the poor continuing to be affected by mortality and the morbidity of treatable illnesses that persist (Jones & Reverby, 2022). Moreover, as recently as 2020, the Centers for Disease Control and Prevention reported that at the height of the COVID-19 pandemic, members of racial and ethnic minority groups were excessively represented among COVID-19-associated deaths (Gold et al., 2020). Race, ethnicity, family of origin, and socioeconomic factors remain critical to the delivery of healthcare for those most affected by health inequality and biased care from the medical establishment (Crossley, 2003; Jones & Reverby, 2022; Rouse, 1996).
The complexity of addressing healthcare inequalities in the context of social determinants of health lies in the conflict between the monetary value placed on healthcare interventions and the social value placed on those who are most adversely affected, such as African Americans (Crossley, 2003; Ojanuga, 1993; Subica & Link, 2022). Addressing such challenges in urban and rural communities demands assessing those who care for vulnerable patients. It demands a voice and a platform for these providers to be heard and challenge their own notions of unbiased care delivery. Studies on disparities have primarily focused on affected communities, affected populations, and affected diagnoses (Betancourt, 2006). The voice of the provider, those vital to the health care delivery system, appears to be missing from the discourse as an agent of change. The path to reducing and eliminating racial and ethnic disparities in healthcare requires attention to the intersection of race, class, education, and geographic location.

COVID-19

The COVID-19 pandemic has provided countries the world over with the critical and extraordinary challenge of examining their abilities to respond to a medical crisis (World Health Organization, 2021b). COVID-19 has challenged countries to evaluate their medical infrastructure and the intersectionality of public health concerns more keenly with private citizens’ personal health (World Health Organization, 2021b). This pandemic has also brought to light the many failings of medical healthcare infrastructure, the vulnerability of certain populations to medical insecurity, and the resulting healthcare disparities (Obinna, 2021; World Health Organization, 2021a).

Though this study did not concern COVID-19, lessons from the ongoing pandemic have provided indispensable information on the consequences of disparities and bias to individuals, families, communities, and nations (Obinna, 2021; World Health Organization, 2021a). For
example, the World Health Organization has provided weekly epidemiological updates since the declaration of the pandemic. Their data indicate that poorer countries in the Americas and Asia experienced the most extensive reports of new cases and deaths in April 2021 (World Health Organization, 2021a). The most recent information from the World Health Organization (2023) indicated as of February 19, 2023, the Americas and Southeast Asia continue to report the highest numbers of new COVID cases and deaths. Given an already fragile infrastructure, it appears that countries that have experienced historical poverty and colonization, and accompanying historical trauma, have been more impacted by the COVID-19 virus.

The population of Africa exceeds one billion and the continent has a “fragile” public healthcare system, but African countries have reported fewer COVID-19-related deaths compared to their European and North American colonizers. Soy (2020) suggested five key elements that contributed to the lower COVID-19 numbers in Africa. One, quick action was taken by the governments of Africa. Two, there was public support for implementing safety measures. Three, Africa has one of the youngest world populations, with a median age of just 19, and most who tested positive for the virus were asymptomatic. Africa also has few nursing homes for older and more vulnerable health-compromised adults. Four, the higher temperatures and climate were less favorable to the virus, and five, with a history of dealing with infectious disease outbreaks, such as Ebola and Malaria, the continent has a sound community health system (Soy, 2020).

The lessons learned from the pandemic include that hospitals and the communities they serve must take the steps needed to better deal with emergencies, such as implementing a hospital incident command system (Seyedin et al., 2022). Having enough staff and space to handle a sudden increase in patients, protecting and managing hospital staff, caring for and
treating patients, coordinating with people inside and outside the hospital, keeping the
environment healthy, educating people, and preventing infections (Obinna, 2021; Seyedin et al.,
2022).

To combat COVID-19 and any other potential public health epidemic, hospitals must
examine the effects of said condition on all hospital departments, patients, employees, larger
communities, and providers of care (Seyedin et al., 2022). As the challenges of providing
healthcare to those most medically vulnerable continue, healthcare bias must be a part of the
discourse and preventative actions (Obinna, 2021). This proposed study aims to shed additional
insight into the division created by bias and seeks to discover and build common ground in
developing interventions for healthcare inequalities.
Chapter 2: Literature Review

The question of bias among treatment providers is not new. The literature on this topic is extensive. However, research has focused primarily on racial discrimination and has not used a qualitative approach aimed explicitly at providers. This literature review includes an evaluation of articles on healthcare disparity and social determinants of health, as these areas are pivotal to the question of provider bias.

Racial Inequities

Racial inequity in health care has long been a topic of discussion. For example, an Associated Press (1966) story in the Oshkosh Daily Northwestern reported that hospitals and healthcare providers were not following the Civil Rights Act of 1965, and civil rights leaders at that time called for legal action, such as lawsuits to force doctors and hospitals to comply with the Act. At the annual Medical Committee for Human Rights convention in 1966, Dr. Martin Luther King Jr. stated, “Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death” (Associated Press,1966). Proctor and Rosen’s (1981) research on clients’ racial preference for treatment providers and Merluzzi et al.’s (1977) assessment of the effects of counselors’ race in treating those not of the same race shows how these inequities operate at the microlevel. As consumers demand more diversity in their respective disciplines, treatment providers have generated more focus on cultural and linguistic competence in the treatment process (Jani et al., 2016).

Social Media

Shocking displays of prejudicial behaviors have been posted on social media of relative strangers using racially derogatory names and physically accosting them. A White physician, Dr. Jeanne E. Moore, an anesthesiologist practicing in New York City, was identified in a series of
viral videos harassing and accosting people of Black and Asian ancestry (Samson, 2021). Kevin Dong, who helped identify and intervened when Jeanne Moore was harassing two Black skateboarders, stated, “I can’t imagine trusting my life to an anesthesiologist with this much ignorance and hatred” (Samson, 2021, para. 6). Although the behaviors displayed by this person evidenced on social media, may represent an extreme example of a provider’s biases, it is imperative to note that Dr. Jeanne E. Moore was a practicing provider, with hospital privileges until she was “outed” and arrested (Manthan, 2021).

**Access to Providers and Treatment Adherence**

Other prejudices regarding factors such as social status, body weight and shape, class, and access to resources present challenging barriers to individuals who must seek treatment from public facilities and are often masked in implicit bias (Alspach, 2018), particularly because disadvantaged patients do not have the privilege to change providers at will. It is, therefore, imperative that those tasked with providing treatment to the most vulnerable populations do so in an impartial and culturally competent manner (Alspach, 2018). Consequently, it appears that the most prudent way to gauge or evaluate a provider’s cultural and linguistic competence level would be to simply ask them, which is what this proposed study has done. Cultural competence is vitally important for patients to trust their providers and to develop the rapport that is needed to garner open dialogue about treatment compliance.

The impact of the expression of bias on treatment adherence, follow-up, and sustainment cannot be underestimated. The Princeton Survey Research Association indicated that one in five African Americans preferred having a member of their race provide healthcare because of their experiences with healthcare bias (Farr, 2020). Although the availability of a provider of the same race, ethnicity, or culture may be more challenging for minority patients, educating providers to
be more culturally aware is crucial. In fact, the inclusion of cultural and linguistic competence must become part of the educational requirements to become a provider, which may improve the lack of diversity in that area.

**Improving Provider Training**

Racial disproportionality is notable in healthcare fields. Indeed, Black medical doctors made up only about 5% of providers (Association of American Medical Colleges, 2019), and Black dieticians only about 3% (Farr, 2020). According to the most recent U.S. Census, the Black population constituted 12.4% of the U.S. population (Jones et al., 2021).

Bias in healthcare is among a range of factors affecting social determinants of health and poor outcomes for racial and ethnic minorities (Eliacin et al., 2020). However, outcomes can be improved by increasing the diversity in medical schools and preparing medical providers (Virdee et al., 2021). The role of medical schools in improving cultural competency and producing providers more reflective of the larger society cannot be underestimated. The literature in this area noted a stark lack of diversity in medical schools producing new doctors and a lack of discussion of diversity issues in textbooks (Amutah et al., 2021; Virdee et al., 2021).

Gagliardi et al. (2022) suggested that the visibility of antidiscrimination messaging with the daily realities of clinical service is a veiled, if not subconscious, course that threatens to erode the enthusiasm of developing providers while spreading long-standing health inequities. This hidden curriculum poses a serious threat to closing health disparities if it is not addressed. On the way to rectifying medical injustice in an operationally partial system, it is crucial to prioritize thoughtful graduate medical education that focuses on the structural determinants of health. Such education should involve raising awareness of organizational injustices in our healthcare systems and supporting student-led community engagement and performance improvement efforts as
crucial types of engagement (Gagliardi et al., 2022). Not only are schools in need of greater diversity, but the very curriculum that is being taught also needs to be more inclusive and varied to include sociocultural influences (Association of American Medical Colleges, 2019; Gagliardi et al., 2022).

Implicit Bias

The literature presents a less-than-optimistic view of the depth of healthcare disparity, particularly around mental health. Much of the literature also presents international research on disparities impacting racial and religious minorities in treatment settings. For example, in their study on implicit racial bias, Gran-Ruaz et al. (2022) discussed how COVID-19 vividly brought to the forefront challenges with mental health care for people of color in the United States and Canada. Their look at the consequences of implicit bias on mental health provided a stark picture of the barriers created by embedded, historical traumas and generational internal attitudes.

Using the Black–White Implicit Association Test and the Modern Racism Scale, participants in a study were assessed for their bias scores, indicating an explicit bias toward Black individuals and a preference toward White individuals (Gran-Ruaz et al., 2022). The study indicated that as the scores on the Black–White Implicit Association Test increased, suggesting a preference for White people over Black people, the Modern Racism Scale scores also increased, indicative of a stronger explicit prejudice toward Black people. This important study reflected how implicit bias weeds its way into an individual’s consciousness and can affect how individuals interact with, respond to, or stay away from each other and influence the perception of treatment providers (Gran-Ruaz et al., 2022).
Project Implicit

Racial discrimination in healthcare appears to be the predominant type of bias covered by the literature. However, research into other areas of bias contributing to healthcare disparities is also gaining momentum in the literature. As noted above, increasing diversity in training and text is just one way to start making improvements. Another avenue for improving care delivery may be Project Implicit, which started as a research collaboration between three universities and is now a nonprofit entity focused on organizational and institutional disparities. Between 1998 and 2006 Project Implicit website compiled the results for over 4.5 million implicit association tests (Green et al., 2007; Greenwald et al., 1998).

The computer-based Implicit Association Test was administered to 393 medical residents from four medical schools. The results were concerning. First, implicit provider bias was pervasive, including a profound finding of pro-White percipience among physicians (Green et al., 2007). Second, treating physicians are subject to the influence of racial socialization, so even those with good intentions can be unaware of their biases (Green et al., 2007). Third, implicit bias based on racial preferences and stereotypes contributes to healthcare disparities and impacts physicians’ clinical decisions.

Finally, unconscious bias needs to be brought into the consciousness of providers. Developing sociocultural and linguistic training through objective measures, such as the Implicit Association Test, may effectively increase awareness and locate areas of bias where changes are most needed (Green et al., 2007). Although this suggestion by Green et al. (2007) is essential for future research considerations, there remains a lack of direct provider input in this literature review.
Individual Perception of Bias and Self-blame

Though the use of the Implicit Association Test may increase provider awareness, what happens when a patient perceives biased treatment? Eliacin et al. (2020) found that patients’ perception of racial bias is associated with poor healthcare and providers’ response to patients’ needs, including lower levels of treatment follow-up. This type of discrimination leads to decreased preventative medical and mental health care, poor adherence to treatment recommendations, and inferior treatment outcomes, resulting in increased mortality among minorities for preventive healthcare conditions. Eliacin et al. recommended improving provider and patient relations, including suggesting that patients would feel more welcome in settings that provided inclusive art, diversity in staffing, and body language awareness of providers.

Snowden (2003) noted that even when socioeconomic status and region were controlled for, access to treatment for minorities continues to be limited. Although disparities in healthcare persist in terms of access and quality of care, the extent to which such differences result from bias is unknown. Snowden suggested that more information is needed on bias levels, other than individual practitioners, to include practice networks and community-based treatment facilities.

Paramount to the discussion on bias is how such discrimination in healthcare affects treatment outcomes for those who self-blame. Feasel et al. (2022) examined the dire consequences of self-blame in predicting poor health outcomes for minority individuals. In this study, first-year undergraduate students at the University of California-Santa Barbara were asked to participate in a research study on first-generation college students, students who identified as Latinx, and students whose household incomes were considered low (below $50,000 annually). This longitudinal study used biometric indicators and self-reporting to determine the health
effects of health risks and self-blame. Feasel et al. concluded that discrimination attribution acutely predicted greater physical health risks to participants 1 year into the study.

**Challenging Concepts of Bias**

The review of the literature would be incomplete without noting the importance of the work Essed, which remains very relevant today in the areas of racial oppression, social determinants of health, and health disparities. What was particularly different about this research was the narrative, which was taken from those who were oppressed and those who experienced racism and other social disparities. Indeed, because Essed incorporated critical discourse and narrative theories using the language and lived experiences of those who were in the study, theirs was the language and the perspective that defined disparities (Collins & Essed, 1992). The term *everyday racism* is often credited to Essed (1991) because she gave a voice to the voiceless and unveiled the unseen as she developed her theory on everyday racism.

What is particularly fundamental to bias is that self-blaming is internalized by those with lived experiences who dare to voice objections to poor treatment or limited access. Essed (1991) validated the reality of self-blame as well as the individual’s perception of bias. She defined containment strategies, which arise in response to the many stereotypes about people of color, to silence their voices. For example, when marginalized people voice opposition or even simply point to an action that is clearly defined by race (e.g., the murder of George Floyd; Eberhardt, 2019; Hill et al., 2020), people who hold majority identities typically fail to address or acknowledge prejudices or refuse to speak out against prejudices when they observe them, thus giving implicit acceptance and permitting these experiences to continue (Gillborn, 2015; Merluzzi et al., 1977). Though Essed shed much light on the issue of oppression and laid the
foundation for further research on everyday racism and the relevance of theoretical perspective in understanding existing isms, it did not speak directly to providers’ experiences with bias.

Mental illnesses are more socially stigmatized than physical health conditions. This stigma generates larger disparities when considerations for race, class, and gender are added (Gabella, 2021; Snowden, 2003). According to the Centers for Disease Control and Prevention (2022), one in five American adults has a diagnosable mental illness. According to the National Institutes of Health, 21% to 26% of Americans have been diagnosed with a mental illness, over 52 million individuals. Mental health treatment has also been unfairly handled by insurance providers. A specific case example of insurance bias towards covering care for mental health and substance abuse treatment is when patients who require substance abuse and mental health treatment are denied this benefit as not being medically necessary. Yet, the insurance company covered the extensive physical health care needed when the patient overdosed on heroin and spent three weeks in the hospital’s intensive care unit before her death. Had the insurance company deemed mental health as essential and as medically necessary as physical health, the patient may have received the treatment needed to prevent her death (Gabella, 2021).

However, the current study intends to add to the literature an in-depth assessment of individual providers’ self-assessments using an interview format. An assessment of personal bias viewed through the lens of the providers rather than me or identified patients. I hypothesized that study participants would become more aware of their biases and become more vigilant in mitigating bias to improve treatment interactions and outcomes.

**Conceptual and Theoretical Framework**

This study’s conceptual framework is narrative in nature (Butina, 2015), informed by narrative and critical race theories and Foucauldian critical discourse analysis (CDA) theory. The
importance of the narrative applied in this qualitative study cannot be overstated, as narrative inquiry is not simply the telling of a story but is how the story is used as data to be analyzed (Patton, 2015).

**The Relationship Between Three Theories**

Narrative theory, critical race theory (CRT), and CDA (CDA) are three approaches that are used in this study to understand power relations and social inequality in society (Foucauldian Discourse Analysis,” 2022; Fraga, 2021; Hardy et al., 2009). Although there are some differences between these theoretical approaches, they also share some fundamental principles. One way in which these three approaches are connected is through the analysis of narratives around race and racism. Narrative theory can be used to understand how individuals construct their experiences and identities through storytelling (Hardy et al., 2009). Furthermore, these narratives are shaped by dominant discourses around race and racism. Likewise, CRT can be used to understand how the broader social institutions contribute to racial inequality and to contextualize these personal narratives in a broader social and historical context (Eberhardt, 2019; Gillborn, 2015). CDA might be used to explore the ways in which language is used to construct and reinforce prejudiced beliefs and practices and to challenge these dominant discourses using counter-narratives (Bischoping & Gazso, 2021).

CRT is an approach that emerged in the field of law and focuses on how race and racism shape social structures and institutions (Caldwell & Crenshaw, 1996). CRT emphasizes the importance of understanding the social construction of race and the ways in which it intersects with other forms of oppression, such as class, gender, and sexuality. Foucauldian CDA emerged in the field of linguistics and focuses on how language and discourse are used to construct social reality and maintain power relations (Bischoping & Gazso, 2021). CDA emphasizes the
importance of analyzing the ways in which language is used to produce and reproduce social
ingquality and the need to challenge dominant structures to promote social change.

Examining racial and biased discussions in society provides a common ground for
connecting narrative theory, CRT, and CDA. Narrative theory serves as a compelling lens to
explore the stories that influence individual lives and cultural traditions (Burrell-Craft, 2020).
CRT offers insights into the larger societal and institutional frameworks that contribute to racial
disparities. CDA allows for an examination of how language is employed to construct and
reinforce discriminatory beliefs and practices. By analyzing narrative structures and meanings,
researchers can gain a deeper understanding of how narratives shape our perception of
prejudices, our position in society, and the underlying motivations behind biased ideologies and
behaviors.

**Narrative Theory**

Narrative theory holds that one must tell stories about one’s life in order to make sense of
the ambiguity of their individual experiences. It is an interdisciplinary approach to studying the
role of storytelling in human experience, communication, and culture. Rather than reflecting on
one’s life, these stories shape them (Butina, 2015; Hardy et al., 2009). Our fresh experiences are
filtered in or out, depending on whether they are aligned with the prevailing life narrative that
we’ve developed. Numerous issues in our daily lives are the result of narratives about our past
that limit our ability to act in the present in a way that achieves our goals for the future (Simpson,
2020; Walsh, 2014). Achieving an understanding of how narrative structures and forms shape
our understanding of the world and ourselves is how this study will add to the existing literature.
It uses the analysis of the narratives of providers tasked with confronting their prejudices (Hardy
et al., 2009).
Narrative theory emphasizes the importance of storytelling in constructing and connecting meaning (Hardy et al., 2009). The narratives provide a way of making sense of experiences, and it shapes people’s understanding of themselves and others, which is reflected in the providers’ interviews. These histories allow us to imagine and explore different possibilities and perspectives and to create shared cultural meanings and values, even in power inequities. Narrative theory allows for the study of the structures and conventions of different types of accounts, such as plot, character, point of view, and setting, as well as the social and cultural contexts in which histories are produced and consumed (Athanneh et al., 2020; Butina, 2015; Hardy et al., 2009). The narrative also examines the ways histories are used to create and reinforce social identities and relationships and how they can be used to challenge dominant cultural norms and values (Athanneh et al., 2020; Butina, 2015).

Through the process of analyzing the structures and meanings of narratives, this study sought to gain insight into the ways in which narratives shape providers’ understanding of the world and their place in it. The patient and provider roles have very different juxtapositions in the social hierarchy. Consequently, the narratives and the lived experiences of these roles are relayed differently (Project Narrative, 2022).

**Critical Race Theory**

CRT can provide a broader theoretical framework for understanding how these narratives and discourses around race and racism are shaped by social structures and institutions and how they intersect with other forms of oppression. CRT is derived from critical theory and the modern legal world. Critical theory’s inception, however, dates to 1930s Marxism. Karl Marx (1818–1883) argued that the capitalist system enslaved and exploited the working poor, benefiting the plutocrats, who owned the businesses and profited from the laborers’ efforts
(Bronner, 2017). Additionally, Marx posited that the disparity in wealth and individual freedoms harmed humans, whom he believed were creative and autonomous beings capable of meaningful social transformation (Bronner, 2017). Such disparities grow and create other social unrest. Moreover, Marx’s writings combined philosophy with economics, arguing that capitalism deprives society of its ability to control its destiny (Campbell, 2020). Thus, these Marxist critical theoretical conceptualizations are the origins of CRT.

Critical theory is rooted in an individual’s understanding of their history (the narrative) and the premise that problems should also have solutions. Unfortunately, the rich history from which CRT was founded is often lost in politicking (Burrell-Craft, 2020; Kelly, 2023; Rouse, 1996). The foundations of inequity that this theory challenges are then undermined and dismissed by CRT’s detractors. However, it is important to note that social inequities remain and is at the root of healthcare disparity (Petros et al., 2018; Proctor & Rosen, 1981; Rouse, 1996). Consequently, those who have attempted to discredit and disparage CRT typically have little knowledge of its history and its benefit to policy formation and social change. Thus, the use of CRT is a relevant theoretical perspective for the examination of provider bias in concert with narrative theory.

Critical theory emerged from criticisms in the postmodern era of conformity, all the while struggling against distorting individuality or distinctions among the masses. Further, the ideology of critical theory was to challenge the economic and class hierarchy of the wealthy and those in power. Critical theory remains the foundation for uncovering repressive situations, establishing paths of opposition, and developing revolutionary concepts to challenge the establishment that seeks to maintain its stranglehold on power and oppression (Bronner, 2017). The very idea of the
resistance of the disenfranchised to mistreatment from those in power is certainly not a new ideology (Versieren, 2016).

**Critical Discourse Analysis Theory**

CDA arose from the work of French philosopher and social theorist Michel Foucault in the 1960s and 1970s (Hanrahan, 2012; Khan & MacEachen, 2021). Foucault’s work on discourse was also influenced by structuralist linguistics, which highlighted the significance of language’s relationship to social reality. Discourse is not just a technique for communicating ideas, but also of constructing and maintaining power relations (Khan & MacEachen, 2021). Research on the history of institutions such as prisons, hospitals, and schools highlighted the significance of language and communication in forming social reality. Institutions are not neutral locations of social control but are instead molded by discourses and power relations. CDA maintains that discourse is not just a means of information transmission but a deliberate instrument for establishing and perpetuating social hierarchies and power relationships (Hanrahan, 2012; Partner, 2016).

CDA is comparable to the impact of critical theory on CRT and the social construction of hierarchical social interactions (Hanrahan, 2012). CDA is concerned with understanding how language is used to construct and preserve sociocultural power structures and how language is used to create and strengthen social identities and connections (Arribas-Ayllon & Walkerdine, 2017). It requires studying both the content and structure of language (as is done in the analysis of the interviews for this study). Additionally, the environment in which language is used is relevant in comprehending how meaning is formed and communicated (Partner, 2016). The inherent hierarchy of the doctor–patient relationship is inseparable from the implicit bias of who holds power and influence in that interaction.
CDA is currently a practical method for evaluating how language and discourse are used to form reality in society and maintain power dynamics. CDA is used to examine a wide variety of writings, including qualitative research data, political speeches, news stories, social media posts, and advertising, to comprehend better how language is used to construct and sustain social injustice. Foucault’s work on discourse has had an impact on numerous fields, including social work, linguistics, sociology, anthropology, and cultural studies, including critical and narrative theories (Khan & MacEachen, 2021).

**The Intersectionality of Narrative Theory, CRT, and CDA**

The use of conceptual narrative storytelling and confrontation is unique to this study on bias with providers and allows for an acute examination of the socialization that has contributed to biases as the foundation of CRT. There is a profound intersectionality between narrative theory, CRT, and CDA and the evolution of biased behaviors in the United States culture (Rouse, 1996). The power of generations of a racially structured society has left its mark on healthcare disparity, social determinants of health, and those charged as providers of care (Green et al., 2007). Critical theory is a social theory that analyzes how sociocultural and socioeconomic status in societies can determine prosperity or pauperism, which contributes to the five domains of the social determinants of health, economic stability, educational access, and quality, healthcare access and quality, neighborhood and built environment and social and community context (US Department of Health and Human Services, 2020). See Appendix A for the five domains of social determinants of health.

Without the stories bringing to life their experiences, the connection needed to interrupt the cycle of biased patient care may be misconstrued as a lack of interest on the part of providers or seen as not needed in healthcare. Further, an educated populace is better for a nation’s
economy, future income levels, and innovations derived from human capital (Szabo, 2020). It is, therefore, prudent for treatment providers to be educated about their role not simply as doctors, nurses, or dentists but as change agents in the improvement of healthcare delivery. It is equally critical for the engagement of critical discourse in the realm of power structures and biased care.

In this study, narrative theory, CRT, and CDA provided a historical lens to examine provider bias. CRT and narrative inquiry work well together as biases tend to be established early in life. The untelling of stories that created and nurtured the biases that providers carry with them may help recognize and weed out latent prejudices. Critical theory remains the foundation for uncovering repressive situations, establishing paths of opposition, and developing revolutionary concepts to challenge the establishments that seek to maintain their stranglehold on power and oppression, as illustrated in the challenges associated with healthcare disparities (Bronner, 2017).

The United States’ current political and social climate has caused there to be harsh attacks on education and educators (Dworicin, 2022). These attacks present crucial implications for censoring, banning books and curricula, and sanctioning educators and school administrators, similar to the Salem Witch trials between 1692 and 1693 (Reed, 2016). Further, the distracting attacks on CRT reduce the critical thinking abilities of Americans while limiting access to educational opportunities (Evans, 2011). This context is critically important to the issue of bias and the issue of who receives lifesaving care and access to medicines.

CDA is an interdisciplinary approach to the study of language and communication that seeks to comprehend how language is used to create meaning and influence social reality (“Foucauldian Discourse Analysis,” 2022; Partner, 2016). The relevance of this theory in social–cultural communications, beliefs, and political ideologies is fundamental to bias issues. When a
society and a community cannot agree on what is factual information, a lack of trust develops, which has the potential to become so infected that the only treatment may be amputation. The question then becomes, are we prepared to cut off parts of our society because we are incapable of having civil discourse? And if the answer is yes, what then will remain of a just (unbiased) and civilized society? Indeed, CDA forces this earnest examination of understanding the ways in which language and communication shape our social reality. The underlying meanings and power-structured relationships entrenched in our variable forms of communication can then be uncovered, as this study attempted to do in the provider interviews.

Narrative theory, CRT, and CDA are three interdisciplinary approaches that share a common interest in understanding the ways in which power relations are embedded in language, discourse (dialogue), and storytelling (Caldwell & Crenshaw, 1996). Although these approaches have distinct theoretical and methodological frameworks, they intersect in a number of ways and can be used together to provide a more nuanced understanding of social inequality and power relations (Merluzzi et al., 1977).

At their core, narrative theory, CRT, and CDA are all useful for exposing the ways language is used to construct and maintain social hierarchies and control (Amutah et al., 2021). Narrative theory emphasizes the role of storytelling in shaping social identities and our cultural values and seeks to reveal the ways in which narratives are used to construct and reinforce social customs and principles. CRT emphasizes the role of race in shaping social inequality and seeks to expose the ways in which racial power dynamics, specifically, are rooted in legal and institutional practices (Obinna, 2021). CDA emphasizes the role of discourse in shaping social reality and works to lay bare the ways in which power is maintained (Korobov, 2020).
Healthcare is at the forefront of society’s social divide in the United States (Seyedin et al., 2022; White House, 2022). This divide can only be closed through open, honest dialogue, which makes the current study uniquely relevant. It was intended to be a dialogue along the lines of narrative theory. Narrative theory brings forward the multivariate circumstances that are part of human development, shaping our cognition, belief systems, and how we learn (Project Narrative, 2022). How we learn and who taught us are also at the center of bias and discriminatory attitudes and beliefs (Christian et al., 2019). Narrative theory sprang from the belief that humans are predisposed to storytelling and telling the stories of our cultural histories and our families will shed light on the development of latent biases (Athanneh et al., 2020). Narratives have been progressively seen as more beneficial in cognitive therapy, shaping behavioral changes and challenging biased thinking (Walsh, 2014). CDA is useful for analyzing the ways language is used to produce and reproduce social inequality and challenge dominant discourses to promote social change. These three theories represent the foundation of this study.

Language, stories, and social hierarchies in the three theories may support diverse individuals understanding of each other. For example, narrative theory can be used to analyze the stories told about race in a particular cultural context and how they shape our understanding of race and racial hierarchies (Burrell-Craft, 2020). CDA can be used to analyze the language and discourse that is used in legal and institutional contexts to construct and maintain racial and economic power relations (Arribas-Ayllon & Walkerdine, 2017; Bronner, 2017; Lee & Johnstone, 2021;). CRT can provide a critical lens through which to analyze the intersection of race, oppression, and power. CRT emerged out of the legal profession and critical theory and can be used to challenge dominant cultural norms and improve social justice interventions. CRT can provide a broader theoretical framework for understanding how these narratives and discourses
around race and racism are shaped by social structures and institutions and how they intersect with other forms of oppression (Christian et al., 2019; Fraga, 2021; Gillborn, 2015; Kelly, 2023). When used together, these theoretical approaches can provide a more comprehensive understanding of the ways in which language, discourse, and storytelling shape social reality (Arribas-Ayllon & Walkerdine, 2017; Partner, 2016; Versieren, 2016).
Chapter 3: Methodology

Qualitative Research

Using qualitative research shows how the individuality in variations of human behavior inhabits its natural position in examining providers’ behaviors, much like in what manner a caterpillar naturally metamorphoses into a butterfly (Kasinath, 2016). It is a known yet unexpected and wonderous process, where there are constant adaptations in behaviors, and the history and cultures behind those actions can be evaluated (Kasinath, 2016). Patton (2015) noted that qualitative inquiry attempts to understand better the providers and environments in which they were raised, live, and work. Thus, a researcher does not attempt to manipulate or control the variables motivating study participants but rather seeks to understand and identify data that may encourage behavioral changes regarding implicit and explicit bias communicated during patient care (Patton, 2015).

Complex, relative context, perspective, exploration, observation, and inductive and deductive reasoning are just some of the central terms connected with qualitative research approaches (Kasinath, 2016). Utilizing an inductive method (often referred to as a bottom-up approach), qualitative inquiry aims to make sense of events without making assumptions about the statements or conditions under study. (Kasinath, 2016). Deductive reasoning is more commonly associated with quantitative research, although it may also be used in qualitative studies by moving from broad to narrow observations, sometimes known as a “top-down” method (Fossey et al., 2002).

This study was a qualitative inquiry, using a semistructured interview guide in one-on-one interviews with medical providers. The providers were all licensed, independent
practitioners trained as medical doctors, nurse practitioners, and doctors of dentistry. Further, all providers practiced in the Memphis metropolitan area in the state of Tennessee.

Institutional Review Board Process

Consistent with and following the University of Memphis Institutional Review Board (IRB) Policies, I sought and obtained IRB approval for this study. The IRB number is PRO-FY2022-450 and was created on May 2, 2022. The process for approval required outlining the purpose of this study, including goals, references, and literature reviews. The methods and procedures explain how the confidentiality of the subjects was maintained and how the integrity and validity of the data have been preserved.

All participants were informed of the consent forms and signed them before the start of the interviews. The consent forms were kept in a locked file cabinet, behind a locked office door, inside a secured office suite, and inside a secured building. In addition, all participants were assigned random codes with no identifiers attached to the codes. Further, the codes were secured on a password-protected computer network, behind a VPN wall, and in password-protected files on a secured drive. To ensure the privacy of the participants, all interviews were conducted in a private office or conference room, with the door closed, in a private office suite. I requested participants’ consent for audio or video recordings of the interviews. Any participant who did not wish to be recorded was not recorded. Once the interviews were transcribed and validated by the committee chair, they were destroyed.

Interview Guide

Developing an appropriate and credible interview guide requires a profound understanding of the issue being investigated. Indeed, Roberts (2020) shared that qualitative interviewing is not simply getting a recorder and asking questions. In fact, it requires experience,
supervisory oversight, forethought, and thorough preparation, lest a researcher risk obtaining prejudicial findings based on their own beliefs. There are ethical pitfalls to consider if the rules of engagement when developing qualitative research questions are violated (Roberts, 2020); (Edwards & Holland, 2020). Summers (2020) provided a counter-narrative to the ethical concerns surrounding qualitative interviews. Although anonymity and confidentiality protect study participants, the group they belong to may be harmed by the study’s findings, necessitating ethical consideration for the group as a whole (e.g., research on LGBTQ people’s experiences; Summers, 2020, p. 594).

The current study aimed to add a first-hand perspective to the existing biased data by having providers tell their stories through their voices. To ensure the trustworthiness of the data collected, interview questions had to be open-ended, unguided, and aligned with the overall methodology, objective, and rationale of this study on biases (Roberts, 2020, p. 3188). Consequently, I designed the interview guide grounded in narrative theory and employed open-ended questions in common everyday language to elicit participants’ stories. The interview guide includes 11 open questions for the providers to answer.

The interview questions were developed from a combination of resources previously mentioned; however, Roberts (2020) provided specific suggestions and protocols to elicit the most objective data while minimizing researcher bias. To that end, I followed Roberts’ interview protocol framework. In addition, to mitigate participants’ anxiety (if any), the first three questions were general and straightforward, and the next four were more probing. The final four focused on treatment outcomes considering any recognition of biased beliefs manifested in practice. Consequently, I designed the interview guide grounded in narrative theory and
employed open-ended questions in common everyday language to elicit participants’ stories. The interview guide has 11 open questions for the providers to answer and consider.

The tool used for the study was a semistructured interview guide to provide consistency in the data being gathered and a similar setting to minimize the influence of environmental distractions. The instrument used was the interview guide provided in Appendix B. The open-ended questions were designed to solicit as much information as possible from interviewees. The interview guide was developed by me using several qualitative research interview tools (see Guest et al., 2006; King et al., 2019; Martin & Grudziecki, 2006; Roberts, 2020).

**Researcher Description**

In the interest of transparency, I believed the social classification of race compared to the ethnic identification of the provider interviewees was relevant to the question of provider bias. This provider’s ethnic and racial self-identification was particularly vivid when viewed in the context of CRT and discourse analysis. I am of African Caribbean descent and was born in another country, not unlike some of the study’s participants. My siblings and I were brought to the United States by our parents, who emigrated from Jamaica. The concept and culture of racial bias was a new and often painful experience for us. However, having lived in the US now for over four decades, I have adapted to and learned from the American culture. To that end, I was cognizant of my experiences and open with advisors, supervisors, and colleagues about racial challenges that may have skewed my judgment in the analysis or process of interviewing the participants. Consequently, I took available precautions to preserve the integrity of the study.

**Study Participants**

A purposeful (also known as purposive and selective) sampling strategy was used for this study. Patton (2015) emphasized that the strategic and specific nature of purposeful sampling in
qualitative research is to identify and select knowledgeable participants for the most effective use of limited resources. This type of sampling emphasizes the strategic and specific nature of data gathering. Participants were chosen because they possessed the requisite expertise to provide the most accurate, in-depth detailed data on the experiences being examined, in this case, provider bias (Statistics Solutions, 2017).

Participation in this study involved approximately 30–45 minutes of the participants’ time to complete the interview. I contacted participants via email, text, or voice phone calls. I informed all the participants that the interview would be recorded before it was scheduled and obtained consent before the interview started. The flyer was attached to the email describing the research purpose and the importance of the study see Appendix C. I requested about 15–20 minutes more time for any clarification needed within 30 days of the initial interview. There were no follow-up interviews needed for clarification following the completed transcriptions of the recordings.

The dates and times were scheduled with the participants to be convenient for them. Participants were given the option to choose the interview location. I had access to a secure, confidential conference room, or we used the participants’ location, provided it was private and secure. Further, participants could choose to be interviewed using a secure virtual format such as Zoom. However, I preferred and requested in-person interviews.

Recruitment

The challenges of identifying and weeding out biases in healthcare profoundly involve providers who can identify their own biases and use that awareness as a catalyst for change (Alspach, 2018). Moreover, by using a purposeful sample for the current study, the sample size
was smaller. Although not generalizable to the larger population of treatment providers, the data generated may provide insight for future investigations (Hagaman & Wutich, 2016).

Several techniques were used to recruit providers for this study. The sample was both purposive and a sample of convenience. I recruited providers were recruited face to face by asking them to participate at the end of meetings where I was also in attendance (Roulston, 2018). I also asked the providers interviewed to refer me to one of their colleagues, and this strategy was the least effective in obtaining additional participants. Moreover, one of the participants sent an email to their colleagues containing my contact information for recruiting volunteers. Last, I recruited the treating doctors at a local psychiatric hospital to participate.

All participants were asked to volunteer their time and received no compensation for their involvement in the study (Roulston, 2018). To control for credibility and validity, it is essential to note that although the sampling was also one of convenience, I had only professional knowledge of and experiences with the providers and had no personal relationships with the providers outside of professional interactions.

**Data Collection**

No special equipment was needed to perform the interviews. As this was a qualitative study, the data came from the content of the interview. The data were collected using field notes and audio and/or video recordings of the interviews. The interviews were recorded and transcribed using Otter.ai. The video recordings were done via HIPPA Zoom video conferencing platform for virtual interviews. Written consent was obtained when the providers were asked to participate in the study and signed before the start of the interview.

At the time of the interview, participants were provided written consent forms and asked to read and sign the consent before the start of the interview. Twenty-six interviews were
completed over a 9-month period. The nine months provided opportunities to clarify data given by the subjects that did not translate intelligibly when transcribed and to control credibility. Data were initially coded using a codebook developed by me.

I used ATLAS.ti to code and present data obtained from all the interviews. Additionally, the artificial intelligence features of ATLAS.ti software transcribed the interviews. Otter.ai has a two-factor authentication sign-on process and was further secured using encrypted subfolders of each interview. The interviews were all audio recorded, and some were video recorded when done virtually. Each interview was transcribed using Otter.ai and reviewed by me to ensure the validity and credibility of the information being transcribed. Field notes were captured via computer notetaking, observing body language, including any perceived discomfort with particular questions and participants’ reactions or awareness of their environment. The primary mode of thematic content analysis was enhanced using ATLAS.ti and Otter.ai software.

Data Analysis

In data analysis, CDA takes “power” into account and can promote inaudible speakers as legitimate claimants (Khan & MacEachen, 2021). According to Khan and MacEachen (2021), qualitative research is descriptive, exploratory, and grounded in people’s lived experiences. Thus, irrespective of the analytical strategy chosen by a researcher to assess the data, the analysis of qualitative data is also informed by the researcher’s subjective experiences and shaped by his or her own perceptions, class, gender, race, ethnicity, and other identifiers. Although objectivity is ideal in research, qualitative inquiry is strengthened by the very nature of the researcher (Khan & MacEachen, 2021).

The interview data were analyzed using thematic content analysis based on narrative, critical race, and CDA theories and using an inductive analytic strategy. Qualitative data
produces a vast amount of information. Therefore, it was crucial for a researcher to employ an analysis process to materialize meaning to make sense of all the information obtained. Patton (2015) explained the purpose of content analysis as a process of evaluating large amounts of qualitative information (e.g., interviews) and reducing the data while identifying key refrains and intimations. Performing such content and themed focused analysis involved specific steps and the use of qualitative data analysis software called ATLAS.ti (Friese, 2019).

The data had to be organized and prepared for review and clarification. Because the interviews were recorded, I replayed the interviews to listen to and document those patterns that were repetitive in the content of the recordings. Atlas.ti was used to review and code all interviews and to create a codebook with merged and grouped concept codes.

The coding of the data was twofold. First, codes were assigned to anonymize the participants and their work locations. Participants were later given Greek pseudonyms to further protect their privacy. However, codes for providers’ gender, race, and age were not utilized because of their relevance to the study. The second coding was to find the words and themes that could be analyzed. The themes were converted to groupings or categories that captured the breadth and depth of the information gathered. Butina (2015) shared that the collection of thematic content should be associated with those noteworthy findings of the research. Once the data had been collected, sorted, and cataloged, it was possible to share an understanding of the findings. Table 1 outlines the steps taken to start the analysis of the interview data obtained, culminating into the ten themed categories.

**Methodological Integrity**

Qualitative research interviews involve direct engagement with research participants, and it is important to ensure ethical concerns are considered throughout the research process. It is
essential to ensure that participants are treated with courtesy and that their privacy and confidentiality are protected. Also, it is vital to the study’s integrity to ensure the validity and credibility of the data, which for this study consists of the interview content. As mentioned above, informed consent was obtained and required for human subject studies. Furthermore, maintaining participants’ confidentiality and anonymity required additional safeguards, locked cabinets, and passwords. As with provider–patient relationships, there may be power dynamics between a researcher and subjects that must be at the forefront of the researcher’s considerations, so participants are not coerced into cooperation (Ojanuga, 1993; Simpson, 2020; Summers, 2020).

Integral to the integrity of the research is researcher bias, including opening the possibilities for independent interpretations of the meaning of the participants’ words, which may lend itself to subjectivity. The researcher in qualitative inquiry is the instrument of data collection and can impact how such data is delivered by participants (Patton, 2015). Considering the avenues open to interpretation is one of the reasons for recording the interviews. As a Black woman of African Caribbean descent, I was aware that my very presence could change the way participants answer questions on bias, experiences with bias, and disclosures of any stereotypes they may have projected on patients.

To mitigate researcher bias, I took several steps. According to Patton (2015), reflexivity reminds the qualitative inquirer to be aware of and attentive to the cultural, political, social, linguistic, and ideological origins of one’s own perspective and voice, as well as those with whom one interviews and reports, a process known as reflexive triangulation. Being reflexive allows a researcher to be self-aware and conscious of how their own socio-political-cultural
perspective may impact the study at hand (Patton, 2015). This awareness is then discussed with advisors and acknowledged by the researcher to mitigate the risk of preconceptions.

I attempted to mitigate self-bias using a structured interview guide, ensuring the interviews were done in similar environmental settings, using a purposive sample to obtain as much diversity as possible among providers. The use of two data analysis software programs (Otter.ai & Atlas.ti) was a mitigation strategy for the risk of making interpretations based on my preconceived ideas and beliefs.

The challenge of data trustworthiness in qualitative research is the result of the researcher serving as the collection instrument. Consequently, the rigor with which a researcher conducts interviews, transcribes the interview content and analyzes the data requires the researcher’s skill, competence, integrity, knowledge, and experience (Butina, 2015). Therefore, to ensure the validity and credibility of the data, the interviews were reviewed by the chair of the dissertation committee to obtain an objective assessment of the content. Further, I hired an independent transcriber to review the deidentified transcripts and compare them to the audio recordings or (blurred imaged) video. Moreover, the data were appropriately scrubbed and coded for analysis using the Atlas.ti software.

To further safeguard credibility (internal validity), interview transcripts and preliminary analysis were shared with a sample of participants to ensure I accurately captured participants’ responses during the interviews. Additionally, I provided access to my dissertation committee chair to review the coding of the data. I utilized the expertise of colleagues versed in qualitative research to audit the findings and check the analysis for researcher bias (Butina, 2015).

Finally, as noted above, I have confronted delicate prejudicial challenges, as provider bias brought my own personal prejudices to the study. As this could taint the data and challenge
the trustworthiness of the data analysis, I shared my biases, discussed these challenges with other researchers, colleagues, and cohorts, and engaged the dissertation committee chair to assist in maintaining objectivity.
Chapter 4: Findings

Study Purpose

The primary objective of this study was to explore the extent to which healthcare providers are aware of their internal or subconscious bias that may be expressed toward patients based on race, ethnicity, class, education, and other sociocultural factors. Using a qualitative research design, providers were interviewed to examine the prevalence of biased behaviors and attitudes among these participating providers.

Study Participants

Twenty-six healthcare providers participated in this study. Demographics and professional affiliations of the participants are presented in Tables 1–3 and Figures 1 and 2. The average age was 42. Black women formed the highest demographic group, with 31% or eight participants. The disciplines of participants were psychiatrists, nine; nurse practitioners, 7. Five participants were born outside the US: Sudan, Ghana, Nigeria, Pakistan, and Venezuela. One participant shared she was of Egyptian descent (born in Egypt to Egyptian parents, lived there till age 7, then raised in the USA). However, when asked about race, she reported, “White.” Therefore, she was not included in the list of providers from other countries. Nevertheless, I deemed it important to maintain the integrity of the study by acknowledging that the social categorization of race, in comparison to the ethnic identification of the provider, held relevance when considering the issue of provider bias. This provider’s ethnicity, Egyptian, and racial self-identification as White is particularly vivid when viewed in the context of CRT and discourse analysis.
Table 1

Demographics of Participants Percent Distribution by Race

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>46.15%</td>
</tr>
<tr>
<td>Black</td>
<td>26.92%</td>
</tr>
<tr>
<td>Black</td>
<td>7.69%</td>
</tr>
<tr>
<td>Middle Eastern Pakistani</td>
<td>3.85%</td>
</tr>
<tr>
<td>African</td>
<td>3.85%</td>
</tr>
<tr>
<td>African Sudan</td>
<td>3.85%</td>
</tr>
<tr>
<td>African Ghanaian</td>
<td>3.85%</td>
</tr>
<tr>
<td>Latina Venezuelan</td>
<td>3.85%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Figure 1.

Percentage Distribution of Race
Table 2

*Demographic Participants’ Gender, Race, Specialty*

<table>
<thead>
<tr>
<th>Gender &amp; race</th>
<th>Specialty</th>
<th>% count of gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black female</td>
<td>DDS–Doctor dental surgery</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>DDM–dentist</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Family nurse practitioner</td>
<td>7.69%</td>
</tr>
<tr>
<td></td>
<td>FNP—Regional ONE</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Nurse practitioner</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Psych NP</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>30.77%</td>
</tr>
<tr>
<td>White female</td>
<td>Emergency medicine</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>NP hospitalist</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>OBGYN</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>11.54%</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>26.92%</td>
</tr>
<tr>
<td>White male</td>
<td>Hospitalist internal medicine</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>7.69%</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>15.38%</td>
</tr>
<tr>
<td>Black male</td>
<td>Hospitalist internal medicine</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>7.69%</td>
</tr>
<tr>
<td></td>
<td><strong>Ethnicities represented by one provider</strong></td>
<td></td>
</tr>
<tr>
<td>African male– Sudanese</td>
<td>MD pulmonologist</td>
<td>3.85%</td>
</tr>
<tr>
<td>African female– Ghanaian</td>
<td>Nurse practitioner—Trauma &amp; weight loss</td>
<td>3.85%</td>
</tr>
<tr>
<td>Middle Eastern female– Pakistani</td>
<td>Internal medicine</td>
<td>3.85%</td>
</tr>
<tr>
<td>Hispanic female– Venezuelan</td>
<td>OBGYN</td>
<td>3.85%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

*Note. N=26*
Table 3

*Distribution of Participants’ Age Range*

<table>
<thead>
<tr>
<th>Age range</th>
<th>Count of providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>30–39</td>
<td>11</td>
</tr>
<tr>
<td>40–49</td>
<td>7</td>
</tr>
<tr>
<td>60–69</td>
<td>3</td>
</tr>
<tr>
<td>50–59</td>
<td>3</td>
</tr>
<tr>
<td>20–29</td>
<td>2</td>
</tr>
<tr>
<td>Grand Total</td>
<td>26</td>
</tr>
</tbody>
</table>

*Note. N=26*

*Age Range 30–39 Frequency*

![Age Range 30-39 Frequency](image)

*Figure 2*
Development of Themes Using Conceptual Combinations

The development of qualitative themes and conceptual combinations for provider bias involves a systematic approach to understanding and uncovering the various factors that contribute to bias in healthcare settings. This process allowed me to identify patterns and relationships that can help inform interventions and strategies for mitigating bias. Once the interviews were completed, the transcripts became the data that was collected. I engaged in a process of data analysis that involved systematically reviewing and coding the data to identify recurring patterns and themes. Interview transcripts were uploaded into the qualitative software Atlas.ti and were read through to establish the initial coding pattern for the data. The insights gained through this process were put back into Atlas.ti and the program continued the coding patterns from which the themes were then developed.

The average number of grouped concepts in each theme was 13, with diversity, inclusion, and professional development having the highest number of concepts (see Appendix D). Furthermore, the results also indicate the degree of groundedness observed in the main themes. Higher grounded scores indicate how many times the codes have been applied in a given theme, as shown in (Friese, 2019). The number data is in Appendix E.

Relationship Between Themes and Providers’ Responses

There appeared to be a strong relationship between the codes for career and professional development, and bias acceptance, experience, personal experience, and bias. The participants in this study were all professionals with graduate degrees. They shared similar narratives in career objectives and communicated using similar critical discourse due to their chosen professions. There is also a profound connection between how the codes have merged to not only develop these themes but find the transactional relationships between the themes, codes, and providers.
Similarities among participants then shift in a review of the diversity, inclusion, interpersonal relationships, and geography theme. It also has a high grounded score but differs in which participants scored higher in this code. It is interesting to note that 31% (eight of 26) participants who had the most codes in the theme of “Bias acceptance, experience, personal experience, and bias” were all women, with half of them White and the other half Black and Latina. However, the overall rating for the sum of this theme was higher for White participants as a whole (see Figure 3). An analysis of the theme of career and professional development, provider’s background, and patient care indicate a similar trend as with the previous high-scoring theme (eight women, 31% of 26 participants).

This trend appears to be consistent with the challenges that the female providers reported with their personal experiences with bias and its impact on their careers. In addition to racial power differentials, CDA suggests that there are gender power inequities between male and female clinicians in communication and patient impression of providers (Khan & MacEachen, 2021). In the top two themes—bias and career and professional development—women, regardless of race, scored higher on both the grounded and thematic measures. Ajax, a female medical doctor discussing the treatment of the nurse practitioner colleagues by a male medical doctor, noted, “And then on the flip some of that, like some of my colleagues have gotten into like verbal altercations with the nurse with NPS (nurse practitioner services) being like, I’m the doctor, You’re the nurse practitioner, you do what I say.”

Although age bias did not emerge as a prominent theme, it is important to note that a handful of participants shared negative experiences with patients based on their being younger in age. For example, Ajax shared her experiences with age bias: “I’m like, you know, I’m flattered that people think I look that young. But it’s also like, I don’t mean to be insulting, but it is kind
of insulting at the same time because you’re, like, kind of questioning my credentials.” These findings capture the implications of shared experiences and how the language used to communicate can enhance or diminish the message. It is important to pay attention to the provider’s voice and experiences. This shows the wide range of biases that can be passed from one person to the next (Ashcraft & Allen, 2003).

Unexpected were findings that White and Black participants accounted for 46% of interviewees, whereas the Middle Eastern and Latina providers were 3.85% each. However, in the themes of self-awareness, personal values, and negative emotions and experiences, the White participants accounted for most codes. The same results were noted for the sum of negative emotions and experiences. The White participants’ number of codes was twice that of Blacks. It is unclear why White participants scored so high in these themes compared to the other participants; however, it is an area to consider for future research.

**Emerging Themes and Theoretical Frameworks**

Study participants presented as animated, engaged, trustworthy, and attentive. They discussed patients who exhibited bias toward them and those who triggered their own feelings of prejudice. All provider participants denied any racial or gender biases toward the patients. The providers did share prejudices with particular patient types, such as substance abuse, personality disorders, and even patients who were on public insurance, such as Medicaid.
**Table 4**  
*Percentage of Total Groundedness by the 10 Thematic Codes*

<table>
<thead>
<tr>
<th>Thematic codes</th>
<th>Sum of groundedness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career and professional development, provider’s background, patient care</td>
<td>25.07%</td>
</tr>
<tr>
<td>Bias acceptance, provider professional and personal experience with bias</td>
<td>20.69%</td>
</tr>
<tr>
<td>Diversity inclusion, relational communications/interpersonal relationships,</td>
<td>13.39%</td>
</tr>
<tr>
<td>geography</td>
<td></td>
</tr>
<tr>
<td>Sociocultural, psychological distress, self-preservation</td>
<td>11.09%</td>
</tr>
<tr>
<td>Community awareness, cultural factors, and institutional structures</td>
<td>6.40%</td>
</tr>
<tr>
<td>Personal development, walking in others’ shoes, reciprocal influence</td>
<td>5.87%</td>
</tr>
<tr>
<td>Self-reflection on psychosocial factors and racial discrimination</td>
<td>5.39%</td>
</tr>
<tr>
<td>Open-mindedness, drivers of behaviors</td>
<td>4.64%</td>
</tr>
<tr>
<td>Negative emotions and experiences</td>
<td>4.43%</td>
</tr>
<tr>
<td>Self-awareness, personal values, bias, and inequality</td>
<td>3.04%</td>
</tr>
<tr>
<td>Total</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

*Note.* The higher the grounded score, the more time the codes are used in the themes.
Figure 3

**Percentage of Groundedness by Thematic Codes**

Table 5

**Percentage of Total Groundedness by the 10 Thematic Categories**

<table>
<thead>
<tr>
<th>Thematic categories (codes)</th>
<th>Sum of groundedness</th>
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</thead>
<tbody>
<tr>
<td>Career and professional development, provider’s background, patient care</td>
<td>470</td>
</tr>
<tr>
<td>Bias acceptance, provider professional and personal experience with bias</td>
<td>388</td>
</tr>
<tr>
<td>Diversity inclusion, relational communications/interpersonal relationships, geography</td>
<td>251</td>
</tr>
<tr>
<td>Sociocultural, psychological distress, self-preservation</td>
<td>208</td>
</tr>
<tr>
<td>Community awareness, cultural factors, and institutional structures</td>
<td>120</td>
</tr>
<tr>
<td>Personal development, walking in others’ shoes, reciprocal influence</td>
<td>110</td>
</tr>
<tr>
<td>Psychosocial &amp; psychological factors, racial discrimination, and reflection</td>
<td>101</td>
</tr>
<tr>
<td>Open-mindedness, drivers of behaviors</td>
<td>87</td>
</tr>
<tr>
<td>Negative emotions and experiences</td>
<td>83</td>
</tr>
<tr>
<td>Self-awareness, personal values, bias, and inequality</td>
<td>57</td>
</tr>
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<td>Grand Total</td>
<td>1875</td>
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</tbody>
</table>
1. Career and Professional Development, Provider’s Background, Patient Care

In healthcare, the theme of career and professional development, provider background, and patient care intersects with the critical issue of provider bias and the tenants of CRT. This theme concerns how by engaging in career and professional development opportunities, healthcare professionals can broaden their perspectives, challenge their biases, and better understand the diverse patient populations they serve. Furthermore, the background of healthcare providers, including their subjective experiences, upbringing, cultural context, and socialization, can influence the development of biases, be it conscious, unconscious, explicit, or implicit. The participants presented themselves as interested in professional growth and, indeed, as committed to the patients in the settings in which they worked.

Those participants from distinct cultural backgrounds shared the challenges of immigrating to the US. Arsen, an internist, was born and raised in the Middle East and migrated to the US as an adult: “That was the main difficulty because, you know, coming to another country. Just leaving your family, leaving everything, and coming and then adapting to a new culture and then succeeding in your career.” Arsen also shared that although she has had a lengthy career in the US, she continues to encounter patients who are biased against her because she is of a different background and refuses to engage with her: “Sometimes I do [experience prejudice from patients]. And there are some patients in my 15 years of career here in US have said that we don’t want to talk to your foreign doctor, I’m not talking to you.”

Intersectionality is a recognition that people can be treated unfairly in more than one way. Stereotypes about gender roles, racial traits, and abilities that change with age can lead to unfair treatment and biased decisions. For example, Arsen shared more about her culture: “Teachers and medicine are the two main professions that women were allowed to do. My aunt, my mom’s
older sister, who raised me, actually was a teacher. And my mom was a doctor.” She talked about how she wanted to work in the arts but could not because it was not considered appropriate for women in her culture. She also discussed the difficulties she encountered due to racial and ethnic bias after moving to the United States of America. “Sometimes patients are very rude. I, I mean, excuse my language, but they do interact with you in a very offending way. And at that time, and it’s, I think, just in the beginning, it really bothered me very much. And I don’t think it’s because of my nationality.” It is an interesting reaction to bias when the person experiencing the offensive behavior is not bothered by it and reports they do not “blame” the individual for being offensive.

Participant Arsen further shared that despite these negative experiences, she has enjoyed her career and is “thankful to God” for being here. She also shared that in her culture, becoming a doctor was one of just a handful of careers women were allowed to have: “For boys, you’re just fine, do whatever you want to do. But for females, either it’s medicine or just sit at home. And over there [Pakistan], like bank jobs. And companies’ jobs other than the hospital environment is not very right for females.”

Consistent with the findings on career and professional development theme, provider Andreas shared that although she enjoyed her varied learning experiences in Bolivia:

In Venezuela, it’s very hard to get into med school because they don’t have private schools, they just have one, a school per state. So I actually I decided like, well, let’s go and try nursing school and I loved it. I went to nursing school for a couple semesters. I loved it. I did three, three semesters there. And um, that just reinforced [for] me that I really want to be a doctor. So then I had the opportunity to move to Bolivia, where my
parents were born, so I went to Bolivia, and I did my med school there. With these various rotations, six years of med school.

Andreas stated she was excited by the opportunities that the USA provided and completed her last year of medical school in the United States. She stated, “And it blows my mind how, like, the resources and the opportunities they were offering, like, if you want to do, like, [do a] rotation there and observership [you get to do it].” Andreas’ excitement, however, was tempered by having to be accepted into medical school in the US and redo the requisite classes she had already taken in her home country of Venezuela and Bolivia. She shared, “I have to study all over again. It was like I studied medicine twice.” She further shared that even with having to redo medical school, she was excited by the opportunities that allowed her to specialize in gynecology and obstetrics.

Regarding why she chose her career, Aphrodite had a different take on this topic and the context of her profession:

I chose psychiatry. I never thought that I would go into mental health, and I was particularly interested in obstetrics and gynecology going into medical school. What pathology did I really enjoy learning about and not mind reading about? And so, for me, it really just made sense because the mental health of people was my biggest concern and what I felt like I could connect with and help with the most. And so, it came very naturally for me to be in mental health. Specifically, practice mental health in Memphis, Tennessee, because there’s a huge need here.

Alistair had an interesting take on how she felt about her career as a psychiatrist for the last 20 years:
You know, as far as careers that pay my bills, being a psychiatrist, I can’t think of anything else. A serious job. I can’t think of anything else that I would rather do. Do I wish I never had to have call; do I wish I didn’t have to answer to a boss; do I wish I didn’t have patients that that drove me batty whatever, sure. But I would not change my current job for anything else.

Alistair also shared that the longevity of her career has also made her more astute and “aware of her weak spots and how to handle them” and in this way, Alistair stated she is better able to recognize and address her own biases. She further shared her exposure to bias growing up in a small community in western Tennessee, where there was no diversity. She stated,

[Bias] not towards me because I was the majority, but definitely a small town in the south in the 70s and 80s. So a lot of racial prejudice, so a lot of racial prejudice. And it probably would’ve extended. It was mostly African American because that was what was in our town. Had there been other minorities in our town, whether it was Asian, whether it was whatever, I think it would have been biased against them too. But it was primarily African Americans.

Alistair was earnest in how she perceives bias and how ingrained behaviors and reactions to unconscious bias may be:

But I think in our core probably we all have some [bias] that are unconscious that maybe come out, like if I’m walking down the street and see an African American man towards walking towards me versus a White man, am I going to move one way or the other depending on the race you would like to think not, but you just you never know, you never know. That is the reality [of the way we live].
Alistair also shared that she thinks mental health providers are more understanding and her biases are not related to race, gender, or diagnosis, but she admitted having spots that are more triggering for her and more related to “drug addictions are very difficult patients usually to deal with.” But thinks her compassion and experience allow her to work with all patients.

Adonis, an OBGYN, shared that she initially wanted to be a nurse practitioner. However, being raised by her strong single mom after being widowed when Adonis was a 2-year-old toddler, and her brother was six months old, Adonis reported being taught she could do and be anything. Adonis said, “Actually, funny enough, I said I wanted to be a nurse practitioner. And she [my mother] said, why don’t you want to be a doctor? I said, well, I guess I could.” Adonis also shared that her work environment fits her personal values and how she values patient care “[It] fits the values that is making sure that people are taking care of, and taking care of as well as we can.”

It is important to note that Adonis is not just an OBGYN. She is highly rated among physicians and a partner in a very busy much sought-after practice. Adonis also shared that this career path allows her to give back to the city she also calls home. The results of the next theme discuss the participants’ experiences with bias directed at them or triggered in them by patients.

2. Bias Acceptance, Provider Professional and Personal Experience With Bias

The theme of bias acceptance, professional and personal experiences with bias explores the intricate dynamics surrounding biases and their impact on individuals and their larger shared communities. Personal experiences can influence biases by either reinforcing or challenging existing beliefs. These experiences could result from direct or indirect exposure. As suggested by CRT, it is essential to examine firsthand experiences reflectively and to recognize how they may influence biased thoughts and values. By engaging in open dialogue, applying the principles of
CDA, actively seeking diverse perspectives, and being receptive to new information, people can begin to build a bridge to a better understanding of themselves and effectively tackle their biases.

This theme is illustrated in how providers have had to deal with and address patients who have demonstrated biased behavior toward them. One of the providers, Astro, shared a professional experience of bias with a patient who did not want her to treat him because she was Black. The following month the inmate came back, now with an abscess, and though he consented to treatment, he would not speak to Astro:

I was working in an all-male facility. And I had a patient who was a White male who did not want to see me because, number one, I was female; number two, I was a Black female. I had to say to myself, you’re in prison. I’m here to do the best I can for you. I’m not here for any other purpose, and you don’t want to be seen because of who I am. He refused to be seen. And it was just a true eye-opener for me because I just would never think someone who’s inside of the prison…you just prefer to have absolutely no treatment at all. And he actually ended up coming back. And when I was trying to communicate with him, he didn’t want to say anything. So, he did at least respond…It [was] especially hard it was during the time when I had recently graduated from dental school. So that was just a shock for me.

Although this patient displayed, racial bias toward Astro stated she had no resentments toward the inmate but rather was saddened and even hurt by his behavior. When asked if there was anything that could have changed the situation, she stated, “Not being Black and a woman, neither of which I could change.”

Another provider, Andreas, shared how patients would not speak to her because of her accent and yet would talk to the White male resident, discounting her as the attending physician.
in charge. “So, and I had another one that also said, it was like, are you talking to me? Are you speaking in English to me? And I’m like, Yes.” As she has become a more experienced provider, she does not get as offended and tries to be more empathetic to the patient, “even the ones who are being intentionally rude.” Andreas was one of several providers with English as a second language. She shared experiences with patients who questioned not only her grasp of English but her credentials as a doctor.

Adrian was born in Nigeria and followed his father’s footsteps in coming to the United States and attending medical school here. His professional perspective on the discriminatory treatment from patients was interesting because he stated it was something he understood. He shared,

It was difficult to really, you know, communicate, or see an elderly White person. They have a, you know, different perspective about who they want to be seen, you know. Which I totally understand, you know. And it was also on both sides because, you know, sometimes you encounter as a young trainee, you can encounter somebody Black, and they will think, ‘well, you don’t, have all these experiences. Are you a doctor?’ and all that.

CDA suggests there is a power dynamic in the way individuals converse, and CRT suggests that sociocultural influences are dictated by a racial structure of Whites being of a superior race to other races. Adrian did not challenge this power dynamic because he was “understanding” of the bias that predicated the poor treatment he sometimes received from patients. He stated, “Because individuals go through things and it’s very, very important to, to understand that, you know, understand their humanity and that- what they’re going through and not be aware that it can happen to anybody, you know.”
Adrian displayed great compassion and earnest respect for psychiatry, and empathy for patients. However, sociocultural norms such as systemic racism can be internalized even in subtle ways that may appear harmless, but at what cost? As Gran-Ruaz et al. (2022) noted, “Internalized racism has been defined as the acceptance of negative racial stereotypes by racialized people, which in turn impacts their feelings of self-worth” (p. 11). I did not purport to know the providers’ levels of self-esteem or self-worth. Nonetheless, rather than experiencing resentment leading to poor patient care, Adrian was able to turn this biased treatment into empathy and compassion for the challenges that patients may be facing.

A few participants provided specific examples of patients who triggered a deep breath response. Adonia, a psychiatrist, shared her bias with patients who have substance abuse or addiction issues and their inability to adhere to or follow up with treatment. She stated,

It’s more about the choices, I guess, is my bias. And again, I mean, I know enough about this field and about psychiatry that not all the choices are moral choices. Some of them are biochemical imbalances that don’t allow you to make, and I like, logically, I know that, but still, to this day, it’s sometimes hard to get my internal bias out of my head about like, nobody chose to have their life spiral down to this level. And trying to get out of that mindset can sometimes be very, very difficult.

This quote provides an example of the conflicted emotions that feelings of bias can illicit from providers and patients.

3. Diversity Inclusion, Relational Communications-Interpersonal Relationships, Geography

The theme of diversity, inclusion, interpersonal relationships, and geography touched on the complex relationships between these variables in healthcare. A considerable influence on healthcare outcomes is the interpersonal relationships established between healthcare providers
and patients. Communication, trust, empathy, and cultural competence influence these relationships. Quality of care can be negatively impacted by biases held by healthcare professionals (and, at times, patients), which can hinder the development of strong interpersonal relationships. By fostering genuine connections and comprehension, healthcare professionals can reduce bias, improve communication, and provide patient-centered care.

Athena, a pulmonologist, is of northeastern African descent. He shared his concerns about diversity and relationships. He shared one of his first experiences as he was being interviewed for medical school in Memphis in 1995:

> I remember my dean in medical school. When I came here, [for] an interview in Memphis, asked me. He said, “You know, you are Black. You are a foreigner. You are Muslim. How do you expect to relate to your patients? You are coming to the Bible Belt, you know.” And I was a young kid, and I was kind of shocked.

Working through his shock, Athena stated he was able to explain that he gets along well with people and that he came from east Tennessee, which was less diverse than Memphis, where he did not just survive but thrived because he was able to develop positive interpersonal relationships that transcended race and religion. Athena shared other experiences with bias directed at him, but as in the previous two examples, Athena shared that the patients would be fine with him as their provider once they got to know him; therefore, a patient’s initial reaction to him was not bothersome. Indeed, Athena stated that his fears about bias was confirmatory bias. He was concerned that physicians could make an incorrect diagnosis and treat a patient based on that diagnosis, even if it is incorrect. Athena shared concern for physicians making the incorrect diagnosis and then treating a patient based on that information which could be inaccurate. He stated,
But sometimes the biggest fear on bias sometimes, especially when it comes to like, diagnosis or treating patients sometimes who are we, we are aware of, is that confirmation bias or like you thinking, this is what the patient has, and you get tunnel visioned. And then, although maybe there’s some evidence points, that there’s something else, but you know, you kind of lock in your decision. So that’s one of the biggest fears that we have, as physicians are those as well as maybe outcome bias. Sometimes you are afraid of, you know, especially in the ICU with a lot of poor outcomes sometimes and you question yourself, and maybe if I make a different decision, will, the outcome will not be different.

The importance of relational communication between providers and patients and between providers and their colleagues cannot be underestimated. These relationships can greatly impact communication, the type of communication, and the power dynamics in those discourses. Atlas shared her disappointment in a colleague, who allowed another male doctor to place himself in between their conversation and completely ignore Atlas as if she were not even there:

I mean, this man precepted [me] right and so another person to come and, like physically place himself in front of me just to talk to him and then he just started talking to him. I was hurt and offended both by the rudeness of the person that stood in front of me, but more so from the other physician who I felt like should have said excuse me, I was having a conversation.

Atlas further shared her feeling of being in limbo, as the hospitalist who is an advanced nurse practitioner and not a medical doctor, but feeling resentment from the medical doctors and the registered nurses. Atlas described a challenging environment to develop collegial interpersonal relationships:
You know, there is this unsaid, unspoken thing where it’s like, yeah, if it comes down to it, I am lower on the totem pole [than the physicians]. And, you know, when I was getting ready to go to NP [nurse practitioner] school, I remember asking one of the NPS [nurse practitioner service] in the ER [emergency room] about the job. I remember her saying to me it’s the loneliest job you’ll ever have. And I was like, why do you say that? And she said, well, to the nurses, you’re no longer one of them because you are a provider. You can give them orders. So not a nurse; you don’t fit in anymore as a nurse, but doctors will remind you every chance they get you are not a physician. So, you’re kind of in this in-between limbo place.

The interview with Atlas was enlightening because she described a different kind of bias associated with her education, title, and gender. In addition, Atlas described what she identifies as an “out of body experience” because she is privy to conversations that are racially biased, but because she is blond and blue-eyed, the patients disparaging other races do not know that she is married to a Black man and has biracial children. Atlas discussed how different her experiences were in Chicago, where she came from, compared to moving to the South, where it is acceptable to use inappropriate language to describe ethnic minorities. Atlas stated,

My husband is Black; my children are biracial. In the South, it’s completely acceptable in some in some areas I feel like to be blatantly open about it. So, I found that very traumatizing because, not that I didn’t think there was racism, just I guess, that was something you hid in your house that’s said behind closed doors, if you were that type of person. It wasn’t something you felt comfortable just saying out in public, right? I guess people see my blonde hair, blue eyes and think that we’re on the same team or something. So, I’ve had people make very racist comments to me just thinking that was okay. So, the
way that I looked the way that I taught it was, it was kind of a hard thing for me to get used to at first.

Atlas described the challenges in developing relationships not just with the patients she was treating but with her colleagues, who would also make inappropriate remarks. The unfortunate result of these experiences for Atlas is her narrative is lost, and her voice has been taken away. Atlas shared that she has not been able to confront patients or colleagues who have displayed biased behaviors or remarks because of fear of the consequences of losing her job. But, even with these challenges, Atlas reported liking her job and feelings of accomplishment when she could help patients. It is important to note the intersection of narrative theory, critical race, and discourse analysis with the providers' experiences. Atlas offers a particularly clear example of a provider who is confronted with the challenges of racial bias, although she herself is not of minority ethnicity. She has also experienced gender bias, as evidenced by the discourse she experienced with a male colleague and former preceptor who treated her condescendingly.

The journey from exploring diversity, inclusion, interpersonal relationships, and geography to delving into the realm of sociocultural, psychological distress, and self-preservation has paved the way for a deeper understanding of human complexities. Now, these findings will explore the concepts of sociocultural, psychological distress, and self-preservation, which presents an opportunity to adopt an open mind and recognize the behavioral drivers behind healthcare provider bias. By recognizing the importance of embracing sociocultural diversity, we can foster a more inclusive and equitable healthcare system for all individuals, irrespective of their race, socioeconomic status, and cultural heritage.
4. Sociocultural Factors, Psychological Distress, Self-Preservation

The theme of sociocultural factors, psychological distress, and self-preservation in provider bias explores the confounding relationship between these elements and the manifestation of bias in healthcare. Understanding how sociocultural contexts, psychological distress, and self-preservation interact with provider bias is crucial for promoting unbiased and compassionate care. Sociocultural factors encompass the social, cultural, and contextual influences that shape individuals’ beliefs, values, support, trust, and personal attributes and characteristics of providers (race, ethnicity, religion, gender, socioeconomic status, etc.). Patients experiencing psychological distress may require additional support and empathy from healthcare providers. Self-preservation is the instinct to protect oneself. In healthcare, providers may unconsciously engage in self-preservation by relying on biases as cognitive shortcuts, which can lead to unfair treatment or differential care.

The experience of bias, as seen through the narratives of the participants, provided some insight into how the social structure of race and language influence their practice of medicine. These experiences are also reflective of the theoretical approaches used in this study. CDA suggests clearly defined power dynamics in virtually all types of relationships. These power and structural dynamics are critical in patient-provider relationships. A Latina provider shared her desire to help Latinos because she has witnessed the mistreatment of Latin patients; therefore, she found it necessary to go beyond standard care in treating them:

I think I’m over sometimes I over protect, because I just I have seen some, unfortunately, some mistreatment or in so I will go beyond that. Sometimes it’s something that is, and I know that everybody should treat everybody the same. And I try. It’s just I sometimes I
feel like I need to speak up because they will not. So, in that way, I think I’m biased on that sometimes.

It is difficult to ascertain the depth of the quote in the absence of the provider. Therefore, it is important to share that it was an emotional moment for this provider who “felt” the mistreatment she had witnessed and wanted to do something about it.

Additionally, Andreas shared her experience of traveling in Latin America, which she embraced as an opportunity to learn from others. She stated,

Being the youngest of five, I was kind of overprotective. So, I was like, I need I need a little bit to spread my wings and, and do my thing, right? So I went to Bolivia, and I did my med school there.

When Aero shared her narrative, she did so while embracing her own diversity and empathy for patients because she had found herself on the other side of the table, not as the practitioner but as the patient.

That’s because I am African American, I am female, and I have been obese. I know what it’s like to be part of each one of those demographics. And to be, I have a history of breast cancer. So, I went through not just as a provider, but I’ve been on the patient side and have felt those biases.

Also, “You know, I say, I grew up as a, you know [experiencing bias and racism], now being here more than ten years, I am a little bit more attuned to it and pick up, you know, subtle and close. [White] patients being uncomfortable, at least initially, until they get to know me and things like that.”

Aero illustrated the challenges of being on both sides of the table as the patient and also as a provider. She further shared that she felt “butchered” following her mastectomy because the
doctor did not tell her the potential of losing her nipple. She shared feeling excluded, and her social and cultural norms were not considered when she was on the patient side of the table. Aero stated,

I, I will say that I have not gotten the best of care, especially when it came to dealing with my breast cancer. Reconstruction surgery, there was not a lot of education, and I felt like I was butchered. My reconstruction surgery was horrible. The physician was Caucasian and did not explain to me that I was going to lose my nipples. Nothing at all until I came out of surgery.

This experience has changed Aero in her practice and how she relates to patients. Although it has made her more aware of engagement and education, partnering with her patients, it has also created mistrust for her in the healthcare system. She shared that it is difficult to trust the care she will receive because of her past experiences.

The psychological distress that is created by a patient’s perceptions of poor provider treatment and communication can leave lifelong scars that impact adherence and compliance, as illustrated by Aero’s narrative. There are also the challenges faced by providers who must treat patients who fall outside of “social norms” and the impact that has on the provider and the patients in their practice. Adonis noted,

I mean, you just never know. I didn’t know that there were swingers clubs in the [metropolitan area] until I started doing this job. And I now understand that there are people that are very active in those environments. And quite frankly, we do a lot more STD testing on them on a frequent basis.

Adonis shared another experience, which required a change in office procedures, hospital procedures for birthing, and even which staff would work with particular patients. Social norms,
customs, and traditions are very ingrained, deeply held beliefs, and when Adonis’ practice was presented with a transgender male who was also pregnant, protocols had to be developed to ensure the safety and comfort of this patient. Adonis describes the process:

I had a couple that’s trans. And that bias was hard to have a bearded person in the office and so that was pregnant. And so I wanted to make sure that he got the best care. But I also didn’t want him to feel like a circus show when he came into the office. And so I told him early on, he, I guess probably for a better word sort of interviewed me to decide if I was going to be a good supporter of him and with listening to him and what, what he needed.”

Adonis shared how some of the procedures were changed to accommodate the patient.

We put his appointments usually first thing in the morning or very much at the end of the day, so he didn’t have to sit in the waiting room with all the other women looking at him. I had to make a care plan for the hospital for a couple of reasons. I didn’t want him coming in to labor and going to the front desk and having them put him in the sideboard, even though he was actually laboring. We also made it very clear that instead of just having any nurse come in, the nurses that were in his room had to be actually assigned to him; they couldn’t be otherwise. And so I think, I think that we overall did a really good job of taking care of him.

Finally, Adonis shared her philosophy of patient care and the values she has put into practice for almost two decades.

It’s hard. And it’s hard not to display your biases, right? Like, it’s, um, I think, I think what’s most important as far as, like, you know, medical bias is to just meet the patient in
an empathetic fashion. And it’s not that you’re ever going to be them; it’s that you try to understand and love them where they are.

She was spectacularly honest and transparent. Adonis’ humanity and love of her patients were admirable, and they provided an important blueprint for unbiased patient care by meeting the patient where they are and simply doing what you can do for that patient in their best interests. It is important to note how narrative theory, CRT, and CDA are woven into the interactions between a provider and their patients. Although CRT emphasizes the critical structure of institutionalized racism, it can also be viewed through the narratives of those who are different or fall outside of societal norms, as in the example of Adonis’ transgender couple.

5. Community Awareness, Cultural Factors, and Institutional Structures

The theme of community awareness, cultural factors & institutional structures, experiences, awareness, and community concerns how cultural backgrounds, diverse experiences, and community engagement influence our perceptions and understanding of bias, which is supported by this study’s theoretical framework. This theme incorporated challenges in the community, work collaborations in the community, and cultural experiences and awareness in diverse ethnic, racial, and self-identification backgrounds. As shown by Adonis’ experience, providers and patients encounter psychological distress that challenges their concepts of social norms and self-preservation. Indeed, ensuring patients feel safe in their treatment environment is an important tenet of self-preservation.

There is a valuable connection to be explored between the impact of the theme of community awareness, cultural factors, and institutional structures. These themes are found in the CDA as the language and customs of a community shape their narratives. The codes that
encompass these themes, while similar, also have some distinctive facets, as illustrated by the thematic definitions in Appendix F.

For example, Artemis shared how his female colleagues are treated compared to the reception he receives from patients as a Black male doctor. He shared how many of them are referred to as nurses or titled “miss” instead of “doctor.” However, Artemis, too, has been scathed by similar community bias experienced by his colleagues. His experience with bias he describes as more subtle but with similar microaggressions or undermining his education and credentials. Artemis stated,

I see older White patients maybe give more preference to a White male medical student, whereas I’m the one with the most authority [as the attending]. And I see that with my female colleagues as well, you know, they may be called nurse a lot. And it’s just frustrating when that happens. So, you know, I try to clearly identify who I am in my role. I’m a hospitalist. So that can be kind of foreign to a patient.

However, in tandem with those patients who may reject a young Black male doctor are those patients who are inspired by his accomplishment and feel a sense of pride for their community. His accomplishments are not only about him but how it reflects on the “Black” community in attaining success. Artemis stated,

A lot of my Black patients, you know, you see a lot of pride when they see a Black doctor. They’re pretty happy, whether it’s a fist pump or just kind of a nod of approval. And typically, the older female, they’re just kind of, they’ll tell you that, but hey, it’s great. Because unfortunately, in the hospital setting, most of the Black employees, a lot of nurses, but outside of that it’s a lot of the janitorial staff. And so, you don’t see too many people of color in that leadership role. And I think it’s a sense of pride. And you know,
I’m happy to provide that. But yeah, sometimes I do see myself in my patients or a family member, rather, if that makes sense.

Artemis presented as very aware and concerned about the community in which he works and lives. He shared his take on community awareness and bias:

But I guess as far as values, I think everyone should be as kind as possible. You know, we all have our struggles, you know, we’re, we were all born into this world, and we’re all gonna die. And those are the two things that everyone has in common. And so sometimes we can lose sight of that, whether it’s racism, sexism, the recent things going on in Memphis, with the police department. But at the end of the day, we’re all human.

But, you know, I just want everyone to be kind to each other, and have empathy, because we all go through things. And we’re all going to have times of happiness and sadness. So that’s what I try to teach my kids, always be nice, and you know, empathetic. And if we can step back and see things through someone else’s eyes, I think that’s really valuable, as hard as it may be from time to time.

Many of the participants shared a strong sense of commitment to the broader community and believed part of their role as healthcare providers was to give back to the community and make it a better place.

Agamemnon, a new younger psychiatrist, gave his perspective on improving diversity and building a stronger community:

Can we start with representation in medical school? Like not just in the class or the faculty, but like in the educational curriculum, just like, like if any of my standardized patients, while I had been in training in medical school, had been African American, maybe I would not have immediately thought that “Oh, I’ve had three African American
patients in a row in this like exam, they must be trying to get me to say sarcoidosis or sickle cell or like, something that is like race related.” Like just simple little steps to like better integrate, diverse backgrounds and, we go through bias training in medical school, but like, it’s almost like it doesn’t freakin matter if I don’t see those patients. Like, at what point am I going to have an opportunity to work through some of those biases that I have if I never get put in a situation where I have to. And again, you know, I’m coming from a tiny rural East Tennessee medical school but like I know that it’s not like every other program just because they’re in a bigger city or they think of themselves as more progressive is doing a better job at that [integrating diversity training]. So that’d be one—that’d be a great one. And though you will get to state that and like, also just put it in nursing school, social work programs, and like all the different things where we’re training people to work with other people.

6. Personal Development, Walking in Others’ Shoes, Reciprocal Influence

The theme of personal development, walking in others’ shoes, and reciprocal influence highlights the significance of self-reflection and empathy in combating bias. By expanding our perspectives, understanding diverse experiences, and recognizing the influences that shape our beliefs, we can develop a more compassionate and inclusive mindset. This was apparent in some of the responses shared by the interviewees, who were all very accomplished licensed healthcare professionals, yet many expressed latent, implicit, and explicit biases towards those who are outside of his social strata.

Interestingly, Alexandra identified himself as having a negative educational bias towards others without his level of education. He stated,
You know, like at a baseline, you know, you try to take everything for what it is. But there are sometimes when the first reaction is oh, you know, well that person isn’t a doctor like I am. I think the same thing about any professional, we need all types of people, but I do recognize that bias definitely in myself, like an educational bias. This was an important discussion on treatment objectivity with Alexandra on his bias because he also denied having any other biases and further shared, “I am more sympathetic to them [the poor], than maybe really super-rich people.” Alexandra did not appear to grasp his inability to walk in his patients’ shoes as described as having more empathy for the highly intelligent patient who also has a mental illness. This example speaks to the latent biases that may be clear to others but not at the forefront of the provider’s awareness. Alexandra remains on the journey to personal development and understanding of bias.

Atticus also shared an education bias:

I mean, I was a White upper-class child of well-educated parents. So, ahh, the bias the racial bias is strong. Ahh, the socioeconomic bias is strong. The education bias is really strong. Ahmm, I mean, I’ve even, like, as a person who’s had health issues my whole life and also some, you know, disabilities, intellectually. I take for granted that I understand that, and then I will find out later that I have biases towards people who are like less able.

Not only was Atticus brutally transparent about her biases, but she also shared her own challenges and the work she put into herself to recognize these biases and do something about them. Atticus shared that her resolve to be different than the household she grew up in began in her late teens. She shared she sees things very differently than she did when she was younger. Interestingly, Atticus expressed much empathy towards her patients, such as in discussing the civil rights movement and her ability to “walk in the shoes of others.”
I became much more outspoken by the time I was in my late teens. Me and my dad butt heads about it quite a bit. But we could usually kind of come around and have like a reasonable conversation about it. Interestingly, psychiatry usually brought us together because I think, at his core, he did believe most strongly in kindness.

7. Self-Reflection on Psychosocial and Psychological Factors, Racial Discrimination

The theme of self-reflection on psychosocial & psychological factors, racial discrimination concerns the impact of bias on individuals’ mental and emotional well-being. By examining the psychological effects of racial discrimination, fostering self-reflection, and promoting awareness, the medical community can address bias and its harmful consequences and work towards a more equitable and supportive healthcare system. This theme reflects the power differential in a patient and provider relationship and the critical discourse that influences and structures all relationships. Anders is a nurse practitioner at a university medical school, and her primary patients are physicians and residents. She shared the challenges of addressing psychosocial issues with this particular population and the differences she has experienced working with a more privileged patient population versus the indigent and primarily Medicaid population of her previous clinic assignment. This provider’s narrative touches on the importance of being self-reflective in keeping personal biases in your awareness. Anders shared her concerns on bias:

It goes back to that situation we talked about with affluence. Whereas the A- I was just saying the B-. The B side is family dynamic stuff, [basic] needs are met. But I do feel the struggles that African Americans have. And, this could be a study within itself. The struggles that African Americans have and the struggles that Caucasian—non-Caucasian, non-African American, non-Hispanic people have—It’s like night and day. And that’s
concerning to me. The struggles that African Americans have financial, making ends meet, trauma, dealing with their own personal bias and racism that they’ve experienced, It’s a whole deal, it’s a different set of problems. So I’m not necessarily biased against the person because I don’t think that’s where I am, but the level of issues and struggles you do have to keep yourself in check. Because you can find yourself saying, Man, is that all you’re going through? You know, I’m saying is that really your problem? So that can be that can be difficult to navigate. I don’t really see that as being a bias for me personally. But it can be. It could be if I don’t keep myself in check.

Both Blacks and Whites have been influenced by various psychosocial and psychological factors that contribute to their individual experiences and perceptions, including cultural beliefs, socialization processes, identity development, stereotypes, and prejudice. They can influence how individuals perceive themselves, others, and their place in society. Anders, like her colleagues, was brutally honest and transparent about the vast differences in issues presented by the two groups. Further, she makes a conscious effort to keep “herself in check” to mitigate her own biases when working with patients. Anders was cognizant of the impact racial discrimination has had on African Americans, but she tried to be reflective in her patient care because, as she shared, her values demand that of her.

8. Open-Mindedness, Drivers of Behaviors

The theme of open-mindedness and drivers of behaviors focuses on understanding and challenging biases. By approaching behavioral drivers or motivation with an open mind, recognizing the history behind the biases, and fostering inclusivity and acceptance, we can create an environment that values a diverse profile and reduces bias directed at specific segments of the
population. Achilles talked about the importance of keeping an open mind when providing patient care, because it is one of the ways she keeps her own bias in check. She stated,

I try to stay very open to feedback. And I can recognize my behavior like I can recognize when I’m frustrated when I’m becoming short tempered and aggravated by you know, somebody’s behavior or certain experiences or when I’m dreading a room and I you know, like, I gotta like pep talk myself take deep breaths and you know, and also the feedback that I received from others I you know, I like to know, what things do you think I can change or feedback from patients even when they’re frustrated. I try to listen, is this a valid frustration, or is this inconsistent? And so yeah, I try to keep an open mind and try to keep staying sharpened and from my coworkers, from patients

CRT speaks to the importance of acknowledging the racial and power structures in cultural and social institutions and structures that influence the behaviors of individuals and groups. Further, seen through the lens of CRT, assessments and treatment interventions are influenced by the provider’s biases.

Apollo, a psychiatrist with a specialty in gerontology, shared the importance of understanding the etiology of illness, as without this knowledge, you could provide biased treatment, which would affect the outcome and patient’s adherence. Apollo stated,

So, there are things that are diseases and illnesses of the brain. There are things that are neurodevelopmental, there are behaviors, and then there’s stuff that happens to you in your life, we call that the life story perspective. And so, but a lot of their ideas, they recognize the limitations of the bio psychosocial model, and they took it a step further and important book in psychiatry, right. That talks about what psychiatrists did, and that it’s our job as scientists to at least categorize that thing correctly. You know, I mean,
there’s a real difference between posttraumatic stress disorder and schizophrenia, right? They’re not the same disorder. I mean, one’s probably a neurobiological neurodevelopmental disorder, and the other one is from a life event. Right? You were fine and then blast in the military or something. The etiology of the disorder is different.

Apollo went on to share that in addressing bias, particularly with patients who have additional needs, knowing what you are treating and how to treat patients is an important tool when addressing bias.

Abacus, a critical care and trauma nurse practitioner, shared how she defined treatment success when a patient has an open mind and is receptive to doing their part in improving their health. Abacus called it the patient’s buy-in.

Cause now, they are looking at other ways—other treatment modalities that I might not even present in that little, short time that we talked. So that’s the buy-in, and that is the success because now they’re looking at how it's opened their mind up to more, so they’ll research.

9. Negative Emotions and Experiences

The theme of negative emotions and experiences explores how bias can impact the well-being of those patients a provider is tasked with caring for. By recognizing the unique challenge they face in fostering empathy and creating supportive environments, we can reduce bias-related negative emotions and promote patients' well-being and more holistic care. This theme was one of the lowest in groundedness, meaning it encompassed fewer codes. Most participants in this study expressed positive emotions about their work with patients and their desires for dream jobs that would promote more equitable and accessible patient care. The negative emotions and experiences usually involved a provider’s experience with a patient or colleague where they were
the recipient of the negativity. The lens of narrative theory highlights the importance of an individual’s lived experiences in assessing and interpreting their own encounters.

Angelo shared her experience seeking a promotion at a large metropolitan teaching hospital, and the lasting impact of that experience is that she shared she would “never” again seek another promotion. Angelo reported,

[Bias] Oh my gosh. It’s the reason why I left the bedside. To be honest. I left bedside nursing, because of all the bias that was placed upon me as an African American nurse. by my peers [and leadership], it seemed like, no matter what it was in there, anything I did was never good enough. It was if I explain things and show what or how much I knew. Then I was being a show off. If I held back a little bit and ask questions, well, then she didn’t know anything. And each time I tried to progress it was met, I was met with roadblocks every time that I tried to step outside of the box that they put me in.

It is important to note that this practitioner has been a nurse for two decades, half of which as a nurse practitioner, and although this event took place before nurse practitioner school, the negative impact of it lives with this provider.

Atticus shared that one of her negative biases was people who hurt other people. As Atticus is a forensic psychiatrist, this bias can be a challenge. She shared how she is able to work with challenging offenders who have hurt people:

Gosh, cause my goodness, aww man (said very softly). Trying to think like, I feel like if a person doesn’t want to change, they’re not going to. But I never want to I never take that for granted. I have a lot of compassion for anybody that I can understand or like, see your childhood then that, I think is very helpful.
Atticus went on to explain that “hurt people, hurt people.” She stated she tried to think about
dangerous offenders as a child and draw out the trauma that is usually associated with the person
they became. This quote is an example of Atticus using CDA as an internal dialogue to mitigate
any negative impact on treating a child sex offender.

10. Self-Awareness, Personal Values, Bias, and Inequality

The theme of self-awareness, personal values, bias, and inequality concerns the
importance of recognizing our own biases and examining how they contribute to societal
inequalities. By cultivating self-awareness, aligning personal values with principles of equity,
and challenging biases, we can actively work towards reducing bias and promoting a more just
and inclusive society. Many of the participants discussed a value system based on spirituality,
and others shared a value system based on humanity. These values were earnestly tied to the
participants’ self-awareness and how they see their role as not just providers by agents of change.

Alcaeus, a physician hospitalist, shared the following about his values:

I think my personal values absolutely overlap with my professional ones. I think I’m
more aware of my values when I’m at work because I really think that my values,
personally, are something that my patients value very much as well.”

Alcaeus also had an interesting yet transparent perspective on his biased recognition toward a
patient. He stated,

I’d like to think so [recognize bias]. But bias is very tricky. It’s a bias for a reason. And to
be quite honest with you, I don’t know that I would. I’d like to, you know, from what I
hear from my colleagues, and you know, when they feel whether it be overlooked or
offended, I like to think about these things. So the next time I encounter a potential
situation, I can avoid that or be a better person. But I think we have biases inherently,
whether big or small. And I think that’s the thing about biases we, we don’t see them, but by acknowledging, or when other people tell us I think we can learn from our potential biases. And then make progress.

Alcaeus emphasized the significance of self-awareness as an essential strategy for mitigating bias during his discussion with the interviewer. He noted that because bias can often be implicit and unconscious, making it crucial for individuals to recognize and understand their own potential biases. By cultivating self-awareness, Alcaeus shared that one can actively learn from our biases and strive towards personal growth and improvement.

Aphrodite, an African American female psychiatrist, shared her experience with being self-aware and how that led to her being called racially biased. She shared,

What do I want to see from my colleagues in addressing bias? Just more critical thinking. More critical thinking about what could how could how I’m treating this person make them feel? How could how I’m treating this person make them feel in terms of how they value themselves? And I would just like to see that understanding more because I think that, yeah, like there. There’s just a sense of entitlement and a sense of superiority from a lot of my colleagues that I’ve experienced myself being a Black physician that I was just like, I was just like more critical thinking and reflection on how they’re treating the patient.

The experiences reported by Aphrodite of feeling less than among her colleagues were visibly taxing for Aphrodite. She was somber when reporting these experiences:

I’ve also been accused of being racially bias as a Black person. And that was reported to my program director for that. Recently actually. And I was told that as the one Black resident present, present in our ranking meeting for who was going to be our incoming
resident, that I was racially biased in that process. And I was brought in for that. So, yeah, and that was because I did speak on behalf of another Black applicant who I know personally.

Summary of Findings

This research on healthcare provider bias has revealed several key observations that lend themselves to future research considerations. Each of these themes highlights different aspects of bias and its impact on individuals and communities. By exploring these themes and actively addressing bias, we can foster understanding, empathy, and inclusivity. It is important to acknowledge that providers also experience incidences of biased behaviors directed at them. Interestingly, one of the more prominent biases appears to be gender and reverse ageism (Ayalon & Tesch-Römer, 2017). Discrimination based on age is not a new challenge. However, I was not expecting to find those results here. Additionally, as most of the participants fell between ages 30–39 and had less than five years of experience, it would appear to make some patients uncomfortable, based on the interviews. The findings were also consistent with the highest coded themes of bias acceptance and experience and career and professional development. Considering the demographic makeup of these participants, higher codes in the area of career were consistent.

Another finding of interest was the demography of this group. When ethnicity was removed and only race was entered into the pivot table, there was an even distribution of race for Black and White participants. There were exactly 12 Black and 12 White, both males and females. There were two outliers, one Latina and the other Pakistani. The theme of cultural factors and experiences had a total of, yet it was the sixth highest ranking theme comprising 129 codes. However, the theme of diversity and inclusion, interpersonal relationships, and geography had 251 codes, almost twice as many as cultural factors. It is an interesting outcome, based on
interviews, because our narratives are our culture; when a provider listens to a patient, they hear the story of who they are. However, is this a lack of cultural awareness?

The next highest theme, made up of 212 codes, was sociocultural, psychological distress, and self-preservation which are areas relevant to healthcare. In this finding, there was a cluster of providers who had between 20 and 34 codes individually just in that theme. Three out of the four providers in this cluster were female, and one was a White male. Each of the female providers was of a different race or ethnicity, one Black, one White, and one Latina. This was an interesting finding because the participants ranked cultural awareness far lower than sociocultural, psychological distress, and self-preservation theme.

Numerous studies have demonstrated that racial and ethnic minorities often experience bias in healthcare settings. Though providers may exhibit implicit biases that result in differential treatment, the providers in this study all denied any gender, racial or ethnic biases, nor were there any subtle microaggressions or exhibits of such bias during the interview. However, as I presented with all the aforementioned categories, she may have been a barrier to more transparency. All the providers were able to identify some biases they have and shared that those patients with addiction, personality disorders, and what many of them termed “frequent flyers” patients who are often in the hospital or emergency departments were some of their challenges. However, those same providers would share that because they are aware of their bias, they are able to treat patients with objectivity.

These findings have opened the discussion for additional research to address healthcare provider bias. Addressing healthcare bias also means challenging existing social norms and isms and will require time, effort, and substantial systemic policy changes to start to make a difference.
Figure 4

Participants’ Race With High Scores for Themes

Note. Total Bias acceptance, provider professional and personal experience with bias Gr=388 and total Career and Professional Development, Provider’s Background, Patient Care Gr=470 sorted by Race and Provider ID Codes
Chapter 5: Discussion

This qualitative research study investigated the multifaceted dynamics surrounding diversity, inclusion, interpersonal relationships, and various related themes that may impact provider bias in healthcare. The study objectives were to provide deeper insights into the intersectionality of these themes and their impact on individuals and their communities but, most importantly, treatment adherence, follow-ups, and treatment outcomes. Through interviews and thematic analysis, the study aimed to reveal the nuanced experiences and perspectives of medical professional participants. Through highlighting the importance of addressing these issues for fostering inclusivity and social cohesion and developing equitable outcomes for better healthcare delivery.

The question of provider bias’s influence on treatment outcomes revealed the following. Ten themes emerged from this study, created from a combination of over 1,870 codes. The higher number of codes in a theme indicated the frequency distribution of those codes in a theme. One of the first themes to emerge was career and professional development, background, and patient care. This theme was reflective of the sample of study participants, who were all professionals. Indeed, in the literature review, the challenge of addressing provider bias must become part of the core curriculum in medical schools and graduate medical education to build understanding and tolerance of difference, as noted by Gagliardi et al. (2022). Relevant to this theme was the background and exposure of providers that may have contributed to creating biased perspectives, which many providers reported they recognized in themselves.

Other themes that emerged included bias acceptance, diversity, inclusion, interpersonal relationships, sociocultural, psychological distress and cultural factors, and experiences. These themes had some of the higher frequencies of codes, and all providers had remarks in one or
more of those areas. This is important to note because, as diverse as the providers were, they also had some stark similarities. For example, the providers who were of African or Middle Eastern descent were empathetic to those patients who displayed biased behaviors towards them or even refused to have them as their doctors. These providers were quick to note that once the patients “got to know them,” they became comfortable with receiving care from them. Interestingly, these providers reported not being upset by the offensive behaviors of patients.

It is important to add that all the providers acknowledged the existence of bias in healthcare and the potential negative consequences on treatment compliance and adherence. However, the practitioners acknowledged their own prejudices and stated that because they were aware, they were confident in their capacity to manage biased concerns and treat patients objectively. For example, participant Anders stated:

But I do have my own internal kind of compass. But the triggers, I think, for me more than anything would probably be I'm in some sort of guilt, maybe that's not how you should handle that, it is maybe like this kind of remorse. Oftentimes that happens instantaneously. I can't tell you that it happens [daily], it typically happens instantaneously, and how the patient responds, and what I typically do to recover, I'll say, you know what, let me say it another way (Anders).

Participants in this study presented themselves as sincere and did not appear to be masking any ill will about actions that I termed reversed bias. When the providers were asked why they were not upset by this treatment, they all responded similarly, disclosing the patients are there for help and it is their obligation to provide that help without judgment. It is almost as if the experiences of those providers of color who have experienced bias directed at them were determined not to perpetuate this narrative and chose to focus on a different discourse that
opened the road for improved communication. By not perpetuating biased behaviors, these providers were able to provide the quality care their patients needed. Subica and Link (2022) noted how cultural trauma directly impacts disparities and shared interventions that have important implications for addressing health disparities. One of the interventions focuses on community mobilizations. In the same way, the participants were attentive to the communities they served and wanted to focus on improved service delivery rather than respond to negative interactions with some patients.

Although providing relevant information, the other themes of personal growth, putting oneself in another’s shoes, neurodiversity, negative emotions and self-awareness, personal values bias, and inequality had lower code frequencies and less data among the providers. These providers did not focus on the negative experiences they may have had with patients but were keener to discuss their approach to addressing bias and suggestions for improving health inequities. For example, Agamemnon was quite animated in discussing changes that need to take place at the curriculum level in medical schools to better educate young doctors on cultural diversity. She was passionate about the need for better education on difference but also cognizant of wanting such education to become systemized so that the next generation of providers will be better equipped to address the sociocultural needs of patients.

All participants acknowledged the importance of self-awareness and expressed their commitment to “keeping themselves in check.” They recognized that bias often operates at a subconscious level and acknowledged the need for their own diligence to prevent their prejudices from influencing patient care. Their shared understanding emphasized the significance of remaining vigilant and continuously reflecting on their biases to ensure equitable and unbiased treatment for all patients.
This research revealed the multifaceted and complex nature of bias when viewed from the provider’s belvedere. Sociocultural factors, such as societal stereotypes, traditions, and value systems, are important to both providers and patients. This was evidenced by the high number of codes that were generated from the interviews. Systemic challenges in addressing bias may be one of the larger barriers to change; however, these research participants were aware of their own limitations and shared their narrative on addressing their own biases. Additionally, these providers rated diversity, inclusion, and interpersonal relationships as important themes comprising over 250 codes.

The racial demographics of participants provided an even division between Whites and Blacks; 12 were White, and 12 were Black (see Appendix K for the breakdown of participants’ ethnic makeup). In addition to Black and White Americans, there were three Africans, one Northern African, one Pakistani provider, and one Latina from South America. Given this cohort’s ethnic composition, it is consistent with the interviews denying any racial or ethnic biases. However, the female providers identified their own negative experiences with bias directed at them either because of age, gender, or ethnicity.

One of the significant hurdles to attaining health equality is addressing provider discrimination or intolerance, albeit unconscious or implicit. It promotes gaps in health outcomes, patient experiences, and access to care. These biases disproportionately affect marginalized people, including racial and ethnic minorities, women, older adults, and LGBTQ+ individuals. The cumulative consequences of intersecting prejudices exacerbate health disparities, highlighting the necessity for an intersectional strategy to prevent bias in healthcare.

To effectively affect change, the providers’ experiences, their counter-narratives, and ways of acknowledging and addressing bias must be a part of the conversation. This study
presented the voices of the providers through the narratives gathered in one-on-one interviews. Future research should explore providers’ cultural awareness and the holistic treatment of patients. Future studies should continue to gather the stories of providers. The process of acknowledging their own prejudices presents opportunities for providers to explore their practices and interactions with patients. The collaboration between patient and provider may impact treatment adherence and follow-up. Indeed, the process of discourse also demonstrates to providers that they do have the power to impact change.

Health disparities and suboptimal treatment outcomes constitute a pressing public health crisis that has not received the necessary attention or funding required to enact systemic changes in culture and policy (Alspach, 2018). Indeed, I recognize that as a Black woman, I come with my own set of prejudices, which require self-awareness to prevent these biases from touching those with whom I work. According to CDA and CRT (Burrell-Craft, 2020; Gabella, 2021), fostering this awareness among healthcare providers could serve as an initial step toward transforming perceptions and dismantling stereotypes. Moreover, acknowledging and embracing bias in the context of medical treatment could have a life-altering impact on patients, potentially determining whether they live or die (Smith & Alpert, 2007).

**Methodological Considerations**

The methodology used in this study provided the participants an opportunity to express themselves and add to the existing literature by sharing their narratives on bias and patient care. This platform was a unique perspective into giving providers a voice as change agents in healthcare and recommended changes to decrease treatment bias. The use of both audio and video recording was pertinent to the data’s integrity. In addition, an independent transcriber was hired to review the scrubbed recordings and compare those transcriptions to that of the researcher
and the Otter.ai software. The use of these techniques is crucial to data integrity and interrater reliability.

**Study Limitations**

There are several limitations to this study that is important to discuss. One of the primary limitations is the sample size of participants. The study included a small number of participants, twenty-six providers, potentially limiting the representativeness of the findings. Furthermore, the sample might not reflect the diversity of healthcare providers in terms of geographic location, healthcare settings, and demographic characteristics. Therefore, this study could not be generalized to include other providers. Although this study encompassed a diverse range of participants, the sample sizes were relatively small, consisting of only a single individual. Therefore, it would be challenging to generalize these findings to a broader population of healthcare providers.

Other limitations include the selected participants were chosen because they met specific criteria. While this was appropriate for the study, it also limited the findings to the study’s participants. It is also important to consider social desirability bias. The providers are professionals who live and work in the community and, while not friends with the researcher, are familiar with the research. Consequently, participants may respond in a manner that they perceive as socially desirable rather than providing completely transparent answers. This bias can affect the accuracy and authenticity of the reported data and viewpoints. It is important to reiterate, as mentioned previously, the participants all presented as honest and transparent in providing their opinions on provider bias.

Indeed, while this study is quite relevant to the significant healthcare challenges in the American culture, it is within a specific, and therefore limiting context, of the provider’s
perspective on bias. As a result, the study could potentially have overlooked other important factors that contribute to bias in healthcare settings that have been included and will need to be taken into consideration for future studies. This narrow focus may limit the comprehensive understanding of bias in healthcare and other contributing variables.
Chapter 6: Implications for Social Work Practice

Healthcare Equity and Advocacy

Patient care and health equity are significantly impacted when healthcare providers exhibit bias (Proctor & Rosen, 1981). To address this issue and promote fair healthcare outcomes, it is crucial to acknowledge the existence of bias, identify its underlying causes, and implement targeted interventions. Achieving an unbiased healthcare system that is culturally sensitive and delivers equitable care to all requires a comprehensive approach involving healthcare organizations, physicians, legislators, and patients, all working together to combat prejudice among healthcare providers (Johnstone, 2021). In the ongoing battle against healthcare inequities, social workers play a vital role in reducing bias and promoting fair care. To effectively advocate for underrepresented groups and marginalized communities, as well as advance health equity, social workers must examine the impact of healthcare provider bias on their daily work (National Association of Social Workers, 2021b; Noel et al., 2022).

Social workers are in a unique position to identify instances of healthcare provider bias and take action. By actively listening, being culturally sensitive, and building rapport with clients, we can effectively uncover experiences of bias and discrimination in healthcare settings. Once these issues are identified, social workers can advocate for clients by addressing their concerns with healthcare providers, supporting and empowering clients in navigating biased systems, all the while advocating for policy changes to mitigate bias (Subica & Link, 2022). For social workers, addressing healthcare provider bias is of utmost importance in promoting social justice for vulnerable populations. We play a vital role in advocating for culturally competent and unbiased care, ensuring that clients receive fair and equitable treatment regardless of their backgrounds.
**Interprofessional Collaboration**

Social workers and healthcare professionals may be hampered in their ability to collaborate effectively by the biases of healthcare providers. Social workers must proactively address and address prejudice in healthcare institutions, supporting multidisciplinary teamwork and a more inclusive, patient-centered approach.

The introduction of standards and guidelines to streamline care and reduce disparities can contribute to the reduction of prejudice. Social workers have been at the vanguard of client-centered practices, the promotion of respectful and open communication, and client empowerment in shared decision-making for decades. Utilizing these abilities, social workers may engage providers and act as a conduit to improve trust and promote fair treatment (Hanrahan, 2012). Education and awareness programs can heighten providers’ consciousness of unconscious biases and build cultural competency. Social workers are well-positioned to become agents of change in teaching and advocating for improved patient care because we have been at the forefront of social and cultural transformations (Lombardi et al., 2021).

**Social Work Advocacy**

A healthcare workforce that is diverse can provide care for patient populations that are reflective of them and their cultures (Noel et al., 2022). As one of the participants of this study shared, after being denied a promotion, she has not had the desire to go through that process again, which she defined as humiliating (SC12182022, 2022). In addition, policies addressing structural inequalities and actions fostering diversity and representation in healthcare leadership will be necessary to bring about any meaningful improvements (Karpf, 2019; Women’s Health, 2021).
The influence of healthcare professional bias on social work practice extends well beyond hospitals and clinics to vulnerable individuals’ neighborhoods (Karpf, 2019). Social workers may contribute to the decrease of bias and the development of health equality by actively addressing bias, increasing cultural competency, encouraging interprofessional cooperation, and lobbying for legislative reforms (Karpf, 2019). By partnering with clients, healthcare professionals, and other stakeholders, social workers may significantly contribute to ensuring that all persons receive equitable and unbiased treatment in the future (Noel et al., 2022; Robbins et al., 1999).

In conclusion, healthcare provider bias poses significant challenges to achieving equitable and just healthcare outcomes. Social workers, equipped with their unique skills and perspectives, play a pivotal role in addressing this issue. By actively listening, advocating for clients, and promoting policy changes, social workers can help uncover instances of bias, empower marginalized individuals, and strive towards a healthcare system that is truly unbiased and culturally sensitive.

As social workers, we engage with clients and navigate healthcare systems. We must remain steadfast in our commitment to social justice. We must challenge and dismantle the barriers created by biased practices, ensuring that all individuals, regardless of their background, receive fair and equitable care. By recognizing and addressing healthcare provider bias, we can create meaningful change, promoting a healthcare system that respects the inherent dignity and worth of every individual. Through our unwavering advocacy and dedication to promoting health equity, we are social workers and are instrumental in creating a future where bias is eradicated and all individuals can access the high-quality care they deserve.
Conclusion

The Research

This provider bias study explored the complex issue of healthcare bias and shed some light on its implications for social work practice. Examining existing literature and research shows that provider bias significantly impacts patient care, treatment adherence and follow-up, inaccurate diagnosis, medical treatment delays, and even death. The steps outlined in this study, including recognizing and acknowledging bias, identifying causes, and implementing targeted interventions, provide a roadmap for reducing prejudice and achieving reasonable healthcare outcomes. The findings underscore the urgent need for social workers to address bias in healthcare settings to promote equitable and just healthcare outcomes for all individuals, particularly those from marginalized and underrepresented communities.

Theoretical Perspective

Indeed, it is necessary to address issues of systemic racism, sexism, and cultural extinction as outlined using narrative and critical race theories. The narratives and experiences of healthcare providers and their cultural backgrounds that contribute to their identities are equally important as those of the patients they treat and care for. Critical discourse analysis forces us to be more transparent and acknowledge the power imbalance that exists in dialogue and all relationships. The role of the provider and patient is one where the differentiation of power is palpable. As this study revealed, the differences between nurse practitioners, medical doctors, and male and female power dynamics were also quite profound, as the providers shared.

Implications for Social Work

Social workers are critical in combating provider prejudice in healthcare settings. Working in healthcare systems requires social workers to actively manage and confront
prejudices while promoting multidisciplinary teamwork and building a more inclusive and patient-centered approach. With their unique skills and perspectives, social workers are well positioned to identify instances of discrimination, advocate for clients, and assist them in navigating the intricacies of a biased system. More often than not, the healthcare system is laden with the challenges of social determinants of health and healthcare disparities. Social workers can uncover and promote policy changes to mitigate bias through active listening, cultural sensitivity, and rapport building. As social workers engage with clients and navigate healthcare systems, they must remain steadfast in their commitment to social justice.

**Future Research and Social Work**

Moreover, this dissertation points to the importance of further research in this area. Future studies should explore the long-term effects of healthcare provider bias on patient outcomes and the differential impact on various marginalized groups. Additional, research is needed to examine the effectiveness of interventions to reduce bias among healthcare providers and the role of social workers in implementing and evaluating these interventions. Furthermore, investigating the intersectionality of provider bias with other forms of oppression, such as racism, sexism, and classism, is crucial for a comprehensive understanding of the complexities involved in discrimination. Exploring the experiences and perspectives of social workers themselves in addressing provider bias would also contribute to the knowledge base and inform best practices.

By continuing to advance knowledge in this area, we can enhance social work practice and contribute to developing a more equitable healthcare system. Ultimately, the goal is to create a future where provider bias is minimized and everyone receives fair and unbiased care regardless of their background. This enchiridion for systemic change requires a collaborative
effort between researchers, practitioners, policymakers, and stakeholders. Social work practice has an obligation to ensure the work is grounded in evidence-based strategies that promote health equity, social justice, and the dignity and self-worth of all patients, irrespective of their ethnicity, race, and cultural heritage.

**Summary**

This dissertation highlights the critical role of social workers in addressing healthcare provider bias and promoting social justice in healthcare systems. By recognizing the implications of provider bias, integrating evidence-based interventions, and advocating for policy changes, social workers can continue to make significant contributions to the field. Future research should further explore this crucial topic, deepening our understanding and informing the development of effective strategies to combat provider bias and advance equitable care.

“I am not interested in power for power’s sake, but I’m interested in power that is moral, that is right and that is good. Change does not roll in on the wheels of inevitability but comes through continuous struggle.”– Martin Luther King
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Appendix A: Social Determinants of Health Infographic

Figure 4

Social Determinates of Health

*Note.* Healthy People 2030 (2020).
Appendix B: Provider Interview Guide

1. How long have you been a MD & where did you work before your current job?
2. Why did you choose psychiatry?
3. Do you see any biases within yourself?
4. Do you see yourself in any of your patients?
5. Tell me about a time when you had to think about your own bias or change the way you work with a patient?
6. What are some of your values, and do they align within your current work environment? Do they align with your colleagues?
7. Do you think you would recognize your own bias towards a patient or particular population? How would you recognize your bias?
8. What would you do about it?
9. Tell how you would describe a treatment success and why?
10. What do you want to see from your colleagues in addressing bias?
11. How would you describe your dream job?
Appendix C: Study Recruitment Flyer

University of Memphis

Volunteers Needed for a Research Study
Title: Can provider biases impact patient treatment outcome?

→ The purpose of this study is to assess providers’ understanding of their own biases and how that may impact patient treatment outcomes or treatment adherence.

→ This research project will be conducted through qualitative one-on-one interviews with community-based providers in a private setting (such as an office).

→ The interviews will last between 30 and 45 minutes, using structured but open-ended questions, that will be asked of all participants.

→ Participants must be physicians, nurse practitioners, or dentists currently practicing in the Memphis community in the capacity of medical or mental healthcare providers.

Your input is valuable and needed to help make changes in healthcare disparity, the increasing cost of providing healthcare services, and the challenges of treatment adherence and follow-through, you, the provider, can make a difference.

⇒ Interviews can be done in person at Memphis Mental Health Institute, the provider’s location, or using a secured cloud-based collaborative service such as Zoom, Webex, or MS Teams. Interviews are expected to be only 30-45 minutes.

⇒ To learn more about this research opportunity, please contact Principal investigator, Tracey Davis Moore, LCSW, MSW, University of Memphis, School of Social Work, Doctoral Student @ t Davis13@memphis.edu, or 901-633-0668.

⇒ This research is conducted under the direction & supervision of Dr. Melissa Hirschi, University of Memphis Assistant Professor, School of Social Work, Doctoral Program Coordinator.
Appendix D: Average Number of Coded Groups in Each Thematic Category

Table 6

Average Number of Coded Groups in Each Thematic Category

<table>
<thead>
<tr>
<th>Ten thematic categories</th>
<th>Average number of groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Open mindedness, drivers of behaviors</td>
<td>5</td>
</tr>
<tr>
<td>● Self-reflection on psychosocial factors &amp; racial discrimination</td>
<td>7</td>
</tr>
<tr>
<td>● Self awareness, personal values, bias &amp; inequality</td>
<td>7</td>
</tr>
<tr>
<td>● Community awareness, cultural factors &amp; institutional structures</td>
<td>10</td>
</tr>
<tr>
<td>● Personal development, walk in others’ shoes, reciprocal influence</td>
<td>10</td>
</tr>
<tr>
<td>● Sociocultural, psychological distress, self preservation</td>
<td>12</td>
</tr>
<tr>
<td>● Bias acceptance, provider professional and personal experience with bias</td>
<td>14</td>
</tr>
<tr>
<td>● Negative emotions &amp; experiences</td>
<td>18</td>
</tr>
<tr>
<td>● Career and professional development, provider’s background, patient care</td>
<td>20</td>
</tr>
<tr>
<td>● Diversity inclusion, relational communications-interpersonal relationships, geography</td>
<td>22</td>
</tr>
<tr>
<td>Total codes</td>
<td>125/10</td>
</tr>
<tr>
<td>Average number of codes in each thematic category</td>
<td>12.5 OR 13</td>
</tr>
</tbody>
</table>
Figure 5

*Total Number of Coded Groups in Each Thematic Category*
### Appendix E: Thematic Categories Groundedness Scores

Table 7

*Provider Thematic Categories Grounded Scores*

<table>
<thead>
<tr>
<th>Thematic codes</th>
<th>Sum of groundedness</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Career and professional development, provider’s background, patient care</td>
<td>470</td>
</tr>
<tr>
<td>● Bias acceptance, provider professional and personal experience with bias</td>
<td>388</td>
</tr>
<tr>
<td>● Diversity inclusion, relational communications-interpersonal relationships, geography</td>
<td>251</td>
</tr>
<tr>
<td>● Sociocultural, psychological distress, self-preservation</td>
<td>208</td>
</tr>
<tr>
<td>● Community awareness, cultural factors, and institutional structures</td>
<td>120</td>
</tr>
<tr>
<td>● Personal development, walk in others’ shoes, reciprocal influence</td>
<td>110</td>
</tr>
<tr>
<td>● Self-reflection on psychosocial factors &amp; racial discrimination</td>
<td>101</td>
</tr>
<tr>
<td>● Open mindedness, drivers of behaviors</td>
<td>87</td>
</tr>
<tr>
<td>● Negative emotions and experiences</td>
<td>83</td>
</tr>
<tr>
<td>● Self awareness, personal values, bias, and inequality</td>
<td>57</td>
</tr>
<tr>
<td>Grand total</td>
<td>1875</td>
</tr>
</tbody>
</table>
Figure 6

*Thematic Codes Groundedness*

Note. The higher the grounded score the more times the codes are used in the themes.
Appendix F: Thematic Categories Defined by Merged Codes

Thematic categories and the multiple merged concepts and subjects (codes) that combined to create each category.

Table 8

*Thematic Categories Defined by Merged Code*

<table>
<thead>
<tr>
<th>Coded Conceptual Themes</th>
<th>Original individual &amp; grouped concepts merged into main conceptual themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bias acceptance, provider professional and personal experience with bias</td>
<td>Merged from:</td>
</tr>
<tr>
<td></td>
<td>• Accepting and addressing Bias,</td>
</tr>
<tr>
<td></td>
<td>• Ambivalence with patients’ bias,</td>
</tr>
<tr>
<td></td>
<td>• Experience with Bias at self and others,</td>
</tr>
<tr>
<td></td>
<td>• Communication Skills &amp; Detecting Bias,</td>
</tr>
<tr>
<td></td>
<td>• Expressions and perceptions of Bias,</td>
</tr>
<tr>
<td></td>
<td>• Family Dynamics, Frustration,</td>
</tr>
<tr>
<td></td>
<td>• Gender Roles &amp; Bias,</td>
</tr>
<tr>
<td></td>
<td>• Medical Issues affect adherence &amp; bias,</td>
</tr>
<tr>
<td></td>
<td>• Respect &amp; Values on Bias and</td>
</tr>
<tr>
<td></td>
<td>• Personal Experiences contribute to bias</td>
</tr>
<tr>
<td>2. Career and Professional Development, Provider’s Background, Patient Care</td>
<td>Merged from:</td>
</tr>
<tr>
<td></td>
<td>• Career Development &amp; Background,</td>
</tr>
<tr>
<td></td>
<td>• Healthcare Systems awareness and challenges,</td>
</tr>
<tr>
<td></td>
<td>• Patient Care Treatment, Satisfaction &amp;</td>
</tr>
<tr>
<td></td>
<td>• Success, Patient Centered Care, Policy &amp;</td>
</tr>
</tbody>
</table>

133
<table>
<thead>
<tr>
<th>Coded Conceptual Themes</th>
<th>Original individual &amp; grouped concepts merged into main conceptual themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Regulations, Professional Development &amp; Identity, Professionalism growth, integrity, affect on bias, Questioning workplace culture &amp; dynamics, Treatment Challenges, This is my purpose, Teamwork, Teaching, Stress, Time, Uncertainty and Understanding</td>
<td></td>
</tr>
<tr>
<td>4. Diversity Inclusion, Relational Communications-Interpersonal Relationships, Geography</td>
<td>Merged from: Defining Treatment Success, Disarming patients’ prejudices,</td>
</tr>
<tr>
<td>Coded Conceptual Themes</td>
<td>Original individual &amp; grouped concepts merged into main conceptual themes</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Discrimination, Diversity, Inclusion,</td>
<td></td>
</tr>
<tr>
<td>• Acceptance, Geography, Injustice,</td>
<td></td>
</tr>
<tr>
<td>• Racial Discrimination,</td>
<td></td>
</tr>
<tr>
<td>• Doctor/Patient Relationship,</td>
<td></td>
</tr>
<tr>
<td>• Education, Career Interests, Inequalities,</td>
<td></td>
</tr>
<tr>
<td>• Barriers to Learning,</td>
<td></td>
</tr>
<tr>
<td>• Empathy</td>
<td></td>
</tr>
<tr>
<td>• Encouragement/Engagement/Equality,</td>
<td></td>
</tr>
<tr>
<td>• Ethics, Ethical Concerns-Unequal Treatment leads to Bias,</td>
<td></td>
</tr>
<tr>
<td>• Helping, Honesty, Humanity &amp; Injustice,</td>
<td></td>
</tr>
<tr>
<td>• Interpersonal Skills, Factors &amp; Relationships,</td>
<td></td>
</tr>
<tr>
<td>• Philanthropy and Personal growth</td>
<td></td>
</tr>
</tbody>
</table>

5. Negative Emotions & Experiences

Merged from:

• Adversity, Aggression, Ambiguity, Anger, Anxiety, Apology, |
• Avoidance of confrontation, |
• Bad luck, Behavioral problems, |
• Communication difficulties, |
• Conflict with coworkers,
<table>
<thead>
<tr>
<th>Coded Conceptual Themes</th>
<th>Original individual &amp; grouped concepts merged into main conceptual themes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Confusion, Contradiction, Criticism,</td>
</tr>
<tr>
<td></td>
<td>• Difficult conversations,</td>
</tr>
<tr>
<td></td>
<td>• Difficult family members,</td>
</tr>
<tr>
<td></td>
<td>• Disapproval, Disapproval, or criticism,</td>
</tr>
<tr>
<td></td>
<td>• Disbelief, Displeasure, Disrespect,</td>
</tr>
<tr>
<td></td>
<td>• Disrespectful behavior, Doubt,</td>
</tr>
<tr>
<td></td>
<td>• Fatigue, feeling constrained, Feeling misunderstood,</td>
</tr>
<tr>
<td></td>
<td>• Feeling of being undervalued, Feeling of insignificance,</td>
</tr>
<tr>
<td></td>
<td>• Feeling underestimated, Frustration,</td>
</tr>
<tr>
<td></td>
<td>• Helplessness, Homelessness,</td>
</tr>
<tr>
<td></td>
<td>• Incomprehension, Inequality, Injustice,</td>
</tr>
<tr>
<td></td>
<td>• Insecurity, Interruption,</td>
</tr>
<tr>
<td></td>
<td>• Job frustration, Judgmental attitude,</td>
</tr>
<tr>
<td></td>
<td>• Lack of empathy, Lack of support, Lack of trust,</td>
</tr>
<tr>
<td></td>
<td>• Limitations, Loneliness,</td>
</tr>
<tr>
<td></td>
<td>• Misrepresentation, Mistakes, Mistrust,</td>
</tr>
<tr>
<td></td>
<td>• Misunderstanding,</td>
</tr>
<tr>
<td></td>
<td>• Negative effects, Negative experience</td>
</tr>
<tr>
<td>Coded Conceptual Themes</td>
<td>Original individual &amp; grouped concepts merged into main conceptual themes</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Negative past experiences, Negative past experiences influencing current behavior,</td>
<td></td>
</tr>
<tr>
<td>• Professional frustration, Regret, Skepticism, Stress,</td>
<td></td>
</tr>
<tr>
<td>• Struggle with Uncertainty and Unfair treatment</td>
<td></td>
</tr>
<tr>
<td>6. Open Mindedness, Drivers of Behaviors Merged from:</td>
<td></td>
</tr>
<tr>
<td>• What drives certain behaviors,</td>
<td></td>
</tr>
<tr>
<td>• Open-mindedness and impact on Bias and</td>
<td></td>
</tr>
<tr>
<td>• Neurodiversity/ableism/no exposure to diverse groups</td>
<td></td>
</tr>
<tr>
<td>7. Personal development, walk in others shoes, life influences Merged from:</td>
<td></td>
</tr>
<tr>
<td>• Dental Care,</td>
<td></td>
</tr>
<tr>
<td>• Provider Bias,</td>
<td></td>
</tr>
<tr>
<td>• Recovery,</td>
<td></td>
</tr>
<tr>
<td>• Do I see myself in my patients?</td>
<td></td>
</tr>
<tr>
<td>• Influence of others in becoming providers,</td>
<td></td>
</tr>
<tr>
<td>• Pride, Provider Personal Development, Psychiatry,</td>
<td></td>
</tr>
<tr>
<td>• Putting yourself in someone else shoes, and recognizing your own Bias</td>
<td></td>
</tr>
<tr>
<td>Coded Conceptual Themes</td>
<td>Original individual &amp; grouped concepts merged into main conceptual themes</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8. Self-Reflection on Psychosocial Factors &amp; Racial Discrimination</td>
<td>Merged from:</td>
</tr>
<tr>
<td></td>
<td>• Prejudice,</td>
</tr>
<tr>
<td></td>
<td>• Psychological Analysis</td>
</tr>
<tr>
<td></td>
<td>• Responsibility and Burden,</td>
</tr>
<tr>
<td></td>
<td>• Psychosocial Factors &amp; Bias</td>
</tr>
<tr>
<td></td>
<td>• Racial discrimination, and reflection</td>
</tr>
<tr>
<td>9. Self-Awareness, Personal Values, Bias &amp; Inequality</td>
<td>Merged from:</td>
</tr>
<tr>
<td></td>
<td>• Social Awareness/Bias/inequality &amp; understanding</td>
</tr>
<tr>
<td></td>
<td>• Self-awareness, personal values, positivity</td>
</tr>
<tr>
<td>10. Sociocultural, psychological distress, self-preservation</td>
<td>Merged from:</td>
</tr>
<tr>
<td></td>
<td>• Sociocultural factors and bias,</td>
</tr>
<tr>
<td></td>
<td>• Psychological Distress,</td>
</tr>
<tr>
<td></td>
<td>• Issues &amp; Factors on Values,</td>
</tr>
<tr>
<td></td>
<td>• Support &amp; Trust in Alignment,</td>
</tr>
<tr>
<td></td>
<td>• Well-being &amp; self-preservation and</td>
</tr>
<tr>
<td></td>
<td>• Personal Attributes or Characteristics for providers</td>
</tr>
</tbody>
</table>
Appendix G: 2016 Physician Bias Infographic

Figure 7

Physician Bias

*Note. Medscape Lifestyle Report 2016: Bias and Burnout (Peckham, 2016).*
The Effects of Bias on Patient Care

A small percentage of physicians indicated that bias actually affected their treatment, but of those who did:

72% reported that emotional problems had a negative effect on treatment.

61% reported that weight bias also had a negative effect on treatment.

These physician biases have been observed in many studies to elicit negative attitudes, including lack of emotional rapport with patients. However, not all bias had a negative effect on treatment.

25% reported that their own bias resulted in overcompensation and special treatment of the patient, leading to positive results.

Source: Medscape Lifestyle Report 2016 | medscape.com

Figure 8

The Effects of Bias on Patient Care

Figure 9

Bias by Region

Appendix H: Percentage of Total Groundedness by Code

Table 9

*Percentage of Total Groundedness by Code*

<table>
<thead>
<tr>
<th>Code</th>
<th>Sum of groundedness</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Career and professional development, provider’s background, patient care</td>
<td>25.38%</td>
</tr>
<tr>
<td>● Bias acceptance, provider professional and personal experience with bias</td>
<td>20.59%</td>
</tr>
<tr>
<td>● Diversity inclusion, relational communications-interpersonal relationships, geography</td>
<td>13.78%</td>
</tr>
<tr>
<td>● Sociocultural, psychological distress, self preservation</td>
<td>10.95%</td>
</tr>
<tr>
<td>● Community Awareness, Cultural Factors &amp; Institutional structures</td>
<td>6.26%</td>
</tr>
<tr>
<td>● Personal development, walk in others’ shoes, reciprocal influence</td>
<td>5.88%</td>
</tr>
<tr>
<td>● Self-reflection on psychosocial factors &amp; racial discrimination</td>
<td>5.39%</td>
</tr>
<tr>
<td>● Open mindedness, drivers of behaviors</td>
<td>4.68%</td>
</tr>
<tr>
<td>● Negative emotions &amp; experiences</td>
<td>4.30%</td>
</tr>
<tr>
<td>● Self awareness, personal values, bias &amp; inequality</td>
<td>2.78%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Figure 10

Percentage of 'Groundedness' by 'Code'

Percentage of Groundedness by Code
## Appendix I: Average Number of Groups in Each Code and Sum of Groundedness

### Table 10

<table>
<thead>
<tr>
<th>Thematic codes</th>
<th>Number codes of groups</th>
<th>Sum of groundedness</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Diversity inclusion, relational communications-interpersonal relationships, geography</td>
<td>22</td>
<td>253</td>
</tr>
<tr>
<td>● Career and professional development, provider’s background, patient care</td>
<td>20</td>
<td>466</td>
</tr>
<tr>
<td>● Negative emotions &amp; experiences</td>
<td>18</td>
<td>79</td>
</tr>
<tr>
<td>● Bias acceptance, provider professional and personal experience with bias</td>
<td>14</td>
<td>378</td>
</tr>
<tr>
<td>● Sociocultural, psychological distress, self preservation</td>
<td>12</td>
<td>201</td>
</tr>
<tr>
<td>● Community awareness, cultural factors &amp; institutional structures</td>
<td>10</td>
<td>115</td>
</tr>
<tr>
<td>● Personal development, walk in others’ shoes, reciprocal influence</td>
<td>10</td>
<td>108</td>
</tr>
<tr>
<td>● Self-Reflection on psychosocial factors &amp; racial discrimination</td>
<td>7</td>
<td>99</td>
</tr>
<tr>
<td>● Self awareness, personal values, bias &amp; inequality</td>
<td>7</td>
<td>51</td>
</tr>
<tr>
<td>● Open Mindedness, drivers of behaviors</td>
<td>5</td>
<td>86</td>
</tr>
</tbody>
</table>

Average number of codes per thematic code: 13

Average sum of groundedness: 1836
Figure 11

Average Number of Groups, Sum of Groundedness by Thematic Codes
Appendix J: Total Number of Themed Codes for All Participants by Race

Table 11

Total Number of Themed Codes for All Participants by Race

<table>
<thead>
<tr>
<th>Provider race</th>
<th>Sum of coded themes totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>953</td>
</tr>
<tr>
<td>Latina</td>
<td>136</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>51</td>
</tr>
<tr>
<td>White</td>
<td>1025</td>
</tr>
</tbody>
</table>

Figure 12

Total Number of Themed Codes for All Participants by Race
### Appendix K: Participants’ Code, Pseudonyms, Gender, and Race

#### Table 12

<table>
<thead>
<tr>
<th>Number</th>
<th>Specialty</th>
<th>Provider ID</th>
<th>Pseudonyms</th>
<th>Gender &amp; race</th>
<th>Age range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Psychiatrist</td>
<td>RM03032022</td>
<td>Atticus</td>
<td>WF</td>
<td>40-49</td>
</tr>
<tr>
<td>2</td>
<td>Psychiatrist</td>
<td>AQ04132022</td>
<td>Adonia</td>
<td>WF</td>
<td>30-39</td>
</tr>
<tr>
<td>3</td>
<td>Psychiatrist</td>
<td>PH03282022</td>
<td>Alec</td>
<td>WM</td>
<td>60-69</td>
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### Appendix L: Data Analysis Initial Steps

#### Table 13

**Data Analysis Initial Steps**

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