Colibri Healthcare

Podcast Transcript

Gender Bias in Healthcare: Consequences and Solutions

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Guest: Candace Pierce DNP, MSN, RN, CNE

Dr. Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. Pierce strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

Host: Scott Giles PT, DPT, MBA

Scott Giles | PT, DPT, MBA

Dr. Giles is the founder and President of Scorebuilders. He has authored numerous best-selling review books and has presented on licensure preparation throughout the United States and internationally for nearly three decades. Dr. Giles has taught over 500 review courses and assisted over 25,000 PT and PTA students to pass the National Physical Therapy Examinations. He received his master's in physical therapy from Springfield College and his Transitional Doctor of Physical Therapy from Simmons College. Dr. Giles received his master's in business administration from the University of Southern Maine. Dr. Giles served as a Clinical Associate

Professor in the Department of Physical Therapy at the University of New England for 15 years. He has disseminated research related to the licensing examination at the American Physical Therapy Association's Combined Sections Meeting, American Physical Therapy Association's Annual Conference and Exposition, and the American Association of Higher Education's Conference on Assessment Quality. He is the former Chair of the New England Consortium of Academic Coordinators of Clinical Education and a former Credentialed Trainer for the APTA Clinical Instructor Education and Credentialing Program. He served on the APTA Committee charged with revising the Physical Therapist Clinical Performance Instrument (PT CPI).

Episode 1: Gender Bias in Healthcare: Consequences and Solutions

Transcript

Candace Pierce: Hello, I am Dr. Candace Pierce with Elite Learning by Calibri Healthcare, and you are listening to our Elite Learning podcast where we share the most up-to-date education for healthcare professionals. Our topic for this podcast is gender bias in healthcare, and this is a topic that I really wanted to dive into because, being a woman and being a mother to girls, I know I've personally been affected by gender bias, and it affected my health outcomes, just like many other females. And joining me to host this discussion is Dr. Scott Giles. Scott, thank you for taking the hosting mic today so that I could discuss gender bias in healthcare.

Scott Giles: I appreciate the invitation. It's a very interesting topic, and just in our kind pre-recording meetings, I've learned a great deal about it, and I'm looking forward to seeing where this goes today.

Pierce: Yes, thank you so much for stepping in, and the floor is yours.

Giles: Okay, well, let's jump in. There's a lot to discuss, and this, like you said, is part one of part two, so we'll be maybe defining the problem a little bit more today, and then in our future session, we'll be getting into some solutions, which is exciting as well. So, Pierce, why don't we jump right in? Tell me a little bit about what gender bias is and how it typically manifests itself in the healthcare setting?

Pierce: Well, when we talk about gender bias, we're referring to the preference, really, for one gender over another. And we're going to see that oftentimes it stems from these deep-seated beliefs about gender roles and the stereotypes of the genders. But in healthcare settings specifically, you're going to see this manifest in a lot of different ways, such as how we interpret symptoms, the treatment types that are offered, and even the level of

seriousness with which patient concerns are taken. So an example that I have is women's symptoms of heart disease. A lot of times, they are often underdiagnosed or misdiagnosed when we compare them to men. And this leads to disparities in treatment and in their overall outcome. We know that heart disease is the leading cause of death for both men and women, and we also know that it presents differently—it can be significantly different in how it presents between genders. And so, women often experience more of those subtle or atypical symptoms when compared to men, which is what leads to that underdiagnosis and misdiagnosis. And I know that as we go through this discussion today, we'll touch on why atypical symptoms can actually lead to a misdiagnosis and underdiagnosis.

Giles: Yeah, I think that's completely fair. Well, look, in our society, we have all kinds of forms of bias, right, that we're dealing with, whether it's cultural, ethnic, socioeconomic, and on and on. Do you feel that, I mean, I think with certain types of biases in my uninformed mind, I tend to think like, look, a lot of it is awareness. A lot of it is examining your implicit biases. I mean, is there something we can learn from combating, not always successfully, but attempting to combat these other forms of biases that can maybe speed up or ramp up the process? Like we must have learned something at this point. I don't think gender bias is terribly different. How it manifests is different, but bias, to some extent, has some commonalities no matter what type of bias we're looking at.

Pierce: Yeah, there are a lot of biases that intersect with gender bias and other forms of discrimination, like what you're talking about. And unfortunately, that's going to create more of these complex barriers to healthcare access and to the quality of care that we receive. So, let's look at women of color. They often face that compounded discrimination because now you're a woman, now you're of a different race. And so, you're going to see those racial and gender biases, which is going to multiply that negative healthcare experience. You also have socioeconomic status. It just adds another layer of complexity. You have lower-income women who are going to have fewer resources to be able to even advocate for themselves or to have the opportunity to seek alternative care when they face these biased treatments. And then you also can look at age bias. I mean, age bias—and I know we're talking about gender bias—but age bias also exists, and medical research often results in a disproportionate focus on your adult population, particularly like our middle-aged and older adults. And so, you're going to see this manifest in funding allocations, clinical trials, and drug development.

Giles: Yeah, I mean, the more you slice it and the more you stack these things. It's funny because I was thinking of more of, okay, what have we learned? What strategies have we implemented with these other forms of biases that could be effective, you know, with gender bias? But it's funny, but then when you put it in the context you did, it's like, my goodness, it's worse than I even thought. We're just stacking these different forms of biases. And look, when they're as broad as, you know, gender or socioeconomic or religious or whatever, I mean, you're not rarely dealing with just one, right? I mean, this is probably two, three, et cetera. Wow, it just makes it over... I mean, I guess that's the value of having a discussion like this, right? Because you have to start somewhere and you have to... part of it, I really feel, is awareness and education that it is real. What do you feel about... I mean,

what specifically does the research show that are the psychological and, to some extent, emotional impacts of gender bias?

Pierce: Well, the impact on your psychological and emotional... that's profound. I mean, that's huge. When patients experience gender bias, they're going to feel, well, invalidated, dismissed, misunderstood. You almost feel like, I mean, when someone doesn't believe you, you're telling the truth, how does that make you feel? And that's, when it comes to your healthcare, it's really going to make you stressed out. You're going to feel anxious. You might even go into kind of a depressive state. You might even start questioning yourself: Is this my reality or am I making this up? What is happening? So again, that's going to cause a lack of trust because you're going to erode my trust in you and your abilities. It's going to lead to decreased adherence to medical advice. I don't know that I want to seek care if nobody's going to believe me. So, there's that reluctance to seek care in the future. And then when you kind of have this cumulative effect of these experiences, it really significantly impacts a patient's overall well-being and their quality of life. So, it all goes back to poor patient outcomes. And if you have some pretty traumatic experiences, you can't rule out PTSD either.

Giles: Yeah, I'm sure. Yeah, it's brutal, right? Because, I mean, when you think about our healthcare system for those that don't engage in self-advocacy, we know the research shows that, you know, positive outcomes are clearly correlated with individuals who do advocate for themselves, et cetera. But if you feel demeaned, if you feel that you're not being listened to, if you feel underserved or your needs aren't being heard or met, then how are you... you're not going to advocate for yourself. Most people will go into a shell and become a very passive participant in healthcare. And I think we know the outcomes that are associated with that, and they're not good. To me, it's a real spiral, right? A downward spiral when that exists.

Pierce: Well, and I know for me, I had a personal experience where I faced multiple biases myself and, you know, mine were I was a female, I was young, and I was a military spouse, and I mean, military spouse, military in general, you usually have some type of bias there towards you. But I had made an appointment with my primary on-base provider and I told them in our meeting that like, "My stomach has really bothered me and I wasn't sure why." And he just kept telling me over and over again that I needed to see psych for anxiety. Even after I told him multiple times, "I have no reason to be anxious right now. I really don't think that this is the problem." But he did not assess my stomach. He didn't take me seriously. And that was early in the week. And by like that Friday, I was in the ER with my stomach so swollen, and I was in some of the worst pain. Even today after having three kids, like I'm like the pain that I was going through then was so much worse than childbirth for me. Yeah, so in the ER, they did a CT scan, and it showed my intestines were so inflamed. It was like my transverse colon all the way down to my sigmoid colon. And the doctor just walks in and looks at me, and he's like, "I cannot tell you if this is cancer or if this is an infection, but they are really inflamed." And so I, of course, being a nurse, I was like, "Is there any way you could just give me some IV antibiotics, a couple of doses, and then just let me go home and finish it out?" And so I did. And of course, they tell you, "Hey, on Monday, go check in with your provider, just, you know, for your follow-up." And so I did, I went in to see him on that

Monday. He walks in, he looks at me, he looks at my chart, and he leaves the room and goes and calls the GI doctor to get me an appointment. So, he personally called to get me an appointment with them. He did not apologize. He did not acknowledge that he failed me. And so many women of all colors and ages deal with the same type of treatment. And it left me with a lot of questions because, I mean, I could have turned septic. I was probably on my way to being septic. And so I questioned, like, if he had taken me seriously, would I have ended up in the emergency room? If I didn't go to the emergency room, would I even still be here today? My care was so delayed. And my outcome was overall not good. They had to go back in for like… after he was like, "Do you want to do a colonoscopy today? Or do you want to wait till your antibiotic is done?" And so, because he was like, "I need to see what's going on. I need to know if this is cancer and infection." I was like, "Just let me finish my antibiotics." And then, you know, but the fact that he didn't even apologize or acknowledge.

Giles: Or take the time to engage in a meaningful physical examination. I'm not sure if this individual felt he was psychic or what the possibility is, because what are you basing that anxiety comment on with doing no formal examination? Now, look, you'd like to think this is just a terrible provider who had a really bad day, but we probably know that's not the case, right? I think we know your example is illustrative of what happens a lot. And just think about, I mean, you're—I don't know you that well, but I think you're very well-educated. You're an assertive individual. You have beliefs. You're not going to get rolled over. I mean, a lot of people don't have the self-confidence that you have, or I don't know how much medical knowledge you had at that time, you know, but either way, I mean, the outcome, I don't think it's dramatic to make it like, you know what, like you said, you might not even be here. And that's not drama. That's reality of that situation as you hear it played out. So that, yeah, that makes me very unsettled to even think about that.

Pierce: Yes, well, let me walk you down another little rabbit hole that I have found really interesting with gender bias. So we know that even if there was thought that the male biology could actually transfer over to the female body, we know today that it doesn't really work that way. So when you look at the medical knowledge that we have, I use this phrase, it has to be in the context of that knowledge. The medical knowledge was primarily created by and for men because women were excluded from medical education, medical research positions, and being in clinical trials. And so that's why I'm saying it was created by and for men. And so we're really having to make up for that today. And so the issue is from the fact that the focus on male subjects has led to like this medical research paradigm where male physiology is still today considered the default for so many things. But what I found really interesting is that this male-centric approach in medical research has actually perpetuated the belief that because the male physiology is the norm, the female physiology is the deviation. So let's look back at the 19th-century biological writings. We have Darwin, and he gave this notion that females were biologically inferior. And we still see that today. It's had lasting effects today. And then you have those Freudian theories where they were like women's experiences contribute to a tendency to our physical symptoms are because of psychological causes, which you see that happened to me. So let's go further down our little rabbit hole. And I want to talk about hysteria for a second. Did you know it wasn't, it was until Freud, it was believed that hysteria was actually the consequence of a lack of

conception and motherhood? So they thought it was a disease of women. Okay. So I have a quote, and I want to read this quote to you from an article. The article is *Women and Hysteria in the History of Mental Health*. And so it says, it says, "Not only is a woman vulnerable to mental disorders, she is weak and easily influenced by the supernatural or by organic degeneration, and she is somehow guilty of sinning or not procreating. Thus, mental disorder, especially in women, so often misunderstood and misinterpreted, generates scientific and/or moral bias, defined as pseudo-scientific prejudice." And we still see this today where women's physical symptoms are attributed to psychological causes.

Giles: I mean, I don't know how I feel when I hear that except incredibly uncomfortable. I can't wait to drop that on my wife. She's going to snap. I mean, it's, yeah, I don't know. I mean, at one level, it sickens you, at another level, knowing that, you know, look, it's not great maybe, but we've definitely made progress, but it's embarrassing maybe that we're still having... this is even a topic today that we have to talk about this. So yeah, I mean, it's like everything, right? Progress has been made, but it's glacially slow. But people like you are fighting the good fight on this and bringing it out in the mainstream and making people aware of it—not just providers, patients, policymakers, and everyone. I think, again, this topic will continue to emerge. It's clearly getting more attention than it used to, which is the only way this is ever going to change. Well, Candace, we're at the end of our time for episode one. I really want to thank you for sharing your insight to help us better understand the root causes of gender bias and the impact on patient care and outcomes. Listeners, please be sure to carve out the necessary time to listen to episode two, where we discuss specific strategies to reduce gender bias in healthcare. Gender equity in healthcare benefits everyone, improving patient outcomes, fostering trust, and promoting a more inclusive healthcare system. Thanks for joining us for today's episode.

Episode 2: Gender Bias in Healthcare: Consequences and Solutions

Transcript

Scott Giles: This is episode two of our series, Gender Bias in Healthcare: Consequences and Solutions. My name is Scott Giles, and I'll be serving as your host for today's episode. I'm pleased to welcome Dr. Candace Pierce from Elite Learning. Dr. Pierce is a nurse with more than 20 years of experience working at the bedside, in management, and in nursing education. Dr. Pierce did a fantastic job in episode one of introducing us to the topic of gender bias, including its manifestations, historical roots, and the impact on patient care and outcomes. In this episode, we will discuss real-world solutions from policy changes and improved medical education to practical steps healthcare providers can take to ensure that they are delivering care that's fair, equitable, and free of bias. Candace, I'm very excited to talk to you again today, and I'm particularly excited to move to solutions because I think there are many solutions potentially available that we'll discuss today. Again, not just at the

patient level, but at the provider level, the policymaker level, and the organization level, and there's a lot to discuss. So, if it's okay with you, I think we're just going to jump right in. Okay. Candace, what are some of the effective strategies that healthcare professionals can use to recognize and address their own implicit bias? Because I think, I don't know, to me, that has to be one of the first steps in terms of making this less theoretical and more real to almost all individuals at some level.

Candace Pierce: Absolutely. And one of the things that I always tell my students and everybody that I work with is we have to know how to self-reflect. And, you know, for biases, biases come from where we were raised. It comes from our community, all the things that are around us. And so, a lot of times, they just become almost innate, it seems like, and we have to be able to be willing to engage in regular self-reflection. And then we have to actively acknowledge that there is a potential for bias in our clinical decision-making. We got to find where it is, because I guarantee you most of us have it, and now we just got to find it so we can get rid of it. You can do this by validating... there are these validated implicit bias tests. You can take those tests online. There are some that are free, and they'll be able to kind of give you an idea of the areas where you have biases. You could keep a decision-making journal where you can kind of track your patterns during your patient interactions to help you personally identify, "Would I have done this differently if it was a different patient?" or "Would I have thought about this differently if it was a different gender or age?" There are also decision-making protocols that kind of help you with justifying your clinical choices on objective criteria rather than your more intuitive judgment, which kind of goes back to those implicit biases.

Giles: And do you feel that people are, do you feel that the typical provider is aware of these resources or engages in these resources? Because it's like anything, right? If you're interested in a topic, then you can go find all kinds of these inventories, these analyses, these ways to reflect on your own implicit bias. I actually did one of these surveys, which I found really interesting. But again, I probably wouldn't have done that if the topic wouldn’t have even come to my mind or wouldn’t have made it that far up my list to do in order to engage in that. But I did because I knew we were going to be talking, and I found it to be super interesting. What is the mainstream clinician doing to even self-reflect on these pieces?

Pierce: Well, honestly, it's going to depend on what state you live in too, because there are some regulations, some statewide regulations that are now requiring education on implicit biases. Like Michigan is an example of one that was requiring implicit bias training for healthcare providers. So, it is starting to become talked about more. But if you're in a state where you don't have... you're not seeing this, you're not going to know that it's here unless you just fall in, unless this podcast just falls in your lap or some other article falls in your lap. If it is something, currently, that you probably... most providers are having to seek out themselves. And I hope that they do. I hope that when they go in and they do there, "I need to go do my continuing education," and they type it in, they see this as an opportunity. But at the same time, how likely are you or I going to be to be like, "That looks interesting. Let me take this implicit bias course," you know?

Giles: Yeah, sometimes things like that, again, not that people don't see the value, but people are so clinically skills-focused in many cases, right? Or you're doing something that you view as much more unique to the individual unit that you're working on or your patient population, as opposed to some of these more global communicative or affective-type domain pieces. Sometimes self-reflection too is a little bit harder, and I'll speak for myself on that, than it is to maybe stay more objective or mainstream, right? But the truth is, a lot of us, including myself, could probably benefit from exploring areas like gender bias and other associated areas that maybe aren't quite as sexy, but could make you a more effective provider, quite frankly, than reviewing another continuing education course on a specific clinical skill.

Pierce: And that's something else that you could do, is like having some participation in case reviews with other diverse colleagues. That's going to help find some of these potential bias blind spots and really help with providing some constructive feedback. But again, those are things that we need to talk about. You will see that some larger organizations will have training or mandated training on implicit bias. But at the same time, self-reflection, it needs to be directed self-reflection. You know, a lot of times, especially in nursing school, when you teach undergrads, there's a lot of self-reflection that happens there. But it's like, "Write down about your clinical experience today." But we don't really give the direction of, "What should I look at? What should I reflect on?" And this is an idea of something they could reflect on. Did you experience something that maybe someone else would have experienced differently from a patient's perspective, but also from a healthcare provider perspective within yourself?

Giles: Yeah, no, I agree. Sometimes you'd like to think the organizations would be more proactive to this topic. But again, they have a lot of things that are on their to-do list as well. But one of the other facts that I came across that I thought was interesting is that 75% of the healthcare workforce—maybe 70%, but 70 to 75% of the healthcare workforce are females— but yet only like 20% of the senior management tends to be female. So again, I'm not suggesting there's some big coup here, but I do feel like that since males have been kind of... I don't think there's as much male bias as perhaps female bias, then maybe the importance of this topic is not that anyone's malicious, but it's that it may not be in their mind as near a bigger topic as it might be for a female in senior management. So I think that needs to change as well, right?

Pierce: Right, well, and as leadership, within leadership, because I've been in leadership at a hospital, why do women, they're basically told to make yourself smaller so I can make myself bigger. And I really feel like that's a huge reason why you see only 20% women in healthcare leadership versus the 80% men. If you and I went into the same type of conversation with the same tone and said the same things, we would be interpreted completely differently.

Giles: Right. Yeah, there's absolutely some truth to that. I mean, regardless of the composition of the administrative hierarchy in terms of male and female, what do you feel are like the minimal things that, even baseline things, that every organization should have in place in order to, you know, keep or bring this issue to the forefront?

Pierce: Well, so if we're looking at creating policies and practices, really, that's what we're going to be looking at with organizations. And you can really take this kind of two ways. You can look at it from healthcare leadership because it's all about the culture that we set. And then it's also how we take care of our patients. So for both of those directions, the answer really is comprehensive policy reforms and structural modifications. You can also expand that for the care that the patient receives, such as implementing several patient-centered policies and practices to reduce gender bias in direct patient care. But that's the areas where we see it happening. I can take that further if you want.

Giles: Well, you think, because again, things that get acted on are usually things that people can acknowledge and have data to show that it is a problem. Do you feel that most large organizations are tracking outcome data at a gender level that even allows them to know that, you know, "Houston, we have a problem here?" Yeah, that was a... I thought that might be the answer to that question. I mean, that's a problem, right? And I mean, in episode one, you provided the example of, you know, signs and symptoms of heart attack. And I mean, you know, there are some real things that you don't have to... you don't have to be a rocket scientist or go too far, you know, to recognize that there are serious implications of mismanaging something in the emerging condition based on gender or not considering signs or symptoms to be different than the classic signs or symptoms in these kinds of scenarios. So it's kind of too bad that, and I know it's a very hard thing to do, but it is a shame that there's not more definitive data that could be pointed to, because if, again, once it reaches that status, action tends to occur. Otherwise, it almost has to be someone has to take it on as a passion project, or they just have to be the voice to bring this forward in order for it to get the time and the attention of other folks in management as far as it, you know, yeah, it's tricky.

Pierce: Yeah. And there is data, and there is data, and there are metrics of how you, as a healthcare provider in a big organization, can speak to your leadership. It's that data and those metrics that really are going to paint the picture so that others see that it really is an issue. Because if they don't see that it's an issue, then they're not going to start tracking and they're not going to start trying to make a difference. So, you could track gender-based differences in treatment decisions. You could track outcomes. You could track patient satisfaction scores. You could even track resource allocations. You could track wait times because it has been documented that women end up waiting longer in ER waiting rooms than men. So, you could actually document and analyze wait times, referral patterns, pain management approaches, and even the frequency of diagnostic testing orders across gender groups. So, there are a lot of things that you can actually look at to get a really big picture and really analyze those metrics and start looking for, say, patterns of bias, even just for informed, targeted interventions because it's not even just bias for gender. You could see bias for race. You could see bias for age. You could look at bias against different symptoms even when they come in. So that can really give you a big picture.

Pierce: But also, like I said in our first episode, pulling in that qualitative data, bringing in that patient feedback along with your quantitative data, and that's going to give you an even bigger picture.

Giles: For sure. No, and I think you provided some really tangible data that could be easily collected. And I think you could draw some inferences from that, or at least be the basis to have a discussion with people. Well, why is it that women wait 15% longer on average? Why is it that men, 15% more of the time, are prescribed pain medication than women? I don't know, to me, the identification of that... there could be other reasons for that perhaps, but one of the reasons is kind of what we're talking about. So, it's healthy to engage in those kinds of discussions, I think.

Pierce: And you can make that data as granular as you want it to be and start connecting other dots like, they're female and they're young, they're female and they came in with symptoms that could have correlated with a heart attack, you know, so you really could make that as granular as you wanted it to be.

Giles: And with the data management systems in place today, that's not even a stretch, right? You just have to care enough to ask the question and put another field in, right? As far as that goes, because obviously, we collect all kinds of data on every patient in every scenario. One of the things that I think about with any form of bias in terms of changing healthcare providers' behaviors comes down to the educational setting. And that if things aren't important or perceived as important or don't perhaps command the necessary amount of time in an educational setting, then oftentimes these skills don't transition over to clinical practice. So, to me, the real change agent, or one of the most effective long-term ways to change gender bias or any form of bias, is to make sure the schools are doing a great job and moving this through their curriculum. And not just in terms of, you know, discussing the topic, but we talked about before, you know, differences in biology between men and women, differences in physiology between men and women, and how it impacts disease diagnosis, et cetera. Where do you think schools are on that continuum? I mean, I know every school would say, yes, that's very important to us, but in practicality, how's this playing out at the educational level? Do you have any sense?

Pierce: Well, I would ask, how much time do we spend in a classroom versus how much time we spend working with other people who are already in the field? In nursing, you do a lot of clinicals, and med school, you know, when they get towards the end of it, they are doing a lot of residency time. And so, your education not only comes in that classroom, but a lot of your beliefs and your thoughts are going to be... it's almost like I'm going to go hang out with you and how you think is going to rub off on me, you know? And that's where we see those generational pass-downs, unfortunately, in healthcare, and where maybe they weren't taught this in school, but they learned it at the bedside, unfortunately. And I'm not saying that it was a bad doctor. I'm not, you know, I'm not saying that they were intentionally trying to be a bad healthcare provider, a nurse, anybody that interacts with patients. But a lot of times, it's how we pick up habits from others. And so, you were talking about how important education and training is, and it's pivotal. It is a pivotal role in mitigating gender bias because education and training lays that groundwork. I think we could do a better job of really hitting on this. But again, this is really starting to become heard more. Women are getting louder to say, hey, I don't think it should be like this. I don't think I should have to sit here and go through this horribly painful treatment without having something that helps me. Yeah, women are trying to stand up and say and be

louder, but it has to go, like you said, it has to go beyond just simple awareness, to actually learning how to practically incorporate the skills. We have to develop the skills of self-reflection. And you know what, you could do self-reflection last month and this month, you don't realize it, but you picked up another bias. You were hanging out with someone else. And so it has to be a continual process of being made aware that this could potentially be a problem and then evaluating how you treat patients and how you take care of patients and developing those skills to be like, well, let me take a step back. Let me change my behavior towards these patients.

Giles: Right, for sure. Do you know if, as far as the accreditation standards for educational programs, do you know if there are specific criteria linked to addressing biases in healthcare, and is that something... I know as a physical therapist in the physical therapy curriculum, I mean, the accreditation standards are endless and do deal with things like cultural competency and a number of things that they didn't use to deal with, they become much more broad in terms of the incentive to some of these issues. Do you know if that's a requirement within the nursing accreditation criteria or even are nurses assessed on that knowledge when they're taking their licensing exam?

Pierce: So, cultural competence is taught. It is something that is discussed. I can't speak for every school that's out there, but it should be. Going through accreditation, usually, you'll have to be like, this is how we teach. But again, that's cultural competence. That's different than gender bias.

Giles: Right, it is, it is. And I'm not saying that, I don't know how far that drills down, but that was just the cultural competence piece was something that I know for a fact that for instance, in the PT accreditation criteria and even on the licensing exam, but that gets tricky too because you want to avoid stereotyping, you want to avoid... so it's again, things that aren't objective, things that are more affective domain issues are sometimes not as easy to address in accreditation criteria or licensing exam, et cetera. And you bring up a great point about the role modeling piece because that's huge, right? Because to some extent, you can learn anything in school, but if you go out in the clinic and you're not seeing that emulated, those things tend to fall off the wagon pretty quickly. Yeah, we really need both pieces for that to be effective.

Pierce: They do. Yes. Well, one of the things that I really want to point out is that, you know, if there's an educator that's listening, that's interested in how can I help students to understand this and see it is case-based learning is a great way to really bring in those real-world examples of gender bias. And that's going to actually help with providers, nurses, whoever, with actually recognizing more of those subtle forms of discrimination. Because a lot of times, that bias is going to be very subtle, hardly recognizable to a lot of us unless you're the one that is affected by it. It's not subtle to us when we are being affected by it. But if I'm the one that's doing it unintentionally, then it's probably going to be more subtle to me. I'm not going to realize that I did it, you know. Doing some regular workshops, even on effective communication, shared decision-making, bringing another person in to be like, hey, this is what I wrote down, this is what I've assessed, and this is what I'm thinking. Can you just, can you double-check me to see if I'm missing anything?

Giles: No, that's good. And I mean, you're right. At the individual level, by people who are passionate about this or people just know they'll be a more effective clinician if they can eliminate any form of bias, not just gender bias, to bring it up, to ask for in-servicing on this information, to bring in someone from a speaker's bureau who's an expert in this topic, all of those things, I think, go a long way in order to do that. What about... what about gender-sensitive communication? Do you have some thoughts? Because obviously, that's very much related to gender bias as well. But do you have some recommendations or thoughts in terms of that topic?

Pierce: Yeah. So, of course, it goes back to our inclusive language where we're not making assumptions, active listening, because a lot of times we listen to respond. We don't listen to understand. I've already made up my mind, so I'm just letting you talk, but I already know what I'm going to say. I've already made up my mind. So, that's not a healthy way to assess somebody. So, we got to practice active listening, validating patients' concerns regardless of their gender. Just like when I was telling you about my stomach issue and I kept saying that something's not right, this is not right, and yet I was just automatically dismissed every time. And we don't need to do that, we need to actively listen, we need to acknowledge, and then we need to assess. We always need to assess. And this is going to really help us with avoiding some of those gender-based stereotypes that we kind of talked about in health discussions and really make sure that the patient can receive thorough explanations of their conditions and treatment options. Don't just be like, "Here he goes. What I'm about to do to you. Here we go." Also, our nonverbal communication can shut a patient down really fast. So, you know, if your nonverbal is not matching what you're saying to me, it's going to shut me down and I'm not going to feel that I can talk to you, which means that I might actually have a delayed diagnosis because you didn't hear everything that I needed to say to you. And then I also want to take you on a little rabbit hole again, if that's okay. But we're kind of talking about gender bias. But what I want to do is tell you about some other biases that can be coming along for the ride. So, all right, so some examples would be anchoring bias. And anchoring bias is like a tendency to make a decision or a judgment based on your initial information rather than taking all of that information, gathering all the information that you need. And so a good example of this would be making a diagnosis based entirely on the initial symptoms rather than also looking at the subsequent symptoms that they might be talking about. There's confirmation bias. And that's where you're choosing to review only the information that is in favor of the decision you've already made, that belief that you already have. So, if you believe my stomach pain is due to psychological distress rather than a physiological issue, you're going to only choose to review the information that is pertinent to your previously established diagnosis. That means you're dismissing anything else that I say to you that does not support your diagnosis.

Giles: I think we've seen some of that in the political sphere recently, right? In terms of people taking in information. But I mean, you could see that. Yeah, well, see, of course I was right, right? But when you said that, that just reminded me of that. It is, yeah.

Pierce: Yes, only that supports, yes, yes, it... Yes, and that's confirmation bias. That's exactly what it is. I mean, these biases are not just in healthcare, I mean, I'm defining them within

healthcare, but just like you're saying, confirmation bias means that what I just heard on this news channel, I'm only taking the bits and pieces to support what I already believe and you've got confirmation bias. And then another one that speaks for itself is going to be overconfidence bias. Totally speaks for itself, doesn't it? That's where my confidence is completely misplaced because in actuality, I'm overestimating my ability, my knowledge, and my understanding of what is actually happening. An example of this would be a provider who is just... he was certain I needed to see a psychologist for my stomach pain. And so, he's correct on his diagnosis and he refuses to order any additional tests to ensure that he's even correct, to ensure that this diagnosis is accurate, or to even consider other forms of treatment or to even thoroughly assess the patient for other possible diagnoses. So, I mean, gender bias, I would say, is kind of the start that leads into some of these other factors that can potentially keep you from providing high-quality care to either gender depending on the situation at hand.

Giles: I mean, without self-reflection and self-assessment, I mean, I don't know how people who have some of these biases, I mean, how you can be an effective clinician, right? I mean, it's just, you can't leap. You have to move methodically. You have to go through the process at any level. You have to provide people the benefit of the doubt. Or the benefit of the doubt. And it's interesting too, because when you talked on the last episode, we were talking about kind of different biases, and then it wasn't just really like, well, how do we deal with this bias? How do we deal with that bias? You know, we kind of made the point that, look, you're dealing with stacked biases here. So, I mean, so, you know, any belief becomes multiplied by numerous biases that become even more difficult to assess, or maybe even more difficult to be aware that you're making the decisions that you're making, because, you know, you can't make good decisions if you're not informed about your blind spots. And clearly, I think we've demonstrated this is a blind spot for many people. I mean, are there some support services or resources that are kind of your favorite for someone who, you know, either recognizes maybe this is an issue for them or just for someone wanting to be like, "I don't think I really have gender bias or I don't think I discriminate against socioeconomic status, but let's, let's kind of assess that objectively." Are there some things that you'd recommend for people?

Pierce: Yeah, absolutely. But what I will say is if we don't know what biases we have and which way they're swaying us, then we can be blind to how we are actually treating our patients, and how we treat them is either going to cause an erosion of trust so they're not going to seek care in a timely manner, or we can build trust so that they do seek care in a timely manner. So, it really does matter how we treat people. But, as far as resources and support systems, first, I want to preface this with saying I'm not recommending any platform that I share here. I think that it's important for you to do your own research, talk to the companies to find your best fit if you're interested in using any of these because there are a ton that are out there. So, I am just... because I say their name, I am not recommending any platform that I share. But we, yes.

Giles: Sure. We'll put in the disclaimer.

Pierce: But we do, you do see that we have clinical decision support tools and some mobile apps like *UpToDate* and *DynaMed*. And those, they can provide evidence-based guidelines for more of your gender-specific symptom presentation and treatment protocols. So that's really helpful with recognizing and appropriately responding to conditions that we see that we know present differently across genders, such as like heart disease, autoimmune, mental health disorders. They're really helpful because they include built-in prompts and checklists to help you with ensuring that when you evaluate them, it's a comprehensive evaluation, regardless of gender. You also have some medical reference databases and specialty-specific resources. And these are things like *PubMed* and *Cochrane Library*. And those are going to provide you with more of your updated information and gender differences in, say, disease manifestation, drug responses, treatment outcomes. A lot of times, you can find case studies and some of those, like we always call them the clinical pearls that highlight some of those common pitfalls that we see in gender bias diagnosis and treatment. So that's what those are good for. We also have professional societies that offer clinical practice guidelines that really incorporate the gender-specific considerations when it comes to patient assessment and care planning. You'll see that with the, I always get the acronym letters wrong, *AMWA*—American Medical Women's Association. The Society for Women's Health Collaborative. There's also the Society for Women's Health Research. There are point-of-care reference tools too, like the *Lexicomp* and the *Micromedex* that where you can pull up like gender-specific drug dosing, side effect profiles, monitoring requirements. *AHA*—they have gender-specific cardiac care recommendations. The World Health Organization has actually some gender-specific considerations for things that are looked at more globally.

The American College of Obstetricians and Gynecologists, they also are starting to include clinical guidelines specific to women's health concerns. And then there are some free resources. *MedlinePlus* through the National Institute of Health, they usually have some good stuff on there. There's a lot of articles about women's health and the history and how we kind of got to where we are on the National Institute of Health, if you're interested in looking at that.

The CDC has some clinical tools that you can find. The World Health Organization also has some free ones online. And then there's the Agency for Healthcare Research and Quality where you can find some clinical resources and guidelines as well.

Giles: That's amazing. And I did happen to look at the Office of Research on Women's Health, it is a research division of NIH. And there are all kinds of free resources on that. And actually, that's one of the places I did one of these inventories that I thought was different. Look, I think what people are hearing is that if this is a topic that's important to you or you believe it can make you a more effective clinician, which I think we all believe that, the opportunities are endless. And many of these will not cost you a nickel. So the investment is, you know, undeniably strong as far as that. We both encourage you to link to that. Candace, I really want to thank you. This 30 minutes has gone super quick, and this is a topic that, you know, we could talk about for hours. But as we conclude today's conversation on strategies to reduce gender bias in healthcare, it's clear that while significant progress has been made, much work remains to be done. Reducing gender bias

in healthcare isn't simply about changing systems, it's about changing mindsets. It requires collaboration among patients, providers, organizations, and policymakers. For more information on topics like gender bias, implicit bias, or many other topics, I encourage you to explore the continuing education courses available at elitelearning.com. Candace, thanks again for joining us today, and thanks to our listeners for tuning into this episode.