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Perspective

Strategies to Mitigate Clinician Implicit Bias Against Sexual and Gender Minority Patients

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Background: *Implicit bias is an ingrained, unconscious cultural stereotype that can negatively affect a person's interactions with members of stigmatized groups, including sexual and gender minorities. Clinician implicit biases may negatively impact the quality of patient care.*
Methods: *This article uses 4 case scenarios to illustrate how implicit bias among psychiatrists and other clinicians can affect patient-clinician communication and diminish the quality of health care provided to sexual and gender minority people. We offer strategies for clinicians to recognize, challenge, and address implicit bias.*
Discussion: *Through continuing education, self-reflection, and practice, psychiatrists and other clinicians can improve communication and foster more affirming care experiences for their sexual and gender minority patients, with the goal of addressing and ultimately eliminating sexual and gender minority health disparities.*
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Key words: sexual minority, gender minority, implicit bias, unconscious bias, LGBT, communication.

INTRODUCTION

Alhough psychiatrists and other clinicians strive to practice unbiased medicine, all people are susceptible to culturally pervasive prejudicial beliefs.[1–7] Implicit bias refers to the association of negative attributes to a particular group without conscious awareness. Studies suggest that clinicians, like those in the general population, hold negative implicit biases regarding lesbian, gay, bisexual, transgender, queer, intersex, and all sexual and gender minority (SGM) people.[8–14] Clinician implicit bias against stigmatized groups has been shown to adversely affect patient-clinician interactions, clinical decisions, and patient perceptions of care. Through these pathways, implicit bias may negatively influence patient outcomes.[1–7] Thus, implicit bias has the potential to intensify significant health disparities among SGM people that are associated with societal stigma, discrimination, and other barriers to accessing safe and inclusive health care.[15–21] Addressing implicit bias may be especially salient in the context of mental health, where a strong therapeutic alliance is the cornerstone of successful treatment.[1]

Fortunately, clinicians can learn to reflect on and address underlying negative assumptions and attitudes, thereby minimizing the impact of implicit bias on the health and wellness of SGM people.[22–24] In this article, we present a brief review of the literature on SGM health disparities and implicit bias, followed by 4 case scenarios that illustrate ways in which implicit bias can produce communication errors that adversely affect the SGM patient-clinician alliance. We then supplement each scenario with suggestions for improving

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self-reflection and communication to enhance trust and rapport with patients. We conclude with additional individual and structural change strategies to address implicit bias.

Health Disparities Among SGM Populations

SGM populations have significant documented psychiatric and behavioral health disparities, including a higher prevalence of mood and anxiety disorders, suicidal ideation and attempts, substance use disorders, and body image and eating disorders.[15–21] Medical health disparities include HIV and sexually transmitted infections among sexual minority men and transgender women and reduced access to cervical cancer screening and other preventive health services among sexual minority women and transgender men.[15–21] Research framed within minority stress theory has demonstrated how chronic exposure to discriminatory and stigmatizing anti-SGM experiences can produce adverse stress responses and maladaptive coping behaviors, leading to poor health outcomes. Perceived and experienced stigma also hinders access to needed health care.[15–19,25]

Research on Implicit Bias

Although the impact of clinician implicit bias on SGM patient care and health outcomes is largely unknown, existing studies suggest that other types of implicit bias (e.g., regarding race, ethnicity, gender, age, and weight) may adversely affect quality of care for stigmatized and minority groups.[1–7] Affected aspects of care include treatment recommendations, prescriptions and tests ordered, and the number of questions asked of the patient.[1–7,26–30] There is not yet research on direct associations between implicit bias and patient health outcomes. There is, however, consistent evidence that implicit bias adversely influences clinician verbal and nonverbal communication and is associated with negative patient perceptions of care.[1–7,26,27] For example, in a study of primary care clinicians, implicit race bias and stereotyping were associated with lower patient ratings of confidence in the clinician, lower positive patient affect during the visit, and lower levels of patient-centered dialogue with Black patients.[26] By lowering a patient's trust in clinical judgment, poorer clinician communication with patients can affect treatment adherence and follow-up. Thus, clinician communication is theorized to mediate the association between clinician implicit bias and patient outcomes.[2,3]

Many studies assess implicit bias with the Implicit Attitudes Test (IAT), a validated computerized tool that measures a subject's response time when sorting positive vs. negative attributes into groups (e.g., race, gender, and sexuality groups).[31] For example, a slower reaction time when matching positive attributes to lesbian/gay people than to straight people would reveal a stronger preference for straight people. Studies using the IAT have consistently indicated that heterosexual healthcare professionals of diverse ages and races/ethnicities prefer heterosexual people over lesbian/gay people.[8–14] This preference exists even among those who do not express explicit bias toward sexual minorities.[11] The IAT does not yet have a test for gender identity bias, and we are unaware of research that has looked at implicit bias and gender identity. Studies suggest, however, that many transgender people delay necessary care to avoid experiencing what they perceive as biased clinicians.[32] Even subtle forms of bias expressed through nonverbal or verbal communication have led patients to not adhere to medical advice or return for care.[21]

Because implicit bias is typically learned early, reinforced often, and left unexamined, clinicians may not realize how certain comments or behaviors may be marginalizing and harmful to patients.[33,34] Clinicians may use terminology that assumes all people are heterosexual; they may convey discomfort with the lives and sexual behaviors of SGM people; they may deny that anti-SGM bias exists; or they may express doubt regarding a person's gender identity or sexual orientation. Moreover, because medical education programs dedicate very little time to SGM health, few clinicians formally learn to provide culturally affirming care for SGM populations.[35,36] We believe that through greater awareness, training, and practice, psychiatrists and other clinicians can overcome communication barriers, address implicit biases, and ultimately offer a higher quality of care.

METHODS

The following case scenarios represent fictionalized adaptations of actual situations experienced by, observed by, or relayed to the authors. As clinical training experts, we regularly design and present case scenarios that encourage clinicians to think about how they would respond in a similar situation. The idea to

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use case scenarios arose in part from national assessments we conducted with federally qualified health centers and from feedback on training evaluations.[37,38] For this manuscript, we developed unique case scenarios based on learning objectives and teaching methods we have iteratively refined over hundreds of trainings for diverse clinical audiences across the United States, developing drafts of each case and internally reviewing and revising the cases.

Analyses of evaluations from our training sessions with case scenarios demonstrate significant gains in knowledge among participants. An analysis of pre-test and post-test evaluations from a case scenario training on effective communication with SGM patients found a significant increase in knowledge among frontline hospital staff (n = 37). In an evaluation of training on care for gender-expansive youth, 85% of clinicians (n = 124) reported their knowledge level at 4 or 5 on a 5-point scale, compared with only 14.3% of the clinicians pre-training. Nearly all participants (92%) reported they were "likely" or "very likely" to apply what they learned to their practice.

Case Scenarios

Case 1: Jaden, Age 19 Years

Jaden is hospitalized for dehydration. The primary team consults psychiatry when he expresses suicidal ideation. During the initial evaluation, the consultation-liaison psychiatrist asks him if he has a girlfriend. He lowers his eyes and replies, "*No, I'm gay and have a boyfriend.*"

Jaden's situation is not unusual. Sexual minorities must often counter others' assumptions that everyone is heterosexual or that people who look or act a certain way have a heterosexual sexual orientation. Sexual minorities also have to decide whether it is safe to disclose their sexual orientation or sexual behaviors. These circumstances can produce stress and intensify any underlying feelings of shame about sexual orientation and behaviors. Experiences of external and internalized cultural stigma are associated with worse physical and mental health outcomes among SGM people.[15–19]

A more inclusive approach to a social or sexual history is to ask all patients standard questions that avoid assumptions about sexual orientation and behaviors.[39] Questions that communicate inclusion of all gender identities and sexual orientations, and inform better clinical decision-making, can be found in Table 1.

TABLE 1. "Clinical Pearls" for Improving Communication With Sexual and Gender Minority Patients

Do ask questions that validate all identities and behaviors and that promote an inclusive environment.	• "What name do you go by?" • "What are your pronouns?" • "Are you sexually active?" • "With whom are you sexually active?" • "What is/are the gender(s) of your sexual partner(s)?" • "What kinds of sexual contact do you have?" • "What body parts are involved in the sex that you have?"
Do not assume you know a patient's sexual orientation or gender identity, and **do not** put the burden of disclosure on the patient.	Ask about sexual orientation and gender identity on demographic forms and/or during the clinical encounter.
Do base recommendations on sexual history and behavior, not on identity.	This helps avoid making clinical decisions based on stereotypes and myths. In addition, identity, behavior, and attraction do not always align.
Do let patients know it is okay to correct you.	• "Please correct me if I make any mistakes."
Do apologize if mistakes are made.	• "I am sorry for my mistake. Let me try again."
Do not ask questions that are not clinically relevant to the visit.	Pause and ask yourself if what you are about to ask is relevant, or from personal curiosity.
Do be aware of how stress may aggravate implicit bias.	Be aware of personal fatigue and work-associated burden. Remember that displays of implicit bias are more common in the context of stress, which erodes cognitive control over expression of bias.
Do access additional resources on culturally affirming communication and care for sexual and gender minority people.	National LGBT Health Education Center: lgbthealtheducation.org/ Center of Excellence for Transgender Health: transhealth.ucsf.edu/ Healthcare Equality Index: hrc.org/hei

Case 2: Madi, Age 54 Years

Madi is hospitalized for pneumonia. The attending internal medicine physician sees in Madi's chart that she has a difference of sex development and identifies as intersex. Having never taken care of an intersex person before, the physician is curious about Madi's healthcare

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experiences. While performing an admission physical examination, the physician says, "*I have never had an intersex patient before. What are your thoughts about genital surgeries for intersex youth? I know that has been quite controversial recently*."

Intersex people often have to contend with inappropriate remarks from healthcare professionals.[40,41] In this scenario, the physician was genuinely interested in Madi's opinion, but her question about genital surgery was contextually inappropriate because it was based on personal curiosity rather than the patient's current medical needs. To avoid crossing such boundaries, clinicians can pause and ask themselves if what they are about to ask is clinically relevant or if the question stems from personal curiosity. Clinicians can also ask themselves if such a question would make them feel uncomfortable if they were in the patient's position.[24]

When inappropriate or biased communication occurs, research suggests that if clinicians genuinely and succinctly apologize, they can reestablish a constructive dialog and repair the alliance.[42] To apologize, the physician in this case could say, "*I am very sorry for asking you about something that is not relevant to your care and that may have communicated bias.*" Later, the physician can reflect on what assumptions and needs were behind her comments to Madi and what she could do differently in the future. She can also educate herself on intersex experiences through accessing continuing education and reading the current literature.

Case 3: Kara, Age 30 Years

Kara, who identifies as bisexual, is following up with her psychiatric nurse practitioner in a collaborative care practice. During the visit, Kara tells the nurse practitioner that she broke up with her boyfriend and is now dating a woman. She notes intention to follow up with her primary care physician about sexually transmitted infection screening in anticipation of having sex with her new partner. During the review of medications, Kara also notes that she plans to stop her birth control. The nurse practitioner says, "I would encourage you to continue taking birth control. My bisexual patients often go back to men and I want you to be prepared in case that happens."

By telling Kara that most bisexual women return to dating men, the nurse practitioner was implying that bisexuality is typically a phase or experiment. She also subtly communicated that bisexual women prefer heterosexual relationships over same-gender relationships and thus perpetuated the invisibility of bisexual people. Studies indicate that bisexual people encounter more negative attitudes and behaviors than do gay and lesbian people, which may account for higher reported psychological distress, isolation, and healthcare avoidance among bisexual people.[43,44] In addition, implicit bias is more likely to affect care when there are few established guidelines to direct the clinician's decision,[3] such as with the sexual health of SGM women.

An alternative approach is to provide recommendations based on the patient's sexual history, reported behaviors, and expressed desires for specific counseling, rather than on assumptions about identity. In this scenario, Kara's psychiatric nurse practitioner could have presented options to Kara without making a generalization about bisexual women. For example, she could have said, "*Sometimes patients start new relationships that require different forms of protection. If you ever find yourself needing birth control that requires a prescription again, you can let your primary care doctor know.*"

Case 4: Ryan, Age 23 Years

During a therapy visit, Ryan musters the courage to come out as gender fluid and asks the clinician to use Ryan's correct pronouns (they, them, their). In a friendly tone, the clinician responds, "*I can certainly try, although every day it seems like there's a new way to talk about gender. It's hard to keep up!*"

Although Ryan's therapist was honest about his lack of culturally specific knowledge, his self-deprecating communication style may have conveyed the message that he did not take Ryan's gender identity seriously. Encounters that undermine a person's identity may negatively impact their motivation to attend future healthcare appointments or to follow treatment recommendations.[5] Being addressed with the wrong name or pronouns is a common and potentially upsetting occurrence for transgender and gender-diverse people who may experience frequent gender minority bias and stigma in their daily lives.[15–19,32] It is therefore important to make every effort to address patients by their correct name and pronouns.

The clinician could have communicated a desire to consistently use Ryan's pronouns by saying something like, "*Thank you for sharing this with me. I'm not*

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accustomed to 'they/them/their' pronouns, though I am eager to try." Although future missteps will inevitably occur, there are ways to prevent them from irreparably harming the patient-clinician alliance. For example, the clinician could let Ryan know that he is open to being corrected by saying, "*Please correct me if I make any mistakes.*"

The clinician could also display an interest in learning more about a topic he is not familiar with; for example, he could say, "*Thank you for sharing this with me. I am not familiar with the term gender fluid; if you are comfortable doing so, could you explain what it means to you?"* Clinicians, however, must also be aware that patients may not want to play the role of educator. Ryan's clinician could later pursue continuing education on gender diversity and could consult reliable resources on relevant terminology and pronouns. Finally, because of the inherent fluidity of gender identity, the clinician should check in regularly with Ryan about their gender identity and pronouns, as these may change over time.

ADDITIONAL STRATEGIES TO MITIGATE IMPLICIT BIAS

To enhance the communication strategies described in the case scenarios, we offer several additional methods for reducing clinician implicit bias and its potential effects on patient health.

Building Awareness

Experts in the field of implicit bias note that motivation to address bias can be enhanced by becoming more aware of one's own preferences, behaviors, and biases.[22–24] This can be accomplished by noticing times when an assumption or prejudicial belief arises, asking colleagues to point out any observed errors, and taking the IAT, https://implicit.harvard.edu/implicit/takeatest.html. The purpose of raising awareness of implicit bias is not to lay blame or instill guilt. Rather, the goal is to help people recognize that they may be unconsciously making decisions based on stereotyped beliefs despite having explicit egalitarian priorities.[22–24]

Engaging in Practice Exercises and Mindfulness

Studies of interventions to reduce implicit racial bias and its effects on patient health are limited, but researchers suggest that awareness paired with training in culturally affirming care and practicing communication strategies may be effective.[3,7,22–24,34] Other exercises to reduce bias include replacing negative stereotypes with positive attributes, such as those of exemplary people from that particular group; taking the perspective of a person from a stigmatized group; and focusing on a person's individual characteristics rather than their group membership.[23,24] Practicing meditation and mindfulness may also reduce implicit bias by limiting the activation of bias, promoting emotional control, increasing self-compassion and compassion toward patients, and improving patient-centered communication.[45]

Addressing Structural Bias

Although this article focuses on implicit bias at the individual level, it is important to acknowledge that healthcare inequities must also be addressed at neighborhood, institutional, and policy levels. Healthcare organizations can make intentional changes to the clinical environment to reduce bias and promote inclusion. Examples of structural and environmental changes within the healthcare organization include having all-gender restrooms, adding sexual orientation, gender identity, and gender expression to patient and staff non-discrimination policies, incorporating images of SGM people in marketing and educational materials, hiring SGM people at all levels of care, training all staff in culturally affirming care, and collecting data on sexual orientation and gender identity to identify and address health disparities.[46–48]

Continuing Education and Research

Problematic patient-clinician communication stems in large part from limited clinician training in SGM cultures and health. To increase knowledge, clinicians can participate in conferences, meetings, and online continuing medical education programs, such as those offered by the National LGBT Health Education Center (lgbthealtheducation.org), the World Professional Association for Transgender Health (wpath.org), and the Center of Excellence for Transgender Health (transhealth.ucsf.edu). A brief summary of "clinical pearls" and additional resources for improving communication with SGM to create welcoming and affirming care experiences is provided in Table 1.

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Increasing Research on Implicit Bias

Finally, clinician implicit bias and its effects on health care is an understudied area. We suggest that researchers measure implicit bias associated with gender identity and conduct more research on the influence of clinician implicit bias on SGM health. In our own work, we are planning further research to determine if to training clinicians on SGM implicit bias through case scenarios and other curricular methods improves clinical communication skills and the health outcomes of SGM patients.

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