Managing the Intersection Between Implicit Bias, Healthcare Disparities, and Ourselves

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Disclosures

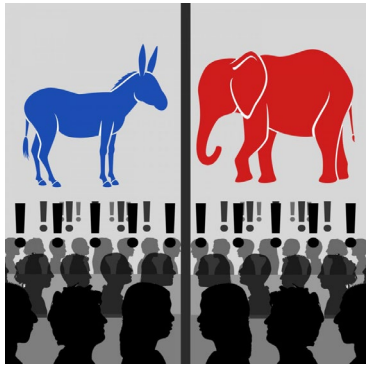
- **Center to Advance Palliative Care:** I have served as a content contributor and advisor for their upcoming module on Implicit Bias

Objectives

- Explore how implicit bias can contribute to team dynamics and healthcare disparities
- Evaluate a framework for how cultural humility and individuation can mitigate the impact of healthcare disparities
- Demonstrate some practical ways palliative care teams can manage implicit bias
- Identify the challenges the pandemic may present to communication in communities disproportionally affected by healthcare disparities

Why I am here today?

Point of View



Important Terms:

- **Healthcare Disparities:** differences in health care between groups who have economic, social, and environmental disadvantages
- **Implicit Bias:** is the bias in judgment and/or behavior that results from subtle cognitive processes (e.g., implicit attitudes and implicit stereotypes) that often operate at a level below conscious awareness and without intentional control
- **Structural Racism**: societal structures/polices that excludes people from a minority background from accessing and participating in social institutions
- **Cultural Competency:** is the ability to understand, communicate with and effectively interact with people across cultures; gaining knowledge of different cultural practices and world views

Guiding Principles

Implicit Bias:

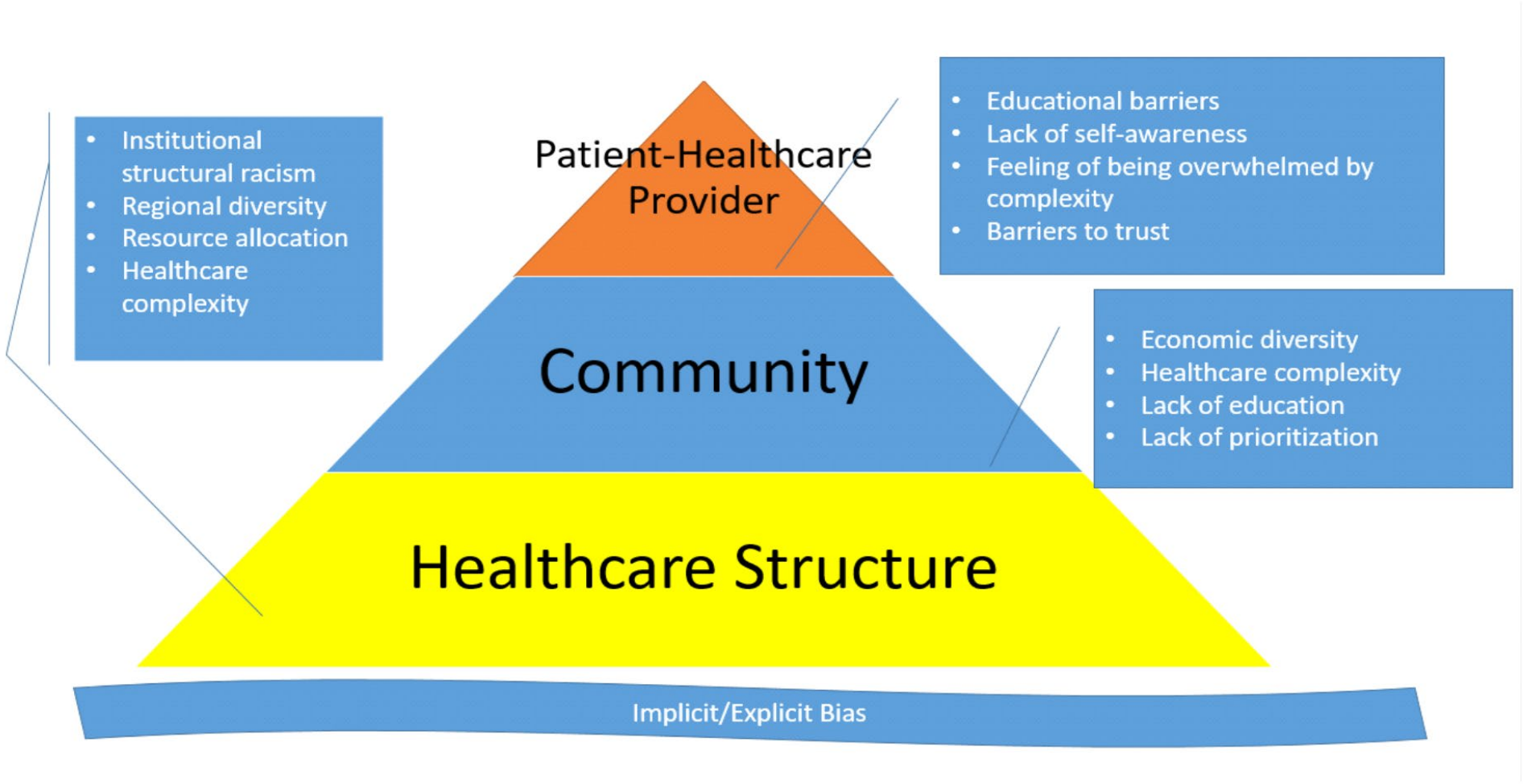
- Having them makes you human
- They have some utility
- They are malleable

Managing implicit bias:

- Provides a deeper understanding of your reactions
- Returns a sense of control and agency
- Empowering
- Leads to more fulling patient/provider/institutional relationships

Butler M et al. Improving Cultural Competence to Reduce Health Disparities; Agency for HealthCare Research and Quality; Mar 2016

Healthcare Disparities Pyramind



What are the questions we are trying to answer?

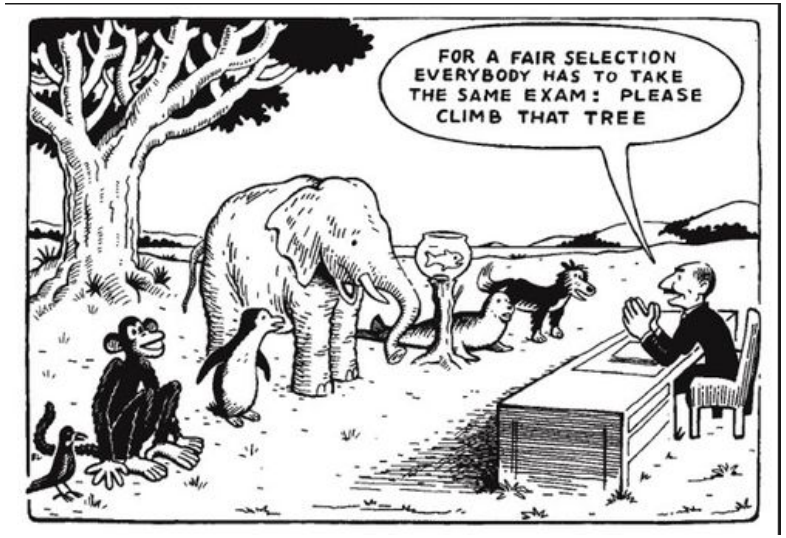
- How does implicit bias affect healthcare disparities?
- How does implicit bias affect in teams?
- How can you manage implicit bias in your team?
- How does implicit bias affect treatment and teams in a pandemic?

Looking Inward

Implicit Bias Impact

- Beyond race: We should think about implicit bias in a broader sense, looking beyond race/ethnicity to factors such as: gender, generation/age, transgender, women, children, social economic status, language, disability, LGBQ, political affiliation, prisoner, religion….etc.

- *"Basically, if you are looking at someone who is not you, you should consider if or how implicit bias maybe affecting your actions"*



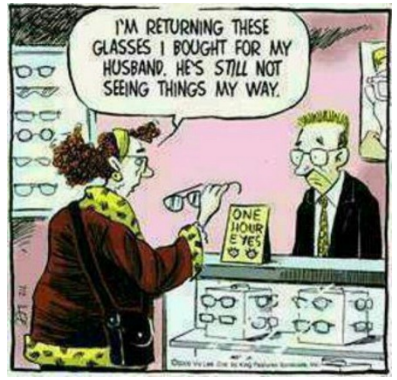
Implicit Bias

- Not recognizing the impact of implicit bias can prevent providers from providing the type of care that our patient's need and deserve
- Implicit bias can rob the provider of the patient interactions along with the type of care that we find fulfilling, leading to frustration and contributing to burnout
- *"I came here to help and I'm not helping, can't they see I am looking out for them"*

When thinking about effects of implicit biases in healthcare we often focus on only the provider with the hope that if the provider is aware and manages their biases, that will be the key to an outcome.

Awareness of one's own biases allow for an opportunity have the best possible communication but may not affect the outcome.

The awareness may lead to better understanding of patient, better patient advocacy, and acceptance of patient's point of view.

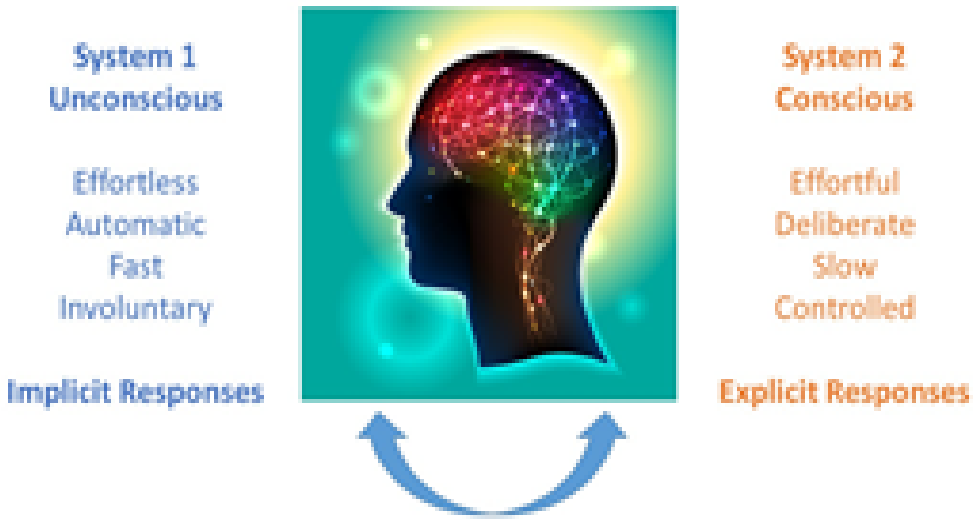


Butler M et al. Improving Cultural Competence to Reduce Health Disparities; Agency for HealthCare Research and Quality; Mar 2016

Implicit Bias

First we need to understand us.

Why do we struggle with this?



http://www.sensanalysis.com/news/implicit-vs-explicit-product-research-which-one-should-be-conducted/

Implicit Bias in Healthcare: What do we know?

- In systematic review published in the American Journal of Public Health in 2015 concluded that: “Although some associations between implicit bias and healthcare outcomes were nonsignificant, results showed that implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient outcomes”

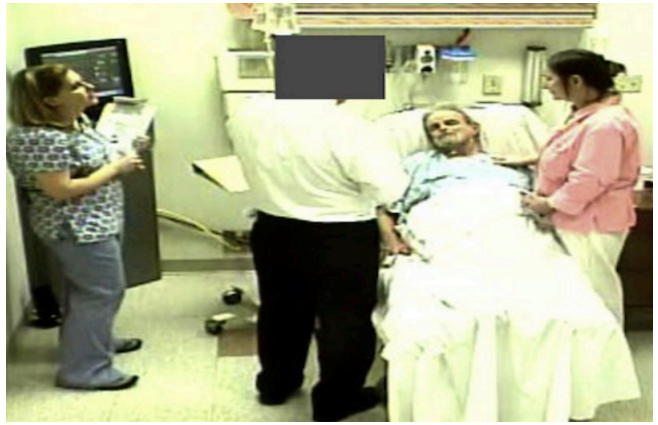
- A study showed that racial bias reduces empathic sensorimotor responses to patients' complaints of pain

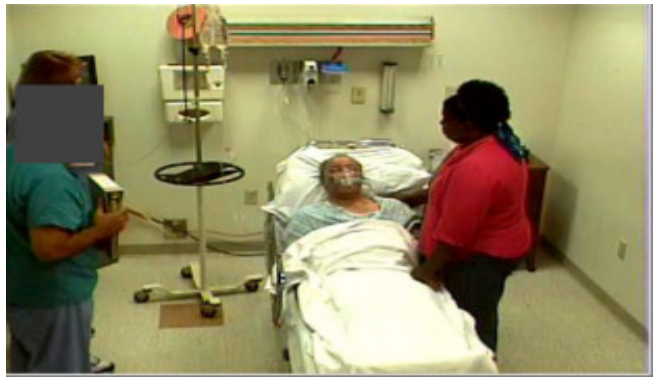
Avenanti et al. Racial bias reduces empathic sensorimotor resonance with other race pain. Current Biology 2010
Hall W. et al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. Amer J of Pub Health; 2015

Implicit Bias in Healthcare: What do we know?

Physician Body Language in Communication with Dying Patients:

- Physician verbal communication similar
- White physicians less likely to touch or make eye contact with non-white patient and more likely to stand by the door





Elliot AM et al. Journal of Pain and Symptom Management. 2016

- In a qualitative study of patient–doctor communication found that physicians' implicit pro-White bias on the IAT correlated with Black patients' perceptions of poorer communication and lower quality care

- Black patients were less satisfied with physicians who had low explicit but high implicit race bias, rating them as less warm, friendly, and team-oriented compared to physicians with equal degrees of implicit and explicit bias

- Study showed implicit stereotype-based bias contributed to gender differences in the diagnosis of COPD, female patients were more likely to receive a diagnosis of asthma or a non-respiratory problem, while identical male patients were more likely to be diagnosed with COPD with same symptom presentation

Cooper LA, Roter DL et al. The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. Am J Public Health. 2012;102(5):979–87.
Penner LA, et al. Aversive racism and medical interactions with Black patients: a field study. J Exp Soc Psychol. 2010;46(2):436–40
Chapman KR et al. Gender bias in the diagnosis of COPD. Chest. 2001;119(6):1691–5.

Implicit Bias Deconstructed: Unconscious Biases Impact Important Decisions

Affinity Bias – favor a person with whom we share something in common, ***"They are Geriatric fellowship trained, they will be the best person lead this community health care effort."***

Conformity Bias/Groupthink – may play out in panel interviews; individuals tend to conform to their perception of the majority of the group ***"Yeah his references were great but after you mention it, I got a weird vibe in the interview, he may not be a good fit"***

Perception Bias– The tendency to form simplistic stereotypes and assumptions about certain groups of people that make it very difficult to make an objective judgement about members of that group; ***"Of course they don't want the vaccine don't you remember Tuskegee; we need to create a culturally competent tool to educate them (teach them to trust)"***

Implicit Bias Deconstructed: Unconscious Biases Impact Important Decisions

Attribution Bias – systematic assumptions about reasons for our own and others' behaviors; e.g., self-serving attributions may associate our own successes with hard work, intelligence while those of others as lucky. ***"I am so happy you got that job; we needed someone of color in leadership"***

Confirmation Bias – once we make a positive or negative assessment about a person, we look for justification that our decision is correct, ***"See told you this patient was not going to do well, I just told them they were on to many medications… It would have gone so much better if they called me sooner."***

Bias and Research: Anti-racist Approach

- Researchers take and proactive anti-racist approach to data collection and question formation
  - **Avoid pathologizing marginalized communities' preferences verses starting from a place of accepting their point of view as having validity**
- Considering structural racism contributions to creating disparities and naming it
- Researchers should engage in not just in transient implicit bias training but receive on going training in implicit bias and anti-racist research practices
- Public Health Critical Race Praxis (PHCRP): based on **Critical Race Theory**
  - CRT: race is a social construct, and that racism is not merely the product of individual bias or prejudice, but also something embedded in legal systems and policies

Owens, Kellie, and Alexis Walker. "Those designing healthcare algorithms must become actively anti-racist." Nature medicine 26.9 (2020): 1327-1328.
Brown, C. E., Curtis, J. R., & Doll, K. M. (2021). A race-conscious approach toward research on racial inequities in palliative care. Journal of Pain and Symptom Management
https://www.edweek.org/leadership/what-is-critical-race-theory-and-why-is-it-under-attack/2021/05

Principle	Definition	PHCRP approach to (palliative care) research
Race Consciousness	**Awareness of one's racial position**	**Clarify one's own racial biases and actively consider how they may impact study design and interpretation choices in palliative care and end-of-life research, especially within the context of studying diverse patient populations**
Primacy of Racialization	Racial inequities and other societal problems are due largely to racial stratification	Include factors hypothesized to reflect and influence structural racism in studies on inequity rather than solely race
Race as Social Construct	**Race is derived from social, political, and historical forces**	**Treat race as a risk factor for racism and other discriminatory experiences**
Ordinariness	Race is embedded in the social fabric of society	Racism is subtle and ubiquitous, including within healthcare environments
Structural determinism	Macro-level forces drive and sustain racial inequities	Consider multilevel healthcare policy and structural factors that promote and perpetuate racial inequities in palliative care
Social construction of knowledge	Established knowledge in a discipline can be reevaluated using antiracist analyses	Clarify how societal position of marginalized patients influences enrollment into research studies and how this affects results and impact on future study designs. avoid conflation of race with racism.
Critical approaches	**Develop a more comprehensive understanding of one's own biases in research**	**Always consider alternative explanations for inequities in palliative care than those traditionally posited, with emphasis on perspectives from those traditionally disempowered**
Voice	**Prioritize the perspective of marginalized persons, "centering the margins"**	**Center the margins" by making perspectives of racially marginalized patients in research a priority**
Disciplinary self-critique	Examine how discipline norms influences the generation of research questions, knowledge, and its impact on broader society	Examine how research norms (e.g., quality of life) influence interpretation of racial outcomes in palliative care and impacts conventional knowledge in palliative care and medicine more broadly
Intersectionality	**Treating social categories like race, gender, and sexual identity as interlocking, rather than additive**	**Awareness of unique and negative history of treatment of patients with multiple marginalized identities in the medical system**

Brown, C. E., Curtis, J. R., & Doll, K. M. (2021). A race-conscious approach toward research on racial inequities in palliative care. Journal of Pain and Symptom Management.,

Modified Table 1 Public health critical race praxis in palliative care and end-of-life research

Bias Palliative Care Research???

What is the lens we look through?

Patients of color utilize hospice less and receive more aggressive care at end of life:

What is wrong with them and how do we fix it?

- Lack of education, misconceptions
- Lack of trust
- Belief in miracles, fatalistic

What is wrong with is us? How do we fix it? do we need to fix it?

Can we accept the choice and still provide care?

- Examine our education (Is it accurate?)
- What could the industry do the earn the trust? How did we lose it? Why do we deserve it?
- Could we adjust our service to the value system of the patients we are serving?
- ***Anti-Bias Approach***

Hundreds of hospice centers in U.S. get failing grades
www.nbcnews.com › news › us-news › hundreds-hospi...
Jul 9, 2019 — Hundreds of **hospice** facilities had serious, life-threatening deficiencies, according to an investigation by the Department of Health and Human

When the Hospice Care System Fails - The New York Times
www.nytimes.com › Well › Live
Oct 17, 2018 — Your father was gasping for breath. The **hospice** care providers had not yet trained you in how to respond. So you called 911.

No One Is Coming': Hospice Patients Abandoned At Death's ...
khn.org › news › no-one-is-coming-hospice-patients-ab...
Oct 26, 2017 — But 21 percent of **hospices**, which together served over 84,000 patients, failed to provide either form of crisis care in 2015, according to CMS.

When the Hospice Care System Fails – Dying & Death Talk
dyinganddeathtalk.com › 2018/11/17 › when-the-hospi...
Nov 17, 2018 — When I saw that your 90-year-old father was in our emergency department, after being resuscitated while on home **hospice**,

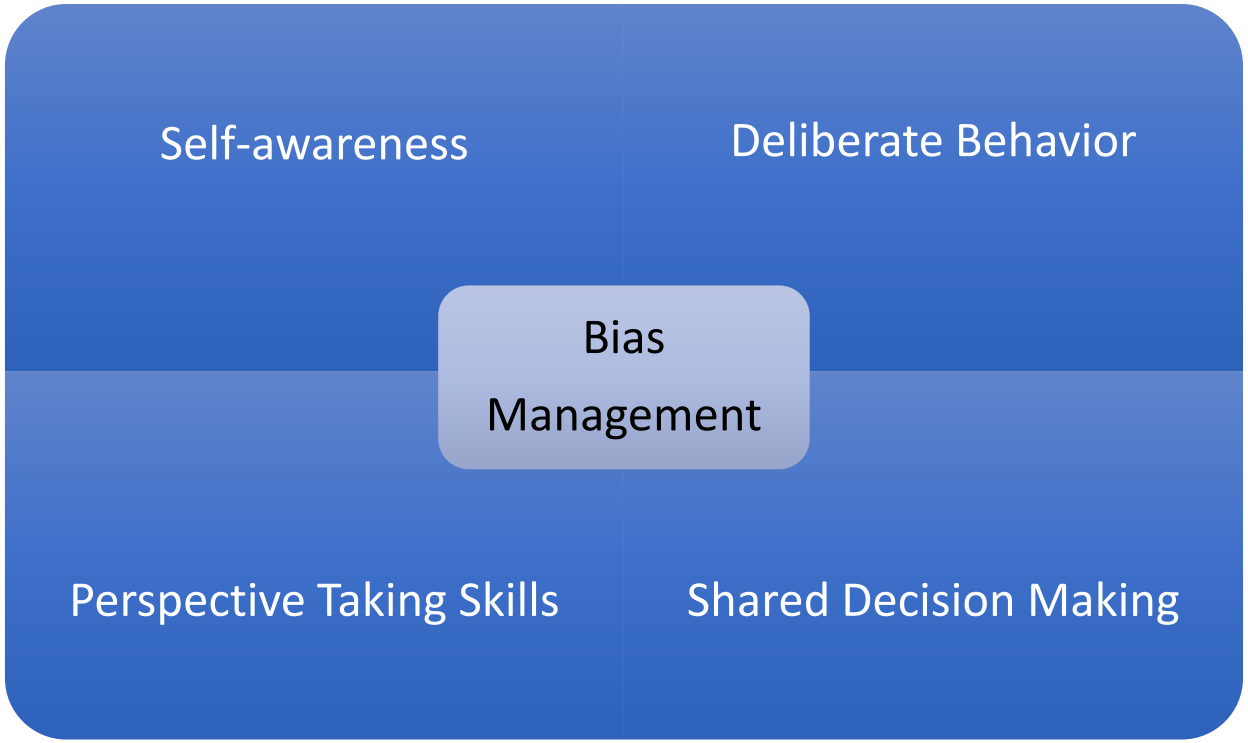
Dozens of For-Profit Hospices Fail to Visit Dying People in ...
www.newsweek.com › ... › Medicare › Medicaid
Nov 15, 2019 — Hundreds of private **hospices** discharged most dying patients in 2017 ... **hospices** in a nationwide survey had serious deficiencies

CASE

- Mr. Martinez is 72 yro male is brought to the ER for the 5th time in the last 12 months with mild confusion, shortness of breath, and poor appetite by his girlfriend.
- Key elements: *(healthcare trigger words)*
  - “non-compliant”
  - “chronic pain”
  - “disability”
  - “angry”
  - “history of illicit drug use”
  - “frequent ED visits”

You are called by the ER provider, ***“He is here in the ED, his family is demanding admission. He is a little confused, but shortness of breath is not so bad. I really can’t find anything.” Can you come and help with disposition?”***

Strategy for Managing Implicit Bias



Self awareness

- Study by Michelle Van Ryn published in 2016 concluded that
  - “Most physicians were unaware of their own biases”
  - “Research shows that unintentional bias on the part of physicians can influence the way they treat patients from certain ethnic and racial groups”

- Study in Journal of General Internal Medicine in 2013 reviewed literature on implicit bias pertaining to physicians which concluded:
  - “The contribution of implicit bias to healthcare disparities could decrease if all physicians acknowledge their susceptibility to it, and deliberately practice perspective taking and individuation when providing patient care”

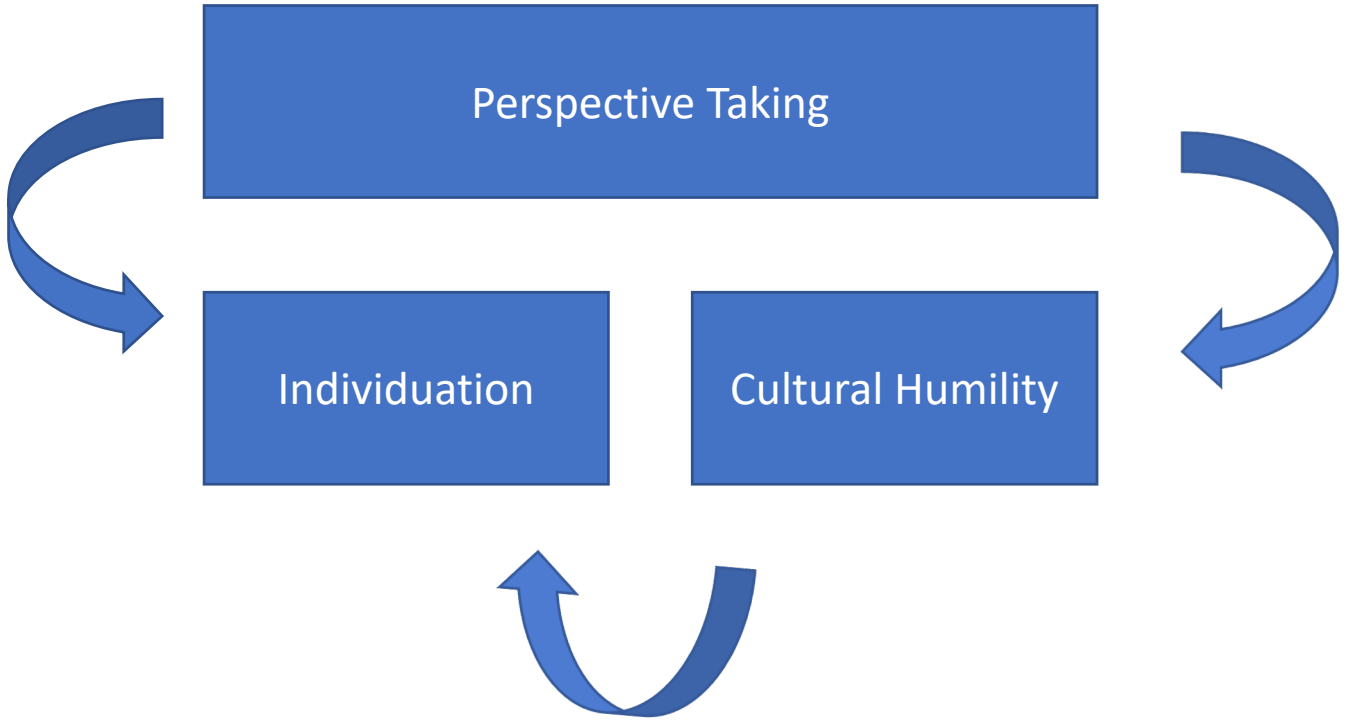
Chapman EN et al. Physicians and implicit Bias; How Doctors May unwittingly perpetuate healthcare disparities. J Gen Intern Med. 2013
Van Ryn M. Minn med. 2016 Mar-Apr

How do you/team develop self awareness?

- The Implicit Association Test (IAT): measures attitudes and beliefs that people may be unwilling or unable to report. It can show an implicit attitude that person may not be aware
  - Confront one's own bias
- Pre-brief: prior to the consult being aware of your feelings (mindfulness) /discuss with IDT team
  - Deactivate the trigger words
  - Awareness how you felt receiving the consult
- Debrief: discuss your case with team members
  - Be open to challenges and different perspectives
  - *"What's another way to look at this?"*

https://implicit.harvard.edu/implicit/

Perspective taking - ability to look beyond one's own point of view to consider how someone else may think and feel



Healey, M. L., & Grossman, M. (2018). Cognitive and Affective Perspective-Taking: Evidence for Shared and Dissociable Anatomical Substrates. *Frontiers in neurology*, *9*, 491. https://doi.org/10.3389/fneur.2018.00491

Perspective Taking: “Road to empathy”

- Cultural Humility: is defined as a person recognizing the limitations of their own understanding of how a person may define their own cultural identity. It’s a humble and respectful attitude towards individuals of other cultures that allows a provider to challenge their own biases and assumptions.

- Individuation: involves conscious effort to focus on specific information about an individual, making it more salient in decision-making than that person’s social category information

Chapman, E.N., Kaatz, A. & Carnes, M. Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities. *J GEN INTERN MED* **28,** 1504–1510 (2013).

Individuation

- Although a person may belong to certain social class in society that does not mean that they are making decisions based on that framework

- Humans maybe apart of many social constructs, the decisions they make under stress maybe made from a different value system, than when they are not under stress

- Cultural humility is vehicle that can get you to individuation
  - *" Cultural humility will help me understand you, individuation helps me understand the you that is making the decision at the time"*

Case

- Mr. Martinez is veteran and lives in rural Ga with his girlfriend of 10 yrs. They have been heating the house with a wood stove, since she lost her job as a CNA. She missed to many days because he was feeling poorly, and she has epilepsy which has been worse recently. She has a line on a new job.

- Mr. Martinez over last year has become less mobile. He is falling and getting confused at night. He is not eating meals left for him when his girlfriend is working.

- He has been using medical cannabis for chronic back pain (gunshot injury in a military training exercise) under supervision of naturopathic provider which allowed him to stop opioids, but his supplier has been shut down, GA has no in state dispensaries

- She called the hospital back angry after his last discharge on a Saturday because he was discharged on several medications including opioids and an expensive antibiotic which none of the pharmacies in his area carry and they are not open on Sunday. They lacked transportation back to the hospital. ***"He is just like he was when he first came to the hospital!!"***

Do we always know what we think we know?

- A recent qualitative study evaluating views of healthcare disparities experts, community members, African-American patients and care-givers facing serious illness
  - Results:
    - Patients and Caregivers: trusted their medical teams; wanted prognostic information communication; and expressed a desire to prepare for the EOL
    - Healthcare Disparities experts: mistrust, spirituality, religiosity, desire to limit prognostication, and fatalism as barriers to effective advance care planning and more aggressive end of life care which is consistent with past published literature

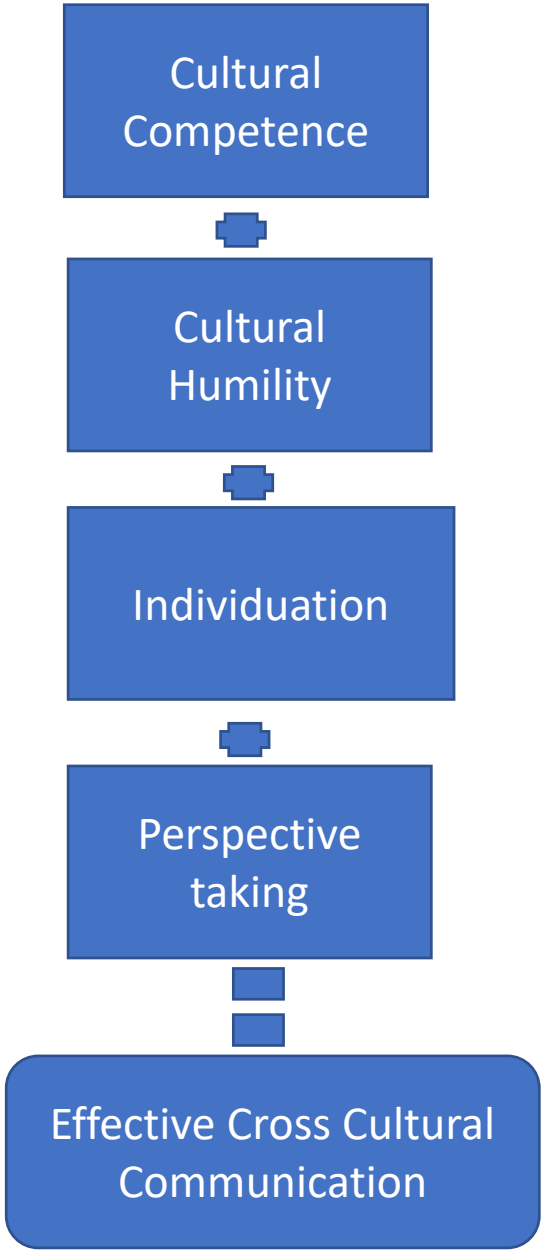
Pitfall of leaning too heavily on cultural competency versus leading with cultural humility.

"Even if our behavior doesn't change the reasoning for it may with time."

Sanders JJ, Johnson KS, Cannady K, Paladino J. et al. From barriers to assets: rethinking factors impacting advance care planning for African Americans. Palliative & Supportive care. 2019; 17(3), 306-313.

So, do we still need to be culturally competent?

- **Short Answer: Yes**
  - There is no way to know everything about a someone culture, but you should have a working knowledge of cultural norms of patients you are treating
  - *"We would never attempt go into a patient's room without reviewing the medical record; nor would we develop treatment plan without talking and examining to a patient"*
  - The inability to know everything about someone's culture is not a reason to not seek knowledge of what you can know



The Mirror Effect: Being mindful of biases allows us to consider that maybe it is not the patient's original feeling but a reflection of what is being shown to them.

"If I suspect you don't trust me
I will not trust you.
If I suspect, you will not talk to me
I will not talk to you.
If I suspect, you will not understand me.
I won't explain to you.
That is how I know you are who I thought you were" --Kc

- Study: Physicians were 23% more verbally dominant and engaged in 33% less patient-centered communication with Black pts than with White patients.
- Study: "strong link between **ageism**, in the form of negative stereotypes, prejudice, and discrimination toward older people, and risks to their physical and mental health- education and intergenerational contact can serve as the basis of effective interventions to reduce ageism"

Johnson, R. L., Roter, D., Powe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient–physician communication during medical visits. *American journal of public health*, *94*(12), 2084-2090. Mitchell, A., Somers, M., Bauder, A., & Lewis, D. (2018). Burnes, David, et al. "Interventions to reduce ageism against older adults: A systematic review and meta-analysis." American Journal of Public Health 109.8 (2019): e1-e9.

Affective Flash

- We can develop cognitive beliefs that are consistent with our first emotional response
- This could influence our nonverbal behavior and set up essentially a negative feedback loop that reinforces our cognitive belief

Example: I'm going out to do a home visit and when I drive up I see a very large Confederate flag hanging over-the-door. What do you suppose my Affective Flash could be?

CASE

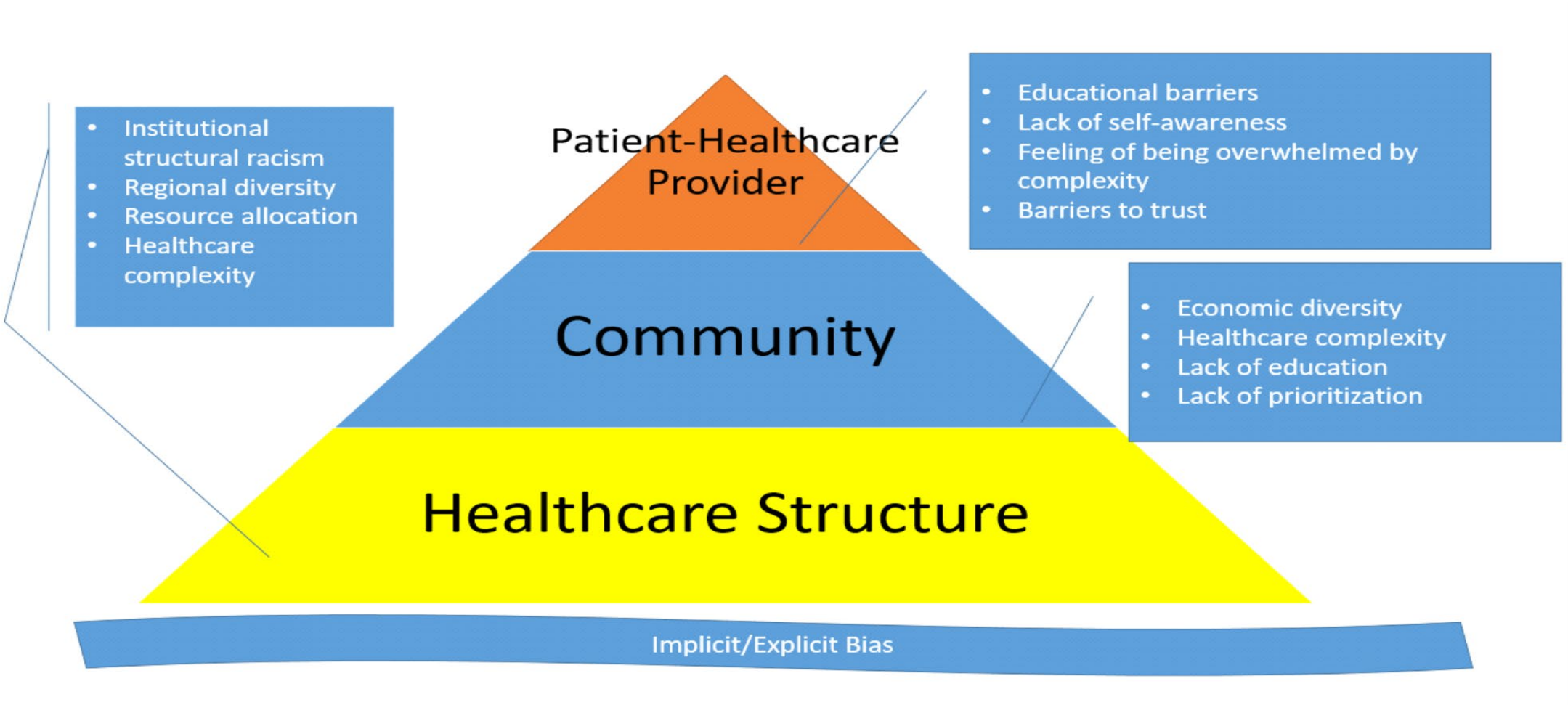
"non-compliant"
"chronic pain"
"disability"
"angry"
"history of illicit drug use"

- He can have a conversation with. He would prefer not be in the hospital again and he is tired of hospitalizations. ***"I am breaking down; I can't breathe well at home with the smoke from the stove."*** Since his girlfriend lost her job, he is worried that without his disability she will be homeless, and he won't discuss considering short-term rehab or code status with you.

- He has a good relationship with his Geriatric APP at the VA. He wants to discuss prognosis with him. Also, he is compliant with the meds his VA PCP prescribes. He can't fill medication from your system's specialist at the VA. ***" VA got programs; I can't figure out how to get them, they won't talk with her."***

- He trusts the doctors here; he just wants to understand what is happening. ***"They talk so fast; I am not always sure when I am sick. I'll do it if I have to. I don't know what my goals are…not to die today. Call Shelia…"***

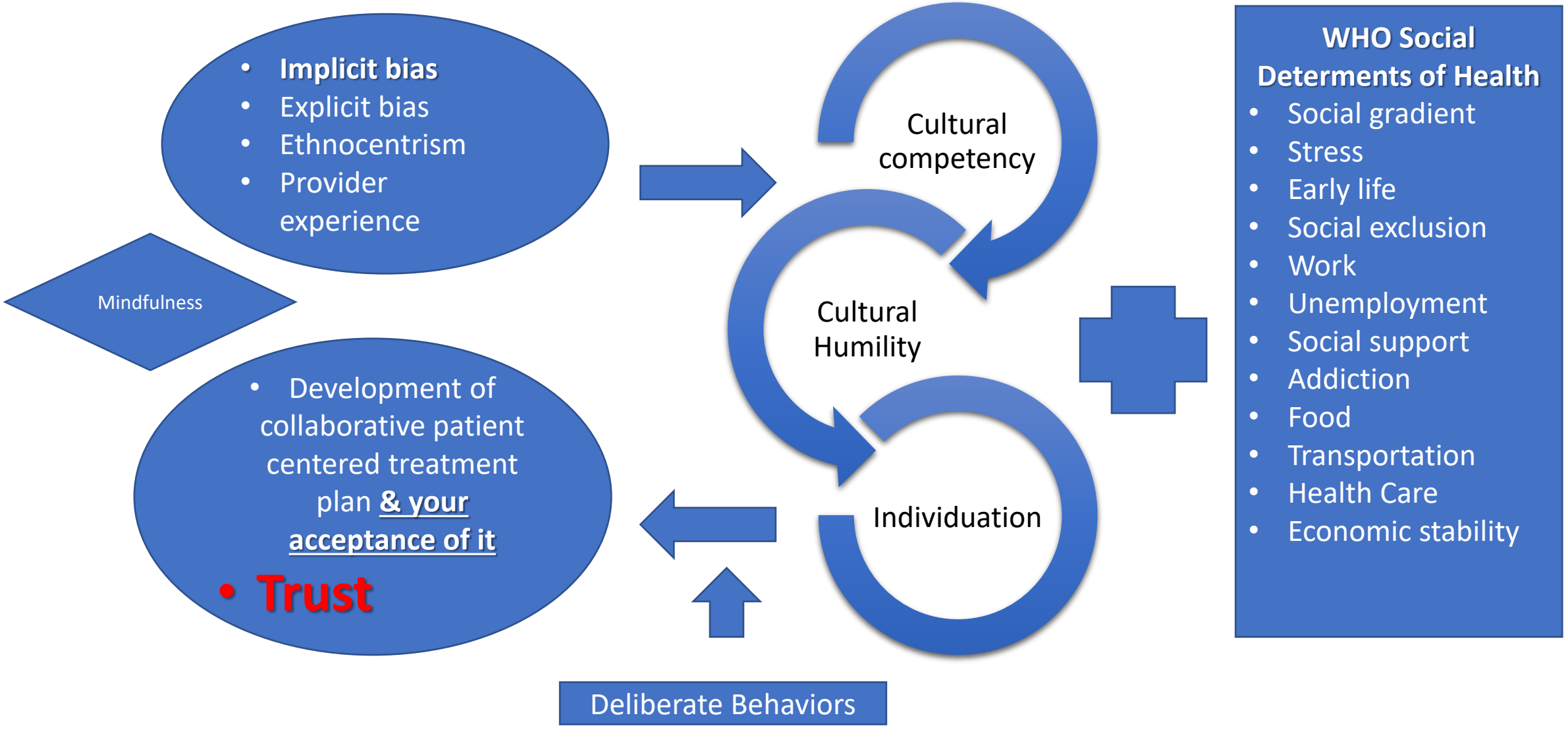
Healthcare Disparities Pyramind



Deliberate Behaviors

- Many providers possess natural abilities that make them good communicators
- When communication is difficult natural skills may become unreliable, because we are uncomfortable. Relying on consistent communication techniques promote equitable delivery of service that doesn't rely on our feelings & talent
  - *"Fix your face and get your mind right. Feel how you feel, it matters what you do."*
- Rely on deliberate behaviors such as: greetings, sitting with open posture, therapeutic silence, I am concerned/wish statements, empathic statements, communication tools etc.…

Tying it all together



Diversity, Equity, and Inclusion: 4 Parts of Creation

- Create a culture of naming
- Create safe space for others
- Create safe space for yourself
- Create an environment that promotes inclusion

Creating culture of naming

- If you see evidence of bias name it
  - Model ways to name bias in a direct and respectful manor
  - **Be an upstander vs a bystander**

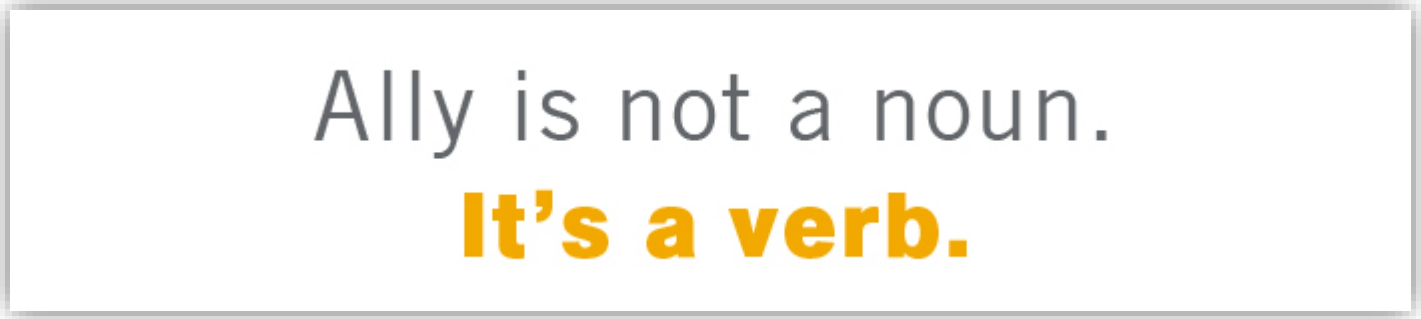
- Encourage others to name what they are seeing
  - Avoid being dismissive
  - Encourage team's member to explain their point of view
  - Validate feelings, even if you do not agree with point of view, you can provide encouragement and gratitude for their willingness to express their viewpoint
  - Make next steps

Create a safe space for others

- Your team should see you as a professional ally
- Foster a culture of positive regard for all colleagues
- Listen with intention
- When appropriate encourage discussion
  - Set ground rules
  - Respect your team fears and concerns they may have expressing their opinions
  - Do not force participation or “blind side” teammates
    - Give a “heads up” that you want to discuss a teammates concern and ask if they feel comfortable expressing concerns to the group
    - Do not dismiss fears colleagues may have concerning retaliation; address concerns

Being An Ally

- Educate yourself
- Own privilege
- Accept feedback
- Become a confidant
- Bring diversity to the table
- See something say something
- Reach out to marginalized co-worker
- Insist on true diversity
- Build a culture of allyship



https://hbr.org/2020/11/be-a-better-ally

Create a safe space for yourself

i need a minute to get my head straight.

- If you ask a question you will have to hear the answer
  - When you explore these issues, be ready to receive what they are saying
  - Some of what you hear may be difficult
  - Hearing someone does not obligate you to agree
- You have feelings and biases too (self-awareness)
  - Find a safe space for yourself to debrief and explore your feelings
  - Practice self compassion
- Take the time you need debrief and work through you own feelings before addressing other
  - You need to correct bias behavior in real-time; but the in-depth discussion can wait for you to work through your emotions
  - Avoid speaking and making decisions when you are emotionally fragile

Create an environment that promotes inclusion

- Foster an environment/culture that does not tolerates bias, micro-aggressions
- Model behavior that we want our teams to emulate
- Address directly, and with care and compassion when teams or colleagues slip into spaces that may inhibit inclusion
  - Acknowledge how easily we call can use language that can be offensive or bias
  - i.e., referring to patients as “drug seekers, crazy, redneck, scary, precious old man, cranky, sicklers…”

Oh and then there's the Pandemic

- Mr. Martinez presents back to the hospital in respiratory distress. He has an advanced directive from his last hospitalization which documented that he elected to be DNR/DNI on that admission. There is documentation that his girlfriend and daughter were present when he completed it and they are together in his car. ED physician gently explains his poor prognosis by phone and reviews his directive with them. ED physician recommends that he not be intubated according to his wishes. He also explains he is COVID 19 +.
  - Girlfriend: ***" Well you know he is not going to get one now, just because he is old, they think he should just die, he contributed more this country than most."***
  - Daughter: ***" I am the POA you do everything for my father."***
  - ED physician: ***"Call palliative care."***

Widely reported that COVID 19 is disproportionally affecting communities of color and elderly in the US

Structural Racism

Essential worker status

Less access to health care

Less financial wealth

Decreased mobility

Housing segregation

Inadequate investment in communities

- Healthcare
- Education
- Infrastructure
- Public safety

Co-morbidities: more prevalent in African American and American Indian/Alaskan Natives

COPD

Asthma

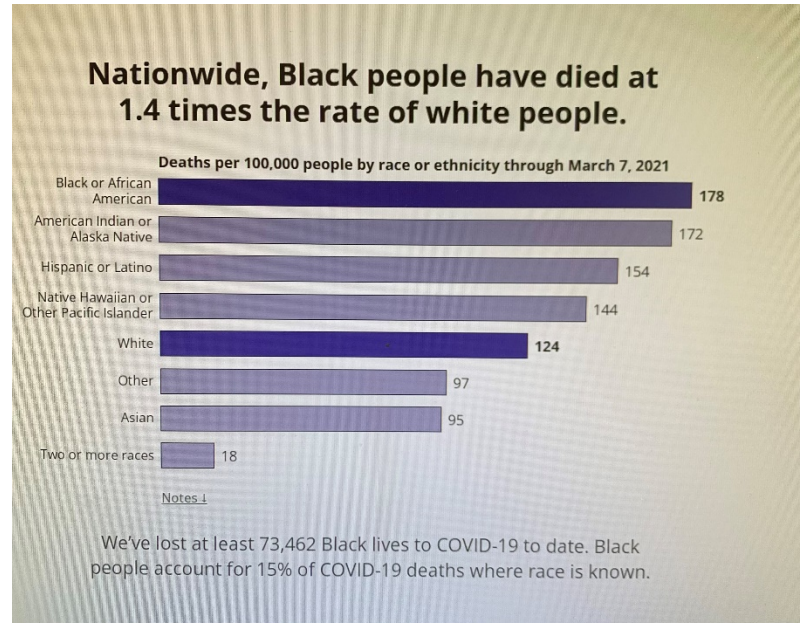
Obesity

Heart disease

ESRD-HD

CKD

DM



https://www.healthaffairs.org/do/10.1377/hblog20200428.904804/full/
https://covidtracking.com/race

Possible impact on patient and community perception

- Google search: 76,800,000 related to resource scarcity and allocation results: Few Titles
  - The Harm Of A Colorblind Allocation Of Scarce Resources; Health Affairs Blog 4/30/2020
  - The Way We Ration Ventilators Is Biased: Not every patient has a fair chance, a *New York Times* opinion piece by Harald Schmidt, April 15,
  - A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic, by UPMC Endowed Chair for Ethics in Critical Care Medicine Douglas B. White and UCSF's Bernard Lo, published in *JAMA* March 27, with a related *JAMA podcast* on March 28
  - Long-term care tracker: 8% of people in LTC died of COVID-19 ie 1 in 12 and 1 in 10 for Nursing home alone http://covidtracking.com (as of 3/2021)

- If allocation of resources such as ICU beds, dialysis machines, ventilators become wide spread during the pandemic there is a concern that policies could disproportionately adversely affect vulnerable communities

- Resource allocation policies that do not take into account health disparities may have unintended consequences

- Implicit bias is at risk of affecting decision making if there are not safeguards i.e. (implicit bias training for allocation committees, diversity on committees – including age; transparent processes that includes consideration of disparities)

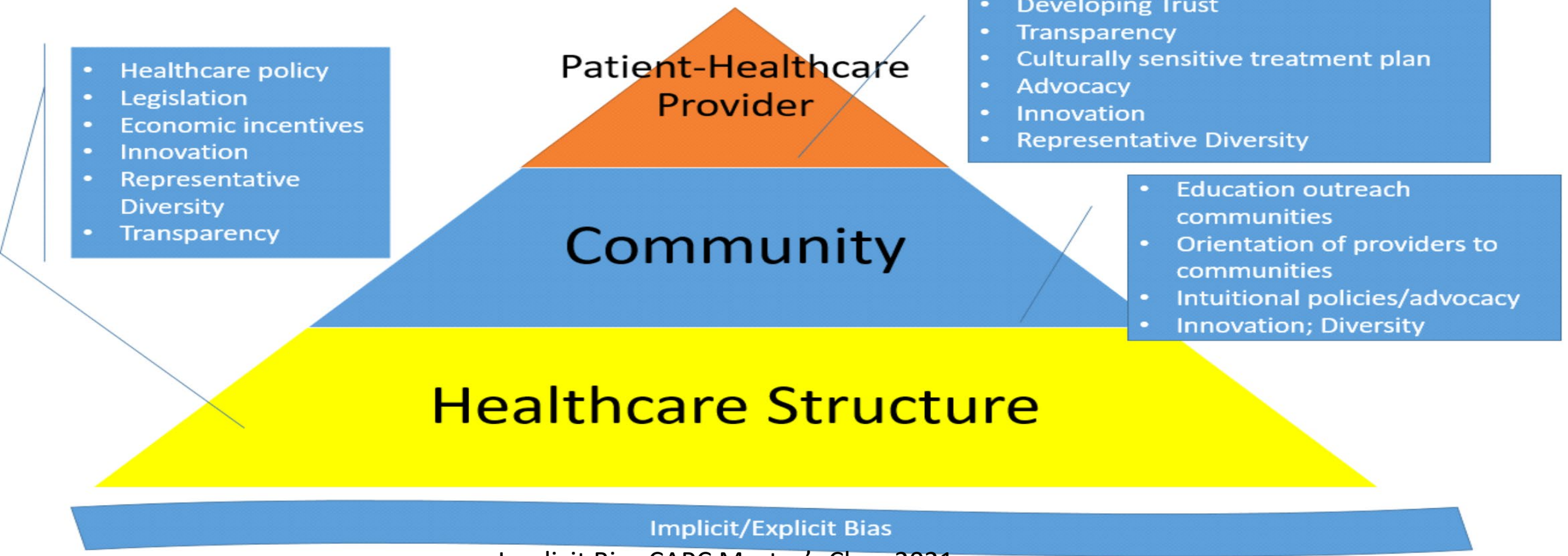
- Tools developed for health care providers to guide appropriate and important conversations could become subject to suspicion

https://www.healthaffairs.org/do/10.1377/hblog20200428.904804/full/

Communication

- Tools we use to guide conversations implies a basic implicit trust- unspoken contract
  - “ I will ask you these questions and you have the agency to answer or not, there will be no adverse consequences from our conversation”
- Fear, societal racism, social class disparity, scarcity of resources may strain the boundaries of this contract
- Primary problem: you may not know when this is happening
- Implicit/Explicit biases flow both ways in any human encounter.
  - Addressing only one of the parties' biases may inhibit effective communication

Healthcare Disparities Pyramid



Summary

- Implicit bias may contribute to healthcare disparities and lay the foundation for their perpetuation
- Trust is the bedrock of every relationship personal and professional
- Identification of one's own biases can allow for better understanding of social interactions with patients and may remove the unintended barriers they create
- Concept of cultural humility and individuation are important tools to use when managing healthcare disparities
- Communication concerning EOL and resource allocation in communities affected by healthcare disparities will require special sensitivity
- ***Yes it is about you too***

Thank you

- Emory Medical School Office of Diversity Equity and Inclusion
- Emory Division of Palliative Care and Emory Palliative Care Center
- Michael Curseen: Human Rights Advocate for the Mentally ill for State of Virginia (retired) *"The purpose of the Right isn't to make a right decision; the purpose of the Right is the freedom to make one"*