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The Patient Narrative and the Impositions of Implicit Biases in Health Care

By

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Senior Thesis

Submitted in partial fulfillment
of the requirement for Honors
in the Department of Sociology

UNION COLLEGE

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ABSTRACT

Dhara Shukla. The Patient Narrative and the Impositions of Implicit Biases in Health Care.

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The patient narrative includes the patient's sentiments about their health condition and how this has affected their lifestyle as opposed to a list of ailments. A large portion of the patient's diagnosis and treatment plan is rooted in the patient's narrative. If the health care provider does not listen to the patient's story, they may miss a vital puzzle piece that could aid them in solving the mystery. The extent to which the health care provider listens to and values the patient narrative could be clouded by implicit biases that the provider holds. Implicit biases are preferential attitudes and associations towards people, which exist subconsciously.

In this study, interviews were conducted with physicians, nurses, medical students, and patients to better understand the extent to which health care providers emphasize the patient narrative and the role that implicit biases play in the doctor-patient and nurse-patient relationships. A multitude of biases were identified through the interviews, and it was established that, overall, the interviewed health care providers do not feel that listening to the patient narrative was emphasized in their medical training. Furthermore, all of the patients shared anecdotes of age bias, and they all felt that female physicians are more empathetic

than male physicians. After analyzing the qualitative data collected from the interviews, it was established that more courses and training about implicit biases, emotional intelligence, and listening to the patient narrative need to be implemented in medical training.

TABLE OF CONTENTS

ABSTRACT	ii
CHAPTER 1: INTRODUCTION	1
CHAPTER 2: LITERATURE REVIEW	4
The Patient Narrative.....	4
Medical Training	8
Bias in Health Professions and the Workplace	10
<i>Implicit Bias</i>	10
<i>Workplace Bias</i>	13
<i>Gender Bias</i>	14
<i>Gender Bias in Medical Training</i>	17
Conclusions	19
CHAPTER 3: METHODOLOGY.....	21
Research Question	21
Sampling Population and Procedures	21
Interview Description.....	23
Data Analysis	24
CHAPTER 4: RESULTS	26
Overview	26
Patient Experience	26
<i>General Facets of Patient Visit</i>	26
<i>Patient Narrative</i>	29
Documentation of Patient History and the use of Electronic Medical Records.....	34
Biases	37
<i>Privilege of Common Interests</i>	37
<i>General Patient Biases</i>	38
<i>Age Bias</i>	40
<i>Gender Bias</i>	42
<i>Recognizing and Coping with Internal Biases</i>	46
CHAPTER 5: DISCUSSION AND CONCLUSIONS	48
Future Plans.....	52
Conclusion	53
APPENDIX A: Structured Questions for Health Care Providers	54
APPENDIX B: Structured Questions for Patients	57
REFERENCES	59

CHAPTER 1: INTRODUCTION

“If you make listening and observation your occupation, you will gain much more than you can by talk” (Robert 2021). This quote holds true in many parts of life but especially in the field of medicine as pertaining to the patient narrative. Being a physician is a tough job and it can feel like there is not enough of the valuable resource known as time in the day to successfully complete all of one’s duties as a physician. Although a physician may ask a patient to share their story, on average, the physician tends to interrupt the patient after only eleven seconds of listening with a close-ended question in response to the patient’s narrative (Ospina et al. 2019). This doctor-patient encounter is very comparable to the concept of pitching a product idea on the television show Shark Tank, but, in this case, the contestants on the show are actually given more time to speak sans-interruption than a patient in a doctor’s office is allowed.

Similarly, the median length of a doctor visit is 15.1 minutes (Tai-Seale, McGuire, and Zhang 2007), which is often not nearly enough time for the patient’s story to be heard, processed, and responded to. Given the time constraint placed on physicians, even the time spent listening to the patient without overt interruptions does not solely consist of the physician listening to the patient. Due to the lack of time that physicians have to spend with their patients, doctors are oftentimes not fully present with the patient and are instead thinking about the tasks they have to complete during the day or are engrossed in their computers while entering patient history into the telehealth system.

In addition to a mere lack of time, it is thought that gender bias could play a role in how receptive physicians are in listening to the patient narrative. Twenty percent of female patients feel that their health care provider has dismissed their symptoms and seventeen percent believe that they were treated differently due to their gender (Paulsen 2020). This is contrasted with the

fact that only fourteen percent of men believe that their health care provider has dismissed their symptoms and six percent feel that they were treated differently due to their gender (Paulsen 2020). Literature has shown that women's sentiments regarding their experience with patient care are true, as women often do not receive the same evidence-based care that their male counterparts get.

In this study, I interviewed physicians, nurses, and patients in a semi-structured fashion to gain a better understanding of how much providers emphasize and value the patient narrative. Additionally, I asked specific questions to gain insight into the role that implicit biases may play in patient interactions. Questions regarding the extent to which patient interactions last, presence of implicit biases in health care, medical training, and the modes of documenting the patient narrative were also asked.

In chapter two, I review literature published on the topics of the patient narrative, necessary medical training for physicians and nurses, general implicit bias, workplace bias, gender bias, and the application of gender bias in the medical training process. I explore, in great depth, the concept of the patient narrative and its importance to the patient-physician relationship. The requirements for becoming a doctor or nurse are reviewed to provide context as to where potential biases that affect the patient narrative could develop. The general idea of implicit bias is defined and the downstream effects of implicit biases in various fields are discussed. I delve into workplace bias to better understand various areas where biases are projected. The history of gender bias and its application to the medical field is delineated, and the presence of gender bias in the medical training process is noted.

In chapter three, I discuss the methodology used in this research study and describe the overall organization of the interviews conducted and research questions explored. In chapter

four, I reveal the results of the interviews in a thematic fashion. General ideas regarding the aspects of a patient appointment, methods of documenting patient information, patient narrative, and biases are explored, and anecdotal evidence is displayed to support the conclusions made.

In chapter five, I discuss the meaning behind the strongest themes identified in chapter four and highlight methods that could be used to solve issues identified in the interviews regarding the patient narrative and implicit biases. Finally, future plans for this research study are considered.

CHAPTER 2: LITERATURE REVIEW

The Patient Narrative

“If you are lucky enough to have a patient place his or her book in your hands, take the time to read it” (Thomas 2010: 149). A patient’s narrative includes the patient’s sentiments about their health condition and how this has affected their lifestyle as opposed to a valueless list of ailments (Charon 2005). Patients’ narratives also open many doors for understanding the inequities that they may have faced and provide an opportunity for health providers to open their ears and hearts to the patients’ stories and sorrows (Dicker and Punch 2020). Such narratives are stories that require a teller, listener, and plot; narratives provide the listener a rich grasp of the teller’s circumstance as it unfolds in time (Schleifer 2012). Stories are able to convey concepts and emotions that statistics and clinical diagnoses cannot. Furthermore, stories add an emotional dimension that allow people to feel some sort of connection to the teller of the story and the narrative itself (Langer and Ribarich 2009).

For example, a 70-year-old patient wrote an autobiography, and her doctor was enlightened after reading it. The physician was able to glean so many layers of information about the patient by simply reading her story. Not only did the doctor gain an understanding of the many hues of emotions that the patient had experienced during her illness, but the doctor learned so much about the patient that she would have not otherwise known. The patient had spent days in a hospital for an incapacitating mental illness, and she wrote about how numb and empty she felt during her hospitalization. This vital piece of medical information slipped past the doctor while the patient was still alive, because there was no formal hospital discharge paper in the patient’s medical records (Thomas 2010). Had the physician truly listened to the patient’s story while the patient was in the examination room, the physician would have absorbed substantially

more information about not only events that make up the patient's medical history, but also aspects about her relationships with others and the multitude of emotions that she has felt throughout her life: the things that make her human.

Physicians and nurses should actively listen to patients while attempting to fill in gaps in their medical histories, as patients are the curators of the records that are kept of them (Charon 2005). Physicians are not physicians without the patients that they treat, and the same ideology applies for nurses. Listening to the patient's narrative provides another aspect on which the health care provider and patient can relate and form a relationship. Furthermore, it is vital that the physician empties themselves of other thoughts, distractions, and goals in order to dedicate their undivided attention to improving the patient's health (Charon 2005). Active listening from the provider is vital to the facilitation of the patient narrative. Providers should maintain eye contact with the patient and encourage the patient to share their full story uninterrupted. This empowers patients because they feel accepted by their provider (Langer and Ribarich 2009). Dr. Rita Charon pays specific attention to the metaphors, gaps, and silences in the patient's monologue, as they can reveal a great deal about the patient's feelings. Astoundingly, it is so rare for a physician to provide their full attention to the patient that one patient started sobbing when Dr. Charon did just that (Charon 2005).

A major issue impeding the proper facilitation of listening to patients' narratives in the doctors' offices is confirmation bias, which is the tendency to search for, interpret, and recall information in a way that favors preconceived notions (Nickerson 1998). Although some doctors may genuinely believe that they are listening to the patient's narrative, the reality is that, many times, they are trying to shape the patient's story to fit a diagnosis that they already had in mind.

Therefore, it is essential that physicians record an objective account of the patient's story before they evaluate the story to formulate a diagnosis and treatment plan.

Furthermore, the translation of the patient's narrative into medical terminology to be entered in the patient's medical record can lead to the patient's narrative being skewing in one direction or another. For example, if the patient describes their chest pain as part of their narrative, the physician may enter this symptom into the patient's medical record as "angina" or "pleuritic chest pain" depending on the physician's interpretation of the patient's narrative. The term "angina" indicates that the chest pain is a result of a cardiac problem, while the term "pleuritic chest pain" frames the chest pain as a result of a respiratory issue. Therefore, it is vital that physicians avoid altering the patient's words to fit a medical mold, but rather enter the patient's narrative into the medical record system in an unaltered fashion through the use of direct quotations, for example. Another way for physicians to avoid being biased in the interpretation of the patient's symptoms is to ask the patient to retell their story without regarding the notes about the patient's symptoms that are already recorded in the system. This way the physician is less likely to be swayed by the diction used in the medical history records (Schmidt 2021).

There are some behaviors which should be avoided when interacting with and listening to the patient. Interrupting the patient is one of the utmost mistakes that a provider can make. The average appointment between a physician and patient lasts about 17.4 minutes and the median talk time for the patient is approximately 5.3 minutes (Tai-Seale, McGuire, and Zhang 2007), which exemplifies just how much of an issue this is in health care. Blaming the patient and asking many probing questions can also hinder the process of listening to the patient's narrative (Langer and Ribarich 2009). This can create an intrusive environment for the patient that

prevents them from trusting and opening up to the provider. Moreover, Sigmund Freud, the founder of psychoanalysis, found that patients live healthier lifestyles when they are encouraged to share their thoughts and feelings, i.e., free association (Langer and Ribarich 2009). Stories also allow patients to find meaning in their illness and unearth coping mechanisms (Calman 2001).

It is possible that some patients may be hesitant to share their stories due to associated stigma or the fear of placing a burden on the provider. Therefore, it is the provider's responsibility to take the initial step that leads to the patient opening up to them and sharing their chronicles. Patients should be encouraged to share their disease experience and how the disease fits into their lives. Providers should attempt to repeat their understanding of the patient's narrative back to the patient to confirm that they have heard it correctly (Langer and Ribarich 2009).

Typically, physicians ask patients a series of questions about their illness, prior ailments, personal medical history, and family health history upon the first encounter. Then, the physician may conduct a review of systems where the physician asks the patient a comprehensive list of questions regarding symptoms pertaining to each organ system in order to identify potential health issues (Charon 2005). Throughout this process, it is very possible to lose the patient narrative.

In this technological age where 94 percent of hospitals employ the use of electronic health records to inform health care decisions (Parasrampur and Henry 2019), the narrative may be lost amidst responsibilities to manage other areas of data collection and management (Moros 2017). However, new technological innovations, such as MyStory© can still capture the patient narrative by prompting the provider to enter answers to questions such as “what comforts

or calms you?” and “what is your normal routine for sleep, meals, and activities” in the electronic health record. It is vital that patients’ anecdotal data is analyzed with the same rigor that quantitative patient data is analyzed (Cognetta-Rieke and Guney 2014). Providers cannot effectively provide holistic patient care without listening to the anecdotal evidence that composes the patient.

Medical Training

The road to becoming a physician requires many years of schooling and training, and there are many steps along the way where bias could be introduced. Once students acquire a bachelor’s degree from a 4-year college, they apply to medical school. Medical school lasts for four years, with the first two years mostly consisting of lectures in a classroom and labs. The last two years of medical school are where medical students have more encounters with patient interaction. They apply what they learned during the first two years of medical school in the classroom to patients. Additionally, students become more educated on the various specialties that they could potentially pursue. Finally, in their fourth year of medical school, students choose their specialty (Thompson 2014).

Once students graduate with a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) degree, they complete a residency program at a teaching hospital in their specialty of choice, which can last anywhere from three to seven years depending on the specialty. Post-residency, physicians can become board-certified by taking an exam, and education can potentially continue for about one to three additional years if the physician chooses to do a fellowship to subspecialize. Lastly, physicians have to complete Maintenance of

Certification (MOC) requirements to continue educating themselves, as the medical field is always evolving (Thompson 2014).

There are many levels of nursing, with registered nurses being the most common. Licensure for registered nursing varies from state to state, but it generally takes about two to four years to become a registered nurse. One must hold at least an Associate's Degree in Nursing (ADN), but some states require a Bachelor of Science in Nursing (BSN) (Maxwell 2021).

Medical training in contemporary society has undergone a number of changes throughout its history. For example, one change relevant to patient narratives was the Flexner Report, published in 1910. The Flexner Report greatly transformed medical education and training. This report motivated American medical schools to cohere to the protocols of mainstream science in their research and teaching (Duffy 2011). Two major recommendations that were made in the Flexner report were to reduce the number of poorly trained physicians and to train physicians to practice in a scientific manner (Johnson and Green 2010). The aftermath of this report led physicians to view the patient's story with skepticism due to its subjective nature. Physicians became trained to almost exclusively rely on clinical data rather than listening to the patient narrative (Shapiro 2011). Furthermore, there were many scholars who asserted that autobiographies were morally suspect, as people are self-deceiving and were likely to portray themselves as being kinder and funnier than they actually were (Hardwig 1997).

There has been a recent shift to emphasizing and appreciating the importance of the patient narrative, but providers almost need to be untaught the information that they learned in medical school and residency regarding patient interaction and the recording of patients' health history. The birth of narrative medicine was an effort to compensate for the negative effects of the Flexner report (Johna and Rahman 2011).

Bias in Health Professions and the Workplace

Bias, in general, is defined as prejudice in favor of or against a person, thing, or group (Yarba 2021). Biases can present themselves in any aspect of everyday life, including in the workplace, health care settings, and schools to name a few. The following sections will define and discuss the implications of implicit bias, workplace bias, gender bias, and gender bias in medical training.

Implicit Bias

Implicit bias is defined as preferential attitudes and associations towards people, which exist subconsciously (Champagne-Langabeer and Hedges 2021). Furthermore, implicit biases inform non-verbal behaviors. On the other hand, explicit biases are prejudices towards a person, thing, or group on a conscious level and are likely to be associated with verbal behavior (Dovidio et al. 2002). Examples of explicit bias included overt misogyny and racism (Rimnac 2020). People are more likely to express an explicit bias if they feel threatened by an individual or group (Dovidio et al. 2002). Since explicit biases are more overt, they have become less socially acceptable, and as a result, implicit biases are dominating the realm of common biases.

These implicit biases are affecting the overall perception of minority groups and the implicit biases that some hold affect their behaviors and actions toward minority groups. These behaviors can manifest as microaggressions, which are frequent, brief exchanges that belittle a person or group. Though the denigrating actions may be small in magnitude, they tend to occur in high frequency and from multiple sources, which can create a snowball effect (Sue 2010). Furthermore, implicit biases often develop early on in life and can be strengthened by social stereotypes (Rimnac 2020).

Implicit biases can greatly harm a person's self-perception. Some examples of the consequences of implicit biases include imposter syndrome and stereotype threat. Imposter syndrome is the constant feeling of self-doubt regarding one's own abilities despite evidence of success. It has been found that imposter syndrome disproportionately affects women and minority groups, as these groups do not historically have many role models of success in their fields (Mullangi and Jagsi 2019).

In health professions, physicians may possess implicit biases towards patients based on their race, ethnicity, gender, sexual orientation, age, or some other variable. These biases can affect the physicians' facial expressions and perception of patients and can detrimentally harm the doctor-patient relationship (Champagne-Langabeer and Hedges 2021). Moreover, implicit biases and stereotyping can further contribute to health care disparities, which is why the implicit biases of health care providers is a prominent area of interest (Sabin et al. 2009).

A study observing the interactions between non-Black oncologists and Black patients found that the oncologists who scored as having more implicit biases on an Implicit Association Test had shorter patient interactions. Furthermore, patients also rated these physicians as being less patient-centered. Moreover, these physicians also experienced difficulty in remembering the details of their interactions with patients (Penner et al. 2016), which depicts a correlation between implicit biases and listening to the patient narrative.

Implicit biases extend beyond the social identities of race and gender. They can also be based on a person's age. Ageism, which is discrimination based on one's age, is a prevalent force in health care (Kydd and Fleming 2015). For example, physicians are less likely to treat elderly patients who present with suicidal ideation although those aged 85 or older statistically have a higher suicide rate than other age groups (Uncapher and Arean 2000). One study observing

medical students at five different campuses concluded that medical students enter medical school with preformed implicit biases and attitudes about elderly patients. This affects the way that they approach certain patient encounters. Since students enter medical school already possessing some defined biases, it is essential that medical schools allocate some part of the curriculum to addressing implicit biases. One example of a supplementary curriculum method to alleviate the poor treatment of elderly patients is to introduce clinical rotations in geriatrics (Reuben et al. 1995).

Interestingly, in another study, an Implicit Association Test revealed that physicians, in general, displayed a preference for patients who were White Americans (Sabin et al. 2009) and that female Black physicians presented no implicit biases (Avant et al. 2018). The Implicit Associations Test is a mode used to detect subconscious associations among one's memories. Most of the time, the results of the Implicit Association Test are used to assess implicit biases in the test-takers (Nosek et al. 2005). The characteristic Implicit Association Test involves a series of seven tasks where the individual sorts the words presented to them into the given categories. The categories vary based on the stage of the test, but some categories include "Black", "White", "Black/Unpleasant", and "White/Unpleasant" (Nosek et al. 2007). The results of the test are then assessed to determine which, if any, implicit biases an individual possesses.

The downstream effects of implicit bias can highly contribute to excessive medical costs (Tsugawa 2017) and health disparities. For example, using the Implicit Association Test, it was found that physicians who presented with pro-White bias had poor communication lower quality of care from the perception of Black patients (Cooper et al. 2012). Interestingly, Black patients also rated physicians who had high implicit but low explicit racial bias as being less warm and

less team-oriented compared to physicians with bias equally distributed between implicit and explicit (Penner et al. 2010).

Workplace Bias

Stereotypes suggesting that males are stronger and more aggressive than women are at the forefront of workplace bias. This can create further divisions in the work setting, as the assumption that males are stronger than females leads to more favorable performance ratings for men (Martell 2006). Furthermore, failing to provide women the same work opportunities as men is highly correlated with poverty and the destruction of human capital (World Bank 2001). Sex stereotypes are likely to be used in complex situations where group-based expectations can make the situation easier to process and handle. When attentional demands require the overextension of limited cognitive resources, gender stereotypes may be evoked, which results in biased performance evaluations (Martell 2006).

One distinct finding about workplace bias is that people who internally believe that they are objective individuals tend to project their implicit biases and act on them more frequently than those who are self-aware of their implicit biases (Devine et al. 1991).

It is vital that people assess the level of their implicit biases using a tool such as an Implicit Association Test to address these subconscious biases. While implicit biases are very much integrated in people as much as their DNA, one can mitigate their implicit biases by employing certain tools. Becoming an advocate for disparaged groups is a great way to bypass implicit biases and improve oneself. Ignoring your biases is unacceptable, as the status quo is not ideal (Implicit 2020). This recognition may go a long way in reducing different kinds of bias. For example, when a quarter of the faculty in a department at University of Wisconsin-Madison

attended an extensive one-day workshop on the topic of gender bias, there were notable increases in actions to promote gender equity (Carnes et al. 2015).

Gender Bias

Gender bias is a preconception about characteristics and roles that men and women have or should have (Gender 2021). There are two main ways in which health service delivery can involve gender bias. The first mode is through assuming equality of men and women. To expand, there have been many clinical trials that were conducted only among men, but the results are assumed to be applicable to women as well although this may not be true. Due to this generalization, there is an absence of knowledge about how to treat and manage women's health problems constructively. The second mode is through assuming differences between men and women that are not actually true. In health care settings, often, physicians will consider men's health complaints as being more urgent and significant than women's complaints (Ruiz and Verbrugge 1979). The diseases that primarily affect women are often viewed as being of less importance than the diseases that largely affect men. This could be because many of the diseases prevalently affecting women consist of more diffuse symptoms in various parts of the body without a distinguished cause. On the other hand, the diseases that commonly affect men have definitive symptoms involving vital organs (Yut-Lin 2009).

In fact, women's complaints are frequently asserted as being due to some psychosomatic component. Further supporting this is the fact that the rate of the prescription of tranquilizers is higher among women than men, which further drives gender differences in health care. Moreover, society assumes that women avail from a better health status than men despite the

higher prevalence of non-fatal chronic illnesses, rates of morbidity, and higher rates of disability in women (Ruiz and Verbrugge 1979).

The health sciences field is facing many consequences resulting from gender bias. Due to the assumption that there is no gender difference in how people experience disease, most research attention is currently targeting fatal chronic conditions. This focus on fatal conditions diverts attention from the non-fatal chronic health conditions that predominantly affect women such as arthritis and migraines. Furthermore, if men live long enough to acquire the same non-fatal problems as women, research on non-fatal chronic health conditions would benefit both men and women (Ruiz and Verbrugge 1979).

Additionally, general practitioners often neglect a full examination of the pelvis and avoid asking questions regarding menstruation when examining female patients, which is why many patients must visit a gynecologist for such examination. The concept of “male as norm” is further supported by the fact that the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) defines the criteria for diagnosing schizophrenia on the basis of male symptoms (Yut-Lin 2009).

Although there are not many studies examining the amount of time that physicians spend with the patient based on the patient’s gender, one study found that the allocation of time spent discussing various topics during patient visits varies based on patient gender. Female patients’ visits had more time spent on physical examination, patient questions, screening, and emotional counseling, while male patients’ visits had more time spent on procedures and health behavior counseling. Furthermore, more men received nutrition, exercise, and substance abuse counseling than women (Tabenkin et al. 2004).

Moreover, in a study of 253 primary care practitioners (PCPs), it was found that 25 percent of the physicians believed that females patients were likely to excessively use physicians' time, while only 14 percent of the physicians felt that men would be likely to unreasonably use physicians' time. In addition, 65 percent of the physicians believed that women's health complaints were likely to be affected by emotional factors, but only 51 percent of physicians felt that way about men (Bernstein and Kane 1981). As relayed in these countless examples, the notion of males being superior to females is unfortunately emphasized in countless areas of health care. Furthermore, a study of total knee arthroplasty revealed that orthopedic surgeons were 22.1 percent more likely to recommend a total knee arthroplasty to male patients over female patients (Rimnac 2020).

Despite the fact that women constitute 50.5 percent of medical students in the United States (Heiser 2019), women only make up 16 percent of medical leadership positions (Lautenberger et al. 2014). This is an astounding statistic, as it is very evident that there is some barrier that is preventing women from working C-suite level jobs. The umbrella term for the barriers preventing women from up corporate hierarchies is the "glass ceiling phenomenon" (Fernandez and Rubineau 2019). Women may be able to enter the workforce with little resistance in lower-level jobs, but when a glass ceiling is in place, women seeking positions of leadership and power in their organizations face a gendered obstacle (Fernandez and Rubineau 2019). Moreover, studies have shown that companies that are comprised of more than 30 percent of women executives are likely to outperform companies consisting of 10 to 30 percent women executives (Dixon-Fyle et al. 2020).

Gender Bias in Medical Training

Gender bias is deeply rooted in medicine and is a major driving force for many of the inequities in health care that are observed to this day. Likewise, medical curriculum has presented the 70 kg white man as the standard for medical teaching (Phillips 1997). For example, the implicit message instilled in standard anatomy texts is that the significant features of a man's body are those that facilitate him to perform any activity while the key features of woman's body are those that perform the functions of a sex partner. This concept suggests that the female body depends on the male body for its anatomical definition (Yut-Lin 2009). Furthermore, a study which employed the use of focus groups revealed that by the end of their time in medical school, most medical students associate women's health exclusively with reproduction (Autry et al. 2002). Training for physicians emphasizes group level information such as population risk factors which can reinforce stereotypes, especially if emphasis is placed on minorities with unfavorable health outcomes (Chapman et al. 2013). All of these components have further reinforced the idea that women are biologically weaker and more susceptible to being invalid, which contributes to the inequities that women experience.

Problem-based learning is a key teaching method at many medical schools. This process involves students working in a small group with a faculty member to exploring a patient scenario for several hours. The faculty member serves as a facilitator of discussion among the students rather than a specialist. An analysis of the problem-based learning scenarios at a Canadian university revealed that in the sixteen scenarios that which involved medical problems where sex is irrelevant, twelve of the patients were male (Phillips 1997). This is a definitive display of how males are considered the standard for medical teaching.

The stereotype that female patients are likely to have vague symptoms or non-medical issues that do not deserve attention prevailed in the problem-based learning at this Canadian university. All of the descriptions of female patients comprised of detailed entries regarding the patients' family and social histories, while the histories of male patients did not place as much emphasis on these components. Moreover, in one scenario, a female patient visited the emergency department and requested pain pills, because her arm fracture was not healing properly, and her hand was blue and hypersensitive. Rather than focusing on the obvious, physical reason for the patient's visit to the emergency department, the faculty member, i.e., facilitator, used the scenario as a forum for discussion about the conversion of pain as an equivalent of hysteria (Phillips 1997). While problem-based learning is an effective teaching tool in medical schools, it seems that many of the scenarios support certain stereotypes against females.

Some medical schools have begun to address the lack of emphasis on women's health by reforming the curriculum and modes of teaching. For example, some schools have introduced women's health electives which address health conditions that are prevalent among women such as osteoporosis, incontinence, and menopause (Manderson 2003).

Regardless of gender bias against patients, interesting trends have been observed regarding trends of physician practice based on gender. For example, a study conducted among Medicare patients revealed that patients who were treated by a female physician were less likely to die or be readmitted into a hospital within 30 days of discharge compared to patients treated by a male physician (Datz 2016). It has been found that female physicians are more likely to engage in preventative care and effective doctor-patient communication (Roter et al. 2002).

The implicit biases that are covertly taught and reinforced in medical training through textbooks readings and patient scenario exercises can pave a path for these biases to persevere even after the medical student has graduated and is practicing physician. Implicit gender bias can affect how a doctor perceives a patient and how seriously they consider that patient's narrative. These biases could also affect the verbiage used by the physician when documenting the patient narrative.

Conclusions

My analysis of various works of literature regarding the patient narrative and gender bias in the medical field reveals that there are some apparent forms of gender bias in medical training and practice, such as presenting a 70kg white male as the standard. Moreover, it seems that there has been a recent shift in the emphasis and understanding of the patient narrative, but some of the unfavorable effects of the Flexner report may still be lingering. While much of the literature paints the picture of physicians not paying adequate attention to the patient narrative and physicians projecting certain biases based on what they were taught in medical school, physicians may have a different story to tell. Physicians and nurses have similarities in terms of the fact that they provide patient care, but they also play very different roles in patient interaction. Therefore, listening to physicians' and nurses' narratives on this issue will help provide a well-rounded assessment of how prevalent biases are in the practice of medicine today and exactly how much health care providers value the patient narrative. Some questions that will be explored in this study are as follows. Does the physician's diagnosis and treatment plan vary based on the gender of the patient? How do nurses and physicians listen to and document the patient narrative? Do nurses and physicians project their biases on patients? Do patients feel that

their providers listen to their story and concerns? To address these questions, physicians, nurses, and patients were interviewed to better understand all three parties' views on the emphasis of the patient narrative and presence of gender bias.

CHAPTER 3: METHODOLOGY

Research Question

The purpose of this study is to explore and understand the extent to which health care providers listen to the patient's narrative and the effect that implicit biases, especially gender bias, may play in patient interactions. There exists literature regarding the importance of listening to the patient narrative and statistics about how often patients are interrupted during a visit, but there is a lack of studies where health care providers are given a chance to tell their own narrative regarding their approaches to treating patients. Furthermore, there is information concerning gender bias in medicine, especially with regards to its presence in medical training, but there are not enough studies where health care providers are interviewed regarding their thoughts on implicit bias in medicine. It is often assumed that there must be a significant number of health care providers who are projecting their biases on patients, given the amount of media coverage this topic has received in recent years, but the people who are affected by this issue, patients, physicians, and nurses, have not been questioned regarding how prevalent implicit biases are in health care. Interviewing physicians, nurses, and patients provided some perspective on how much the patient narrative is emphasized and the role that implicit biases play in health care experiences.

Sampling Population and Procedures

Upon receiving exemption from the Human Subjects Review Committee, I contacted physicians and people who have visited a doctor within the past year. Initial contact with the physicians was made through email or phone call and nurses were recruited through snowball sampling, meaning that they were recruited by referrals from participating physicians in the

study. The patients that were interviewed were recruited through word-of-mouth, and they all fall under criteria of having visited a doctor in the past year.

Physicians (n=5) ranged in age from 38 to 68 years (average age of 54.6 years) and had 8 to 37 years of experience as practicing physicians (average of 23.2 years). Two female physicians and three male physicians were interviewed. Three nurses (two female and one male) were interviewed. They ranged in age from 33 to 54 years and had 18 to 28 years of practice. Five patients (four female and one male) were also interviewed. One of the interviewed nurses also shared some of her personal experiences as a patient during her interview, so she was partially counted as a patient, since she was not asked all of the questions that the other patients were asked. Two of the patients were medical students, so they shared some of their experiences from the perspective of a medical student during their interviews. Patients ranged in age from 21 to 54 years (average of 28 years). The breakdown of the participants, including specialty if applicable, is displayed in Figure 1 below. The interviews were conversational with a set of open-ended questions for each group being interviewed listed in Appendices A and B. However, some questions were omitted depending on the subjects' responses to previous questions, and follow-up questions were asked when appropriate. Prior to beginning the interview, the study was briefly described, and consent was obtained to start the interview and record the interview.

Figure 1: Group Breakdown of Interview Participants

Identity	Group				
	Patient	Medical Student	Physician	Nurse	Specialty (if applicable)
A	✓	✓			
B	✓	✓			
C	✓				
D	✓				
E	✓			✓	Emergency

F				✓	Emergency
G				✓	Ophthalmology
H			✓		Emergency Medicine
I			✓		Regenerative Medicine
J			✓		Ophthalmology
K			✓		Pediatrics
L			✓		Cardiology

The interviews took place during the months of December 2021 and January 2022. The interviews were mostly conducted over Zoom, with one via phone call and one in-person, and the duration of the interviews ranged from 11 to 35 minutes. The interviews conducted over Zoom were recorded and transcribed manually post-interview or transcribed during the interview if the participant was not comfortable with the interview being recorded.

Interview Description

The interviews were semi-structured, and all interviews commenced with a general demographic question asking about the participant’s age, race, sex, and specialty if applicable. The questions to health care providers were divided into three overarching categories. The initial questions focused on general factors involved in patient interaction such as the method of documentation of the patients’ medical history and the length of time spent with patients. The middle section of the interview included questions that were concentrated on the patient narrative such as the effect of methods of patient information documentation on the ability to listen to the patient and ways that the patient narrative was emphasized in their training. Then, the questions regarding the patient narrative segued into a discussion about implicit biases and the health providers’ perceptions of the presentation of biases in health care. General questions regarding the average length of patient visits were asked to ease into the discussion of the patient narrative

so that the provider was more comfortable and willing to share their thoughts on the importance of the patient narrative. Questions regarding implicit biases were asked in order to comprehend the relationship between implicit biases and patient interactions, especially the patient narrative.

The interviews with patients were largely focused on questions regarding the patients' perceptions of their physicians. These thoughts were gauged by asking the patients questions regarding how much time and attention their physicians give to them during appointments and whether the patients feel that their concerns have been addressed. In order to gain clarity on how satisfied patients are with encounters with their providers, patients were asked to rate their levels of satisfaction on a Likert scale and expand as to why they chose the rating that they did. Lastly, the patients were asked questions regarding their interactions with doctors of different sexes and the way that implicit biases from health providers have or have not affected the patients' overall health care experiences. All of these questions together aimed to understand what the doctor-patient relationship looks like from the patient's perspective in terms of attentiveness from the doctor, bonds formed between the patient and physician, overarching satisfaction levels, and the role that implicit biases may play in the physician-patient relationship.

Data Analysis

The data collected from the interviews were analyzed using thematic coding on Excel after transcribing all of the interviews. Inductive, interpretive, and descriptive thematic analyses were primarily used. Inductive thematic analysis focused on examining the data itself rather than heavily incorporating theories in the analysis. Descriptive thematic analysis mainly serves to summarize the major findings of the data. Lastly, interpretive thematic analysis serves to decipher the deeper meanings in the data. This was done after inductively and descriptively

analyzing the data (Clarke et al. 2015). Key questions from the interviews were placed in columns in the spreadsheet and each participant was assigned to a row where their responses were copied and pasted. Their collective responses were compared and analyzed to find common themes, and vital quotes from the interviews were highlighted.

CHAPTER 4: RESULTS

Overview

Five physicians, two medical students, three nurses, and five patients were interviewed for this study. The physicians and nurses were asked questions regarding how much time they spend with patients, how they document patients' history and complaints, the extent to which they have learned about and emphasize the patient narrative in practice, and implicit bias (Appendix A). The patients were asked questions about how much time their physicians spend with them, how satisfied they feel after speaking with their physician, preference for doctors of a specific sex, and factors that may influence their ability to speak to and connect with their physicians (Appendix B).

The interviews revealed many biases present in health care, including gender, race, and age biases along with a bias of health care providers favoring patients that they share common interests with. A multitude of themes were identified among the interviews, some of which include a lack of curriculum regarding the patient narrative in medical training, methods of documenting patient information, age bias, and the hesitancy of providers to discuss their personal biases. These biases and themes will be delved into in the following sections of chapters four and five.

Patient Experience

General Facets of Patient Visit

When asked how much time they allot for the patient to tell their story, physicians' responses greatly varied. Two physicians said that they allocate about two to five minutes for the initial conversation with the patient, and one physician said that they spend about ten minutes

listening to the patient uninterrupted at the beginning of the appointment. Interestingly, only one of the five physicians interviewed stated that they give the patient as much time as necessary to tell their story. This physician stated:

“You have to have patience, because if you rush the patient you are going to miss something that the patient might say to help you diagnose them better.”

This statement aligns with the values placed forth in narrative medicine. The patient’s story is the door leading to the diagnosis of the patient.

Overall, most of the physicians said that volume of patients is a determining factor for how long they spend with their patients. Acuity of the patient’s concerns was also mentioned as a determining factor by two of the five physicians that were interviewed.

When patients were asked approximately how long an appointment with their PCPs last, two patients said ten minutes, one patient said twenty minutes, and one patient said thirty minutes. Interestingly, the two patients who stated times longer than ten minutes said that only about ten minutes are spent discussing medical issues while the remainder of the appointment time is used to converse with their physicians about life updates related to medical school. Moreover, when asked if they are able to adequately address their concerns during their visits, all four patients felt that ten minutes was enough time to address all of their medical concerns with their PCPs.

All three nurses said that they allot about five minutes for the patient to tell their story to them. Two of the three nurses who were interviewed work in the emergency department where they must move at a faster pace and multitask due to the high volume of cases with urgent issues. One emergency department nurse said:

“People will want to tell you your life story, but I do not want to hear it because I am the first line of contact. I do not want the life story. I do not even want half of the information that they are giving me. I tell all my new grads that you want to get in and out with all the

info as quick as possible because while you are seeing that patient, someone could bring in a whole new patient.”

While the nurse does not get to fully hear the patient’s narrative in the maximum of five minutes allocated for the patient to initially tell their story, it is not too worrisome as this is because the nurse is essentially triaging the patient, which is the process of assigning the patient’s case a degree of urgency so that the emergency department can better manage the patient volume. Moreover, the physician will also be seeing the patient after the nurse gets the initial history, so the physician will have the chance to collect a better patient narrative. The nurse also stated that her emergency department normally operates at a 4:1 patient to nurse ratio, but due to the COVID-19 pandemic, the ratio is now 7:1 sometimes. As mentioned earlier, patient volume can affect how much time providers spend with each of their patients. Therefore, it can be assumed that the COVID-19 pandemic has placed strains on many resources including time, given the increased volume of patients in the emergency department especially.

Factors other than patient load also affect how much time nurses are willing to spend with patients. One interviewed nurse discussed how the patients’ mood and the pleasantness of interactions with them affects how much time she spends in their room.

“Some people are so kind and so nice and so happy that you are caring for them. These are very rare people. You never get thanked. So, with the irate and nasty people, I try to leave as quickly as possible... It is very difficult to be compassionate. I hate to say that because I have lost all compassion, especially with the people who come in all the time and do not take care of themselves.”

The formation of this bias is inevitable, especially when the nurse is taking so much effort to care for her patients. It can be frustrating when people do not take the personal steps needed to stay healthy. This can lead to the nurse respecting the patient less, which could ultimately affect the overall care of the patient. Therefore, while it makes sense that nurses could have biases against

patients who do not look after themselves, they should not let these biases cloud their judgment when treating patients.

A nurse who works in a private practice was also interviewed to provide a different perspective from the fast-paced, task-oriented work style of the emergency department. When asked to expand on what factors decide how much time she initially spends with the patient, she said:

“It should not influence it, but sometimes it does. If they are coming in, and they have a serious problem, I am going to really slow down and take time with them and see what is going on. If it is a routine thing, then I might cut it short since the doctor will also take a history.”

It was interesting how the nurse guiltily admitted that the severity of the case should not influence how much time she allots for the patient to tell their story, but at the same time it makes logical sense that the patient with a more complex history will have a longer story to tell. Therefore, the nurse would have to spend more time collecting the patient history.

Patient Narrative

The patient narrative is a key component of the doctor-patient and nurse-patient relationships. Furthermore, the diagnosis and treatment plan are built based off of the patient’s narrative. When patients were asked to share anecdotes regarding their doctors’ visits, one patient noted that her physician seemed distracted and was not bothered to learn more about her backstory. Therefore, she felt that she was not receiving adequate care during her telemedicine visits. Another patient stated that her physician would interrupt her while she was sharing her concerning symptoms.

“The doctor would cut me off and say that I am probably fine despite the list of symptoms I had. She did not care to listen to what I had to say and did not want to consider other treatment options.”

When this would happen, the patient said that she would sit in the examination room and anxiously remember the concerns that she wished she had a chance to discuss with the doctor. This sentiment was shared by another patient who said that if their physician seemed to be in a rush, they would not feel comfortable sharing their health concerns and would ultimately not share them in as much detail as they would have liked.

The patients were asked to indicate how satisfied they feel after speaking with their physicians on a scale of 1 to 10, with 10 being very satisfied and 1 being very dissatisfied. The results were consistent across all interviews, with all four patients rating their level of satisfaction as 9, meaning that they were very much satisfied with their encounters with their physicians. Although, this was a very high rating, I was curious as to why the patients were not fully satisfied enough to give their physicians a rating of 10. The answers to this question varied, but all of the reasons had to do with aspects of bedside manner and listening to the patient narrative. One patient said that she appreciated that her doctor had made the effort to learn more about her education and career goals, but there was one incident where her physician did not listen to her complaints and it led to a medical scare.

“The doctor told me the IUD should lighten my periods, but I was still bleeding a lot and told my doctor. She said she would not worry about it if you are feeling better cramp-wise. When I went back to see her a couple of years later and told her that my bleeding still had not stopped, she said she would put me on an oral birth control in addition to the IUD to make the bleeding stop. I was like ‘but isn’t there a bigger problem?’ so she said okay and ordered an ultrasound. She found that my IUD had moved and was stuck to one of the walls and said we need to remove it because that could tear my uterus.”

This is a prime example of a situation in which the physician could have emphasized listening to the patient narrative more. The doctor could have valued the patient’s symptoms and complaints more, which may have led to the doctor ordering an ultrasound earlier on rather than prolonging

the problem for so long. If the doctor had listened to the patient's story, the patient would have probably had less pain, discomfort, and frustration.

Physicians had mixed responses when asked about the extent to which listening to the patient narrative was taught in their medical training. Three of the five interviewed physicians stated that the patient narrative was not greatly emphasized in their medical school and residency experiences. One physician said that he did not learn much regarding patient interaction in medical school or residency but rather developed those skills over time as a practicing physician.

“We get told about empathy and that we should sit down because patients have the perception that you spent more time with them if you sit. But people can tell when you are genuine or not.”

The above quote is an example of how health care providers may be taught to take a certain action to paint the façade that the health care provider cares about and is listening to the patient when they in fact may not.

The physician went on to discuss how patient skills are developed through practice over time and how certain patient situations require more expertise in terms of communication skills.

“Anybody can take care of a person with a sore throat but telling Mrs. Jones that her mom has got terminal cancer and you having nothing to offer other than palliative care. That takes a bit of a skill and that takes some time to develop.”

On the other hand, another physician had a differing experience and actually learned quite a bit regarding patient interaction during residency. This physician stated that approximately a quarter of her patient interaction skillset is a result of a course that focused on bedside manner in her residency program. As part of the pediatrics residency program, the physician also took part in a pharmacy rotation where physicians tasted the medications that they commonly prescribe to children to better understand how the child perceives the medication. The physician said that course greatly affected her methods of practice and she makes sure to place a

request to the pharmacy for palatable flavors to be added to certain medications that she calls in. This portion of the residency program placed the physicians in the patients' shoes which is a great lesson on how valuable the patient narrative is.

While all five of the interviewed physicians did not feel that listening to the patient narrative was emphasized in their training, all of the physicians affirmed that they value the patient's narrative and work to ensure that the patient's story is heard. A couple of physicians were slightly vague in responding to the question of how they emphasize the patient's narrative. One physician simply stated that he makes sure to ask open-ended questions and emphasizes understanding the patient's social history throughout the appointment. Another physician affirmatively stated that eighty percent of the patient's diagnosis comes from the patient's history. The physician went on to use the example of appendicitis to describe how the physician can oftentimes diagnose the patient solely based on the symptoms that the patient describes without even examining the patient. Another physician imparted a similar piece of knowledge by saying "if you just listen, the patient is telling you their diagnosis".

A pediatrician discussed the multitude of factors that have to be contemplated when treating children.

"You have to consider insurance, home background, and cultural beliefs when coming up with treatment plan because you know whether or not they will be compliant with treatment plan. You also have to think about: Does child go to daycare? Do parents work? Is there a caregiver that will give the medication to patient? Is patient in foster care?"

The statements made by this pediatrician display how she values the patient's narrative and truly considers external factors, such as aspects of the patient's lifestyle, that could affect the patient's symptoms and treatment plan. These are attributes that are vital to the processing of the patient's

narrative so that the individual patient's circumstances can be examined and weighed into the decision-making process.

One physician described how every patient is different and that he tailors his approach of speaking with the patient and treating the patient based on the patient's personality and lifestyle.

The doctor said:

“Some patients are more complicated than others and you have to spend more time. They have multisystem involvement, and you have to see how these all fit together and decide which one to treat first. Some patients will give you every last detail and stuff that you do not need to know, and you have to redirect them. Some patients are sparing in their words, so you have to tease it out of them.”

This description paints the picture of what listening to the patient's narrative means and how it is vital that the physician factors the patient's story into the treatment plan. Moreover, the physician commented on how every patient is not the same, and the physician must tailor their approach to each specific patient; this exemplifies how listening to the patient's narrative can lead to a more personalized approach of treating patients. In addition to what one doctor said in the preceding quote, another physician also discussed how she tries to ensure that the patient feels that the examination room is a safe space where the patient can comfortably discuss all of their concerns.

The doctor said:

“At end of visit, I ask ‘what else can we talk about?’ rather than ‘is there anything else you want to talk about?’ which allows patient to say whatever is on their mind.”

The concept of making sure that the patient does not feel rushed is vital to gaining an understanding of the full patient narrative. If the patient feels like the health care provider is in a hurry or distracted, they may not be as open in discussing their health concerns which can lead to an incomplete patient evaluation. Thus, it is imperative that the health care provider shows that the patient and their narrative are valued, so that the patient can openly speak about their concerns, which will ultimately lead to the physician treating the patient more efficaciously.

Additionally, health care providers will also be able to treat their patients more efficiently by listening to the patient narrative, as they will be cognizant of all puzzle pieces involved in the patient's story which can make for a less labyrinth-like diagnosis and treatment plan.

Documentation of Patient History and the use of Electronic Medical Records

The interviewed nurses and doctors were asked about their use of electronic medical records (EMRs), in particular, and whether EMRs pose any risks to the health care provider's ability to interact with the patient and listen to the patient narrative. The physicians varied in their methods of documenting patient information. Two of the five physicians stated that they use pen and paper to record patient information during the visit and scan it into an EMR afterwards. One physician does not use any form of documentation during the visit but rather enters all of the information into the EMR post-visit, and the other two physicians utilize their computer or EMR in some form during the visit. The two physicians who use pen and paper appreciate how they can face the patient while recording information. One of these physicians noted that using a computer while talking to the patient can make the patient feel that the doctor is more engaged with their computer than the patient. Therefore, the use of a computer during the patient visit is a strong deterrent for this physician.

The emergency medicine physician discussed how prior to the COVID-19 pandemic, his hospital had a scribe program so that the scribes could record the patient information during the visit and the doctor and nurses could focus on interacting with and treating the patient. However, due to budget cuts, the hospital no longer has a scribe program, so now the physician has to document the information. The doctor said that he avoids using his computer while he is with the

patient and saves the task of documenting in the EMR until directly after he leaves the patient's room.

Another physician that I interviewed uses a similar method of documenting all of the patient information immediately after the visit is over rather than during the visit. This physician said he also utilizes the free-text option on the EMR, which allows the provider to type anything without limitations in a textbox in the EMR. The physician said that he finds it more efficient and allows him to cover all of the categories and information that he would like. The physician who stated that he uses his computer during the patient's visit said that he informs the patient that he will be taking some notes so that they are aware of why he is looking at his computer. Furthermore, the doctor keeps his computer off to the side and sparingly documents information during the visit. The physician said that he tries to save most of the documentation till after the visit is over and mostly uses free-text and dictation. It appears that all of the interviewed physicians feel as though the use of a computer while speaking to the patient can distract away from fully listening to and understanding the patient narrative.

One patient expressed how her doctor's use of a computer during her visit can hinder her ability to tell her narrative uninterrupted.

“When I see that my doctor is typing on her computer, I slow down while telling my story, because I do not want them to miss what I am saying. But because I am pausing while talking, I often times get to the next item on my list and reconsider whether I even want to mention it.”

This is one piece of evidence that depicts how the use of a computer by the health care provider during the patient's visit can hamper the patient's ability to express their narrative. The patient even admitted that she omits parts of her story while her doctor is typing on her computer. The use of an EMR while the patient is talking to the health care provider can deter the patient from providing a thorough history as he or she may feel that the doctor is not providing their

undivided attention or because they are trying to be cognizant of the provider's ability to keep up with the patient's speed of speaking while they are typing. Unfortunately, this can lead to vital patient information being excluded. Especially in the case of the interviewed patient who finds that she second guesses the importance of her next thought while the physician is typing and ultimately leaves out parts of her story due to this.

Another patient said that his physician uses pen and paper to document his medical history and complaints during the visit. The patient expressed that he appreciates this, because he is certain that his physician is focused on him and recording what he is saying. In contrast, if the physician were to use their computer to document information during the visit, the patient would be weary of what the doctor is actually doing on his computer and have doubts about whether he is focused on recording his complaints or is busy tending to something unrelated to his visit.

One interviewed nurse who uses pen and paper to document patient information during the visit said that she likes how she is still able to face the patient while talking to them. She stated that she pauses her conversation when writing so that she is always looking at the patient when they are speaking. It is important to note that she emphasizes the importance of making eye contact with the patient and providing her undivided attention.

One nurse stated that he mostly checks off boxes on the EMR rather than using the free-text option where one can type unstructured text to provide more complete descriptions that cannot be captured in the preset checkboxes. The nurse said that he used the free-text option occasionally to communicate information to the doctor, and he prefers using the checkbox method overall due to the fact that it saves time. This makes sense since time is a scarce resource in the emergency department.

Biases

Privilege of Common Interests

It appears that the privilege of being a physician in training or being closely related to a physician can oftentimes provoke preferential treatment toward the patient from the acting physician. One patient said that physicians respect her more when they find out that her parent is a physician. Moreover, in addition to garnering more respect, the patient also feels that physicians take more efforts to help her when they hear that she has a parent who is a physician. The patient shared an anecdote about how when she was in the emergency room and was receiving subpar medical treatment, she called her physician parent to speak with the emergency medicine doctor. As soon as the emergency medicine doctor found out that the patient's parent was a doctor, the physician took the patient's symptoms more seriously. During the interview, the patient stated, "all of a sudden, they were treating me like a princess".

Interestingly, two of the interviewed patients were in medical school and stated longer average appointment times than the other two patients who were interviewed. One explicitly said that their health care providers spend a good portion of their total appointment time catching up with them about how medical school is going and what their future plans are. This aligns with information that one of the nurses shared during her interview. She stated:

"Yes, there are times where the doctor might spend more time with one patient versus another one if they have similar economic backgrounds. If they have more in common with the person, not necessarily related to problem that they are coming in with. It seems independent of the exam that they would have to do versus how much time they are spending with the patient."

It is interesting how this trend that the nurse pointed out in the interview reappeared in the conversations that I had with some of the patients. These interviews collectively highlight that physicians may spend more time with patients if they have more in common with them. The fact

that a physician is spending more time with certain patients could mean that the physician inadvertently values the narrative of a patient with whom they can relate to more than the narrative of a patient with whom they do not form a connection with. This could lead to inequity in the overall treatment of patients, especially regarding how much the health care provider listens to the patient narrative. It is possible that if health care providers do not share common interests with the patient, they may not listen to the patient narrative as intently and may not spend enough time with the patient to get a full patient history and gain an understanding of the context surrounding their symptoms and medical concerns.

In addition to sharing common career interests, it is possible that racial similarities between the health care provider and patient could also lead to the patient feeling more comfortable. One patient noted that his previous health care provider was of the same race as he is, and he felt that commonality helped him in relating to his physician more.

General Patient Biases

While there are many implicit biases comprising of preferential attitudes based on social identities, people can also present with biases based on other components such as certain behaviors or mannerisms. The biases discussed in the interviews include biases against frequent fliers in the emergency department, individuals unvaccinated against COVID-19, and individuals with lower level of education. Weight bias was another issue that was discussed. For example, one nurse said:

“When we see “repeat offenders”, the people that are there (emergency department) every week or some people come in day after day after day—it wears you down and everyone is tired of it. Especially now, nursing and health care has changed so much in the past five years, but significantly in the last two years.”

Another nurse agreed and shared a similar sentiment:

“If we see a repeat offender who does not follow what we say and that is why they keep coming back, then we get a type of stance and attitude towards them a little bit, but we are still trying to be respectful.”

The preconceived notions surrounding these so-called repeat offenders, also known as ‘frequent fliers’, are forms of bias. Frequent fliers often are patients with serious mental health conditions. One EMR system even denotes frequent fliers with an airplane icon next to the patient’s name (Landi 2016). It is possible that a health care provider fails to treat a frequent flier patient as diligently as they would any other patient due to this implicit bias.

The nurse said that she got upset with a COVID patient in the emergency room because he was not vaccinated. She expressed her discontent with him and told him that he would not be in the hospital if he had gotten vaccinated. During the interview, she said:

“These people who are not getting vaccinated and are not wearing masks, they do not live my truth. Those people, I have zero tolerance for.”

While health care providers should not let biases affect their diagnosis and treatment of patients, it can be especially difficult when the patient is putting others at risk of being harmed.

The idea of biased verbiage being used in medical records was examined by asking health care providers if they have ever noticed any instances where a health care provider has used vocabulary implying some sort of bias in any medical records. One physician stated:

“I think twenty years ago you would see more of that. Patients now have instant access to their visit over Epic (EMR system) which is a new feature since a year.”

The physician felt the fact that health records are easily accessible to the patient will discourage health care providers from using biased vocabulary in their write-ups.

When asked to think about biases she has noticed among other physicians, one pediatrician shared a story about her patient’s bad experience with a specialist that the pediatrician had referred the patient to. The patient was obese, and the specialist recorded the

patient's history in the medical record using demeaning terminology. The specialist also told the parents of the patient that "they eat like pigs and look like pigs". Due to this horrible, degrading experience, the parents ultimately decided against visiting that physician again.

The idea of socioeconomic bias was not a topic that was brought up often in the interviews, but a patient and a nurse both shared examples of socioeconomic bias that they have observed. The patient who is a medical student shared an anecdote about a doctor-patient encounter that she witnessed while shadowing a physician.

"A doctor assumed that a patient's family did not understand what was going on with their child's treatment and tried to dumb it down because I am assuming the parents only had high school degrees. He (the doctor) said he was so surprised by what they knew and said. I was surprised by that."

Many of the instances of bias noted from the interviews are due to the health care provider making invalid assumptions based on no clear evidence. This is another example of a physician presuming that they know everything about the patient and the patient's family. Due to this hasty assumption, the physician treated the patient's parents as being lesser than.

Age Bias

A theme that held true across all of the patient interviews was age bias. Interestingly, stories that depicted the manifestation of age bias fell on both sides of the spectrum: the assumption that the patient was too young to understand what was going on and that the patient was old enough to receive the diagnosis coldly. One patient shared a story about how her doctor did not believe her most likely due to her young age.

"When I was eight, I had a bad cough, but the doctor said I just had a cold. I felt I had pneumonia but the doctor refused to believe it, so I went into the office five times until finally I had hip pain and they sent me in for an x-ray and realized that my lungs were filled with fluid."

This anecdote demonstrates how health care providers might not take a patient's symptoms as seriously if they assume that the patient is too young to understand what going on. This bias can affect the patient's overall wellbeing, so it is vital that health care providers do not make such assumptions for the safety of their patients.

On the other hand, sometimes health care providers will assume that the patient is old enough to take bad news well and they will refrain from sugar-coating the diagnosis. This could backfire if the patient is not as prepared to hear the diagnosis as the physician believes that he or she is. One patient had a situation that she shared in the interview, which elaborated on this topic.

“I had a lot of knee and hip problems when I was younger... The way that I was treated when I was thirteen versus seventeen was very different. They started to see me as an adult, not a kid anymore, so they expected me to take it better, but when I went in to see my doctor, the doctor straight up gave me my diagnosis and said I need surgery. I was in shock because when I was younger, they would express that they will try to find a way to fix it, but this time it was straight up ‘you are getting surgery or you are going to have arthritis and need a hip replacement when you are forty’. Point blank.”

It is important to note that the health care provider made assumptions regarding the patient's maturity and ability to handle a diagnosis. In order to avoid making assumptions, the health care provider could evaluate the patient's demeanor to gain an understanding of how to approach serious topics with the specific patient; this should be easier to do if the health care provider listens to the patient narrative.

One nurse reflected on her own biases and recollected an encounter in which she presented with an age bias against a patient.

“I thought of an example of personal implicit bias. It was regarding age. There was an elderly patient being seen. There is a subjective test for an eye misalignment called torsion that is a bit complicated to explain to patients. Because the patient was so old and had a little trouble communicating regarding other things, I did not perform the test thinking it would be too difficult for them. When the doctor looked over the chart he noticed this and asked me to do it so I went back in to try. She was actually able to do the test and I was very embarrassed that I assumed she could not. Now I always try all the

tests appropriate for the patient's problem, so I know for sure if a patient is unable to do them.”

It is significant that the nurse learned from this experience and has allowed this unfortunate situation to impact her practice and patient interactions in a positive manner.

One physician shared a bias that some physicians at her practice possess against women of older age.

“Some doctors will roll their eyes thinking that a woman is going to speak forever. There is some bias towards older women with a long list of complaints. You do not see this as much with men who have a long list of complaints”

It is interesting that this anecdote contains both age and gender bias. The physician was not sure how this bias came about, but, based on literature, this could potentially be the result of the gender biases deeply rooted in medical literature and teaching (Phillips 1997 and Yut-Lin 2009). Furthermore, it is notable that this was mentioned in an interview, as one piece of literature that was discussed in chapter 2 focused on how there is a discrepancy in how physicians perceive male versus female patients. This study found that 25 percent of the physicians believed that females patients were likely to excessively use physicians’ time, while only 14 percent of the physicians felt that men would be likely to unreasonably use physicians’ time (Bernstein and Kane 1981).

Gender Bias

When asked about whether they have a preference for a physician of a certain sex, most patients stated that they do not have preference overall, but the female patients said that they prefer a female physician as their obstetrician/gynecologist (OB-GYN). The overarching reason behind this was that they felt that female physicians would better understand their symptoms

since they have the same anatomy. Similarly, the male patient said that he would prefer a male PCP but does not have preference for a male physician in other specialties.

One nurse shared her thoughts on female and male providers from the patient perspective.

“If I had my choice, I would only want a female provider because they understand more about the female perspective than men do. You go in and tell someone that you are having menstrual cramps and the guy is going to be like ‘suck it up’, but women know what menstrual cramps are and how debilitating they are. There are some very empathetic men but you cannot know it unless you live it.”

Her sentiments about how female physicians understand the female body better than male physicians align with those of the female patients who were interviewed.

Three of the four interviewed patients expressed certain notions regarding female physicians in comparison to male physicians. The patients said that female physicians can be more empathetic and that they work to address the different layers of the issue being discussed. On the other hand, the patients believed that male physicians are more straight to the point and do not necessarily spend as much time as female physicians do preparing the patient for a serious discussion. Furthermore, one female physician also noted that studies show that women spend more time with patients to collect the patients’ stories. For example, one study found that female physicians spend an average of 2.4 minutes more per visit with their patients than their male colleagues (Ganguli et al. 2020).

A male physician discussed his thoughts on how the interactions between a doctor and patient of different sex may vary from the interactions between a doctor and patient of the same sex.

“Can women comfort other women easier? Probably. Particularly, if the woman patient has been subject of abuse or trauma. That is not something that a male physician can do as easily, but that does not mean that the male physician cannot do it.”

Two patient scenarios were presented to each of the health care providers during the interview (see Appendix A). The two patient scenarios were very alike in that the age of the patients were almost the exact same and the health condition was the same. The only difference between the two scenarios was that the names of the patients were different and implied that the two patients were of a different sex. The two patient scenarios were strategically spaced out in the interview, with approximately nine questions being asked in between the two scenarios. The purpose of these patient scenarios was to observe if the health care provider's response regarding the collection of the patient's history and formulation of the treatment plan varied based on the gender of the patient. The goal was to make the interviewee subconsciously assume the gender of the patient based on the name of the patient, and the scenarios were not presented consecutively so that the interviewee's instinct was not to simply state that they would treat the patients in the same way. None of the interviewed health care providers answered these prompts in any way that indicated the presence of gender bias.

A common example that a nurse and two physicians recounted when asked about whether they have noticed health care providers treating patients differently based on gender was the idea of women's and men's chest pain being perceived, diagnosed, and treated differently. Females tend to experience pain in their stomach, neck, and back in addition to the chest, while men mostly complain of pain solely in the chest. One nurse noted that women's chest pain used to not be treated the same as men's chest pain, because the condition manifests differently in females compared to males. The nurse said that she personally believes that health care has changed, and that this bias regarding the presentation of chest pain in males versus females has been overcome. A physician stated the same view as the nurse on this issue and said:

“Twenty years ago, we downplayed chest pain in women and thought their cardiovascular risk was less but now we are more educated and have been made aware of this. We now know that women present with atypical symptoms compared to men”

It is worth noting that the physician’s last sentence displays an inherent bias. The physician described the females’ symptoms as being atypical in comparison to males’. This is evidence of the idea instilled in medical literature of males being considered the medical norm.

Interestingly, one nurse said that she might possess some bias against men because they will come in with small complaints, while if women were suffering from the same issues, they would continue caring for children and complete their daily tasks.

Racial Bias

One patient who is a medical student discussed how there is a class where they learn about implicit bias and racism, but all of the proctors are white. Additionally, in many of the class discussions surrounding implicit biases in this course, students are unsure of how to approach the conversation and tread very lightly. This does not make for very conducive discourse, because people are uncertain of how much they should speak regarding various topics. The patient also noticed that people of color spoke the least during this discussion.

When a nurse was asked about any biases that she noticed her preceptors having during her training, she spoke about an experience she had during a rotation. A patient expressed that they did not like how high the level of clarity of their vision was with the corrected lenses, so after the patient left, the person training the nurse that I interviewed shared a racist stereotype.

“The lady (her trainer) said that there is a stereotype with Asian people that maybe they do not want to see as clearly and do not like to be corrected to 20/20.”

This anecdote was surprising and is an example of how important it is that sensitivity and bias training be incorporated in medical training and education.

“Working in some of the more urban areas, some of the populations there tend to migrate to certain things, so if you see that kind of ethnicity come in, it can be easy to think oh they are just having a panic attack.”

This quote was also surprising, but it was telling of the thoughts that go through some health providers’ heads and is another example of how vital it is that health care providers undergo more sensitivity training.

Recognizing and Coping with Internal Biases

It is vital that individuals realize that it is normal and inevitable to possess implicit biases, but the way that one goes about managing their internal biases so that they are not projected onto others is what is most important. Physicians were asked about their thoughts on the presence of implicit biases in the health care system. When one physician reflected on this he said:

“By large, these issues that bias was through the health care system really was flagrant and I just disagree, I do not think it is. I think most doctors are very objective and they may have some implicit bias but I do not think it is as severe as what is made out in the media, at least I am not seeing it. I mean, there may be places where people are just racist and treat people improperly. But assuming someone is not a racist, it was hard for me to understand where they were getting their data, because it was not what I was seeing in the practice. I do not know where they were getting their data, so to me it was a cautionary tale but it was not like ‘oh yeah, we are all full of bias here’. I just do not see it. Most doctors are doing an honest job and treating people based on their presentation, not on their sex, race, or social disposition. We need to be aware of it (bias), but I am just not seeing it (bias) but maybe there are places where it is more prevalent.”

When one doctor was asked about whether he has seen or heard of any of his colleagues projecting their internal biases on patients or revealing their biases in conversations among colleagues, he said:

“All of us talk about patients in times when we probably should not. But I think folks at the place where I work now are good about making sure their implicit biases do not interfere with patient care, because if they did, we would be in the wrong field”.

Although the doctor does not feel that biases are as prevalent in health care as the media has made it out to be, he does acknowledge that there probably are biased providers practicing

somewhere, but he has not personally encountered biased health care providers himself. He also reflected on his own personal biases.

“I never really considered that I had bias but in reading some of the things that are out these days, I think I would be foolish to think that I am not susceptible to some kinds of bias. Those of us who deal with pain medications and opioids have a sixth sense for who can be trusted with opioids and I am sure there is some bias in my head. I wonder if there is some bias after reading some studies that were done where Black people going to the emergency room were less likely to get pain medications. So I asked myself if I was less likely to give a Black person pain medications. I do not think so, but now I am extra careful and think about that.”

After reflecting on the fact that biases exist in health care, physicians were asked to share how they prevent themselves from acting on their biases when interacting with patients. One physician said that in order to eliminate the chance of biases clouding her vision, she tries to ask the same list of questions to all of her patients. Another physician said that he has not noticed any personal biases but he is aware that they exist, so he goes to implicit bias training sessions and continues to educate himself to think about bias more.

CHAPTER 5: DISCUSSION AND CONCLUSIONS

In the interviews conducted with five physicians, three nurses, and four patients, a multitude of biases were identified. These biases include gender, race, and age biases along with a bias of health care providers favoring patients that they share a common interest with. There were many themes identified across the interviews. One theme was that the volume of patients can determine how much time health care providers allocate to spend with each patient during their visit. Literature has shown that physicians with a high volume of patients had visits that were thirty percent shorter than low-volume physicians. The study noted that this is an increase in efficiency for the physician's practice, but it comes at the cost of decreased patient satisfaction, decreased delivery of preventative services, and a strained doctor-patient relationship (Zyzanski et al. 1998).

Another theme which existed among the interviewed physicians was that the majority of the physicians did not feel that they were adequately trained in listening to the patient narrative during medical school and residency. Therefore, it is imperative that courses regarding emphasizing the patient narrative and learning emotional intelligence is added to medical school and nursing school curriculum. Emotional intelligence is the ability to use one's emotions to empathize with others, communicate effectively, and overcome conflicts and obstacles. Health care providers who exhibit high emotional intelligence are more likely to have better clinical outcomes, increased empathy, and improved teamwork abilities. Some of the building blocks of emotional intelligence that should be taught in medical training are self-awareness, self-management, and empathy (James 2019). Teaching health care providers how to be aware of their emotions, strengths, and weaknesses along with teaching them how to stay calm when their

emotions are running high are key ways to indirectly affect the providers' relationships with their patients and how much value they place on listening to the patient narrative.

With regard to the method that health care providers use to document patient's history and concerns during the visit, all five physicians stated that they try to avoid using a computer during the patient visit. Instead, some physicians use pen and paper to document the patient's history during the visit, as it enables the physician to face the patient while taking notes and sustain eye contact with the patient most of the time. The overall consensus across both the nurses and physicians who were interviewed was that using a computer while speaking to the patient should be avoided if possible. All of the health care providers who were interviewed ultimately use an EMR to finalize the documentation of the patient's records, but many of them refrain from interacting with the EMR until after they have left the patient's room. There will always be some flaws in the method of documentation of health information. For example, for the physicians who wait until after they have left the patient's room to document any piece of information, there is always the chance that they forget a vital piece of information. For the health care providers who utilize pen and paper or a computer during the visit, they will not be able to maintain eye contact with the patient through and through.

The most infallible method of documentation would most likely be to have a scribe document all patient information during the visit while the physicians and nurses provide their undivided attention to the patient. Of course, hiring scribes would require funding, so this may not be an attainable option at all practices and hospitals. However, in order to reclaim the importance of the patient narrative, it would be advantageous for practices and hospitals to reallocate funding so that a scribe program is possible to implement.

Interestingly, two emergency department nurses mentioned the idea of frequent fliers in the emergency department. The term ‘frequent fliers’ can hold a negative connotation, as these patients are often assumed to be problematic. For example, in psychiatric facilities, frequent fliers are sometimes considered to be drug seeker. The fact that an airplane icon is placed next to certain patients’ names in EMRs to warn the health care provider that the patient is a frequent flier can damage the patient’s potential to have their narrative be heard (Landi 2016). This icon could lead the health care provider to dismissing the patient’s symptoms and not taking the patient’s narrative as seriously as they should. In order to mitigate this bias in health care, it would be beneficial for EMRs to get rid of the frequent flier marking in their system.

One of the interviewed nurses made statements regarding how she has lost compassion for nursing and is frustrated, especially with the impact of the COVID-19 pandemic. This highlighted the reality of burnout in health care. Burnout is characterized by emotional exhaustion and detachment from colleagues and patients. Some of the factors that could lead to burnout are heavy workload, lack of autonomy, insufficient compensation for job, or a lack of missions or goals. Burnout amongst health care providers can lead to medication errors, infections, and overall patient dissatisfaction (Dall’Ora and Saville 2021). Since physician and nurse burnout is such a monumental issue in health care, more measures should be taken to cope with this issue. One study found that providing nurses more flexibility in scheduling their shifts lowered burnout rates (Dall’Ora and Saville 2021).

A notable theme was the concept of age bias, which was mentioned by all four interviewed patients. This was the only bias that was explicitly shared by all of the patients; a nurse and physician also shared their own experiences with age bias. This is evidently a common bias in health care; therefore, it would be worthwhile to include more sensitivity training specific

to age bias in medical and nursing schools, residency, and continuing education courses. It makes sense that age bias was the only bias unanimously identified by the patients, as patients normally have the ability to pick which physician they decide to make an appointment with. Therefore, since they have the opportunity to research and learn more about the physicians that they could potentially visit, there is a lower likelihood of them experiencing biases. One interviewed physician shared a thought that effectively summarizes this phenomenon. “Some patients like male doctors and some like female doctors. They have a right to implicit bias. Doctors do not have that ability. They are supposed to be the right doctor for every patient and support that patient as best as they can.”

Another shared theme was common notions regarding female versus male health care providers. Three of the four interviewed patients and some of the physicians and nurses discussed how female physicians can be perceived as being more empathetic. This is a more positive bias towards female health care providers, which was refreshing as oftentimes, females are considered to be inferior to males.

Lastly, all of the health care providers struggled to answer the question regarding whether they have noticed any personal biases that they possess and how they manage these biases. Some interviewees simply said that they have not noticed any personal biases, while others said a similar statement but mentioned that they are sure that they must have some biases, but they are unaware of exactly what biases they hold. Only a couple of the interviewees were able to give examples of instances where they may have acted on a bias that they have. This theme emphasizes how important it is that more implicit bias training is implemented in health care, as so many of the interviewed health care providers were unable to name their biases. If one fails to identify their biases, it cannot be assumed that they do not possess any biases, but rather it could

be assumed that they might be unknowingly acting on their biases, since they were incapable of recognizing their biases to begin with.

While there is literature published about the importance of listening to the patient narrative, little literature exists regarding the extent to which health care providers listen to the patient narrative. Furthermore, most of the literature regarding the patient narrative focuses on the topic through the perspective of a physician has the health care provider rather than considering the viewpoint of nurses. This study contributes information regarding the extent to which health care providers value the patient narrative to the literature already existing on the general idea of the patient narrative. Moreover, this study also explores the variety of implicit biases that exist in health care from both the providers' and patients' perspectives. This is another aspect that existing literature has not discussed. While the existing literature mentions various biases that may present in health care, the literature fails to provide anecdotal evidence of these biases. This study also introduces a bias that is not frequently discussed, which is the idea that health care providers are more likely to spend time with patients that they share common interests with. Some limitations of this study include the relatively small sample size, the amount of time available to conduct the study, and the lack of diversity in the sample population.

Future Plans

The health care provider is only as good as what the patient tells them, so it is vital that the health care provider genuinely listens to the patient's narrative. Therefore, it is imperative that initiatives are taken to emphasize narrative medicine through courses and seminars beginning in medical/nursing school and continuing throughout the health care provider's years of practice.

In order to further explore the patient narrative and topics of implicit biases, this study will be extended to contain a larger sample of interviewees. Furthermore, this initial study effectively identified major implicit biases present in health care, so the future study will tackle the specific biases such as age, gender, race, and the privilege of common interests in more detail. Another idea that may be explored in the study is interviewing two separate groups of patients: ones who did not get to choose their doctor and those who had the opportunity to pick their doctor. This will enable the exploration of the incidence of implicit biases in these two different situations. Furthermore, in the future study, efforts will be made to diversify the sample population, especially in regard to race and age.

Conclusion

The findings of this study revealed that many biases are present in health care including but not limited to biases related to age, gender, race, and common interests. Furthermore, the interviews with health care providers showed that there is a lack of patient narrative training in medical and nursing school, so this is something that could be focused on in the future. Additionally, the interviews also revealed that health care providers are not always aware of or willing to discuss their personal implicit biases, so this is another aspect of training that could be enhanced in medical training. This study contributes information about the extent to which the patient narrative is emphasized in medical training and practice and the ways that various implicit biases could affect the doctor-patient and nurse-patient relationships. This study will be expanded to contain a larger sample size in the future and will also explore the role that the patient's ability to choose a provider plays in biases and having the patient narrative be heard.

APPENDIX A: Structured Questions for Health Care Providers

1. Could you please state your age, gender, race, and specialty?
2. How many years of experience do you have as a practicing physician/nurse?
3. Can you walk me through a typical visit with a patient, from start to finish?
 - a. During the visit, how much time do you allot for patients to tell their story to you?
 - b. Is that influenced by anything, like limited time during the visit, etc.?
4. Now I would like to ask you to consider this scenario. A patient named Ann who is 43 years of age comes to see you complaining of (insert health condition relevant to provider's specialty). What types of questions do you ask the patient and what is the treatment plan for this patient?
5. How do you document the patient's complaints? EMR, pen and paper, document after the visit, etc.?
 - a. Do you think that documenting patient information using an EMR during the visit affects how you are able to interact with a patient?
6. Approximately how long do you spend with new patients on average?
7. Approximately how long do you spend with established patients on average?
8. Is understanding the patient narrative important to you? If yes, can you please describe how you emphasize the importance of the patient narrative during your visits?
 - a. Definition: A patient's narrative includes the patient's sentiments about their health condition and how this has affected their lifestyle as opposed to a list of ailments
9. In what ways do you record the patient's narrative?
10. Do you think that EHRs take away from the patient narrative?

11. How does the EHR affect how you record patient narratives?
12. Was listening to the patient's narrative greatly emphasized in your medical training?
13. What were some key takeaways regarding patient interaction that you learned in medical school and/or residency that you value in practice today?
14. Now I would like to ask you to consider this scenario. A patient named Andrew who is 40 years of age comes to see you complaining of (insert health condition relevant to provider's specialty). What types of questions do you ask the patient and what is the treatment plan for this patient?
15. Can you define what implicit bias is?
 - a. Definition: preferential attitudes and associations towards people, which exist subconsciously
16. Have you noticed any implicit biases among your colleagues: physicians or nurses?
 - a. If yes, can you give me some examples?
 - b. If no, have you heard of any stories regarding biases and patient interaction from your friends who work in health care?
17. Thinking back to your time in medical school/residency or nursing school, did you ever notice any biases that your mentors or other physicians in training held?
18. Considering gender bias specifically, have you ever noticed any physicians or nurses treat a patient differently based on the patient's gender?
19. Have you ever reviewed a medical record and noticed that the verbiage used by the provider seemed to differ based on the gender of the patient?
20. Have you noticed any implicit biases that you hold? If yes, how have you worked to prevent yourself from projecting these biases on patients?

21. In your view, how does the gender of patient affect the way patient narratives are collected and understood?
22. In what ways does the gender of a provider affect the way patient narratives are collected and understood?
23. What about when the doctor and patient have different genders. How does that affect how they interact and how narratives are collected and understood?

APPENDIX B: Structured Questions for Patients

1. What is your age, race, and gender?
2. Approximately how often do you visit a doctor?
3. When was the last time you visited a doctor?
4. Can you please walk me through what a typical visit with your doctor looks like? What types of questions do they ask you?
5. During a typical visit to your primary care doctor's office, how long does your doctor spend with you on average?
 - a. Do you think that they spend enough time with you or do you feel that time is limited?
6. Do you feel like your physician addresses all of your concerns during your visits?
7. Do you ever feel like you are being interrupted by your physician when you are talking?
8. Does your physician seem to provide their undivided attention to you or does it seem like they may be distracted by other responsibilities such as tending to other patients and/or duties as a physician such as entering information in their computer, etc.?
9. How satisfied do you feel after speaking with your physician (scale 1-10)?
 - a. Ask follow-up questions about why they gave the rating that they did?
10. Have you ever felt like a physician has treated you differently due to your gender, race, or some other factor?
 - a. If yes, ask them to expand.
11. Do you have a preference in seeing a male or female doctor? If so, can you tell me why?
12. Thinking about the times you have seen a doctor of the opposite sex, did you ever feel that the way you talked with them was different? If so, can you tell me how?

a. In your experience, was the way they listened to you or your concerns different?

If so, can you give me an example of a time that happened?

13. Are there any other factors that influence the way you interact and are able to talk with your health care providers?

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