Maybe They Had a Bad Day: How Marginalized Patients React To Bias In Healthcare and Struggle to Speak Out

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Abstract

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Background

Marginalized people, including Black, Indigenous, People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, Queer, and sexually diverse and gender diverse people (LGBTQ+) are subject to implicit bias during healthcare interactions which negatively impacts patient-provider communication and the quality of care. In this qualitative study, we collected 25 personal stories of unfair treatment from patients from marginalized populations. We report on participants' reactions to implicit bias and the longer-term consequences and harms of experiencing that bias.

Methods

We recruited racially- and gender-diverse participants through institutional networks, social media, and community champions. Inclusion criteria were: (1) to be BIPOC and/or LGBTQ+, (2) be 18 years of age or older, and (3) reside in the United States of America. Participants completed an hour-long remote semi-structured interview. In these interviews, we asked participants to tell us their stories about experiencing discrimination when visiting a healthcare provider. Interview data was summarized with qualitative thematic analysis.

Findings

From our thematic analysis, we found four distinct ways patients responded to implicit bias (**Reactions to Bias**) and a myriad of longer-term consequences and reactions from having to adapt to bias (**The Aftermath**). Our findings explore in detail how patients from marginalized communities choose to respond to bias and surfaced key institutional barriers to speaking out against and reporting bias.

Interpretation

Our themes describe how individuals navigate Implicit bias in healthcare, how that bias can cause longer-term harms for marginalized people, and the barriers to reporting that bias. More research is needed to explore the prevalence of this bias and make providers more aware of the effects of implicit bias on patients.

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Introduction

Healthcare bias- the implicit stereotypes and prejudices providers can carry towards a patient's race, gender, sexuality, or socioeconomic status can have severe detrimental impacts on marginalized patients' health outcomes and mental health. (1) (2) (3)

For example, in the United States of America Healthcare System, Black patients experience worse pain management treatment and are sometimes stereotyped as seeking opioids. (4) Black patients may be subject to worse health outcomes even when adjusted for socioeconomic status (5), may not be listened to, or experience psychosocial hardships, such as stress and anxiety brought on by perceived discrimination (6) while seeking medical care. LGBTQ+ patients experience their own hardships from provider bias. (7) Providers may not be up-to-date on LGBTQ+ issues and health needs (8), hold an implicit preference towards treating cisgender heterosexual patients (9), and are a frequently underserved population with complicated, individual healthcare needs (10).

While there has been a wealth of research to explore discrimination and disparities in healthcare, little work has been done to understand marginalized patients' lived experiences of bias in healthcare interactions or explore why individuals do not report bias or seek correction within the institutions that serve them when issues occur. This study seeks to better understand how patients react to and internalize bias, and the long-term consequences of that bias.

Methods

Objective and Study Design

The purpose of this qualitative study was to describe the lived experiences of marginalized patients who experienced biased interactions with healthcare provider. We conducted semi-structured interviews and administered an online survey. Interviews asked participants to tell us their stories when they visited the healthcare provider and felt not heard, disrespected or made uncomfortable. Study procedures were approved by the University of Washington Institutional Review Board.

Study Population and Recruitment

We recruited via convenience sampling from social media, distributing online flyers through healthcare networks, and snowball sampling through word-of-mouth referrals. Interviews took place from June to November 2020, during the COVID-19 pandemic. Recruitment continued until thematic saturation was reached. Participants needed to be LGBTQ+ and/or BIPOC,
reside in the United States and have experienced healthcare there (e.g. primary care, dental care, outpatient clinic), speak English, and be over 18 years of age.

Data Collection

Participants completed an online survey to provide demographics (i.e., age, gender, race, ethnicity, education) and the 10-item Day-to-Day Unfair Treatment Scale (Kreiger et al., 2005). Participants were then interviewed over Zoom for approximately one hour with two interviewers. One interviewer acted as lead, asking interview questions, while the secondary interviewer asked follow-up questions and took field notes. Semi-structured interviews were conducted in two parts: Participants first described instances in which they experienced bias in their interactions with a healthcare provider ("personal stories"), then participants suggested strategies to improve those interactions in the future (Table 1). For this analysis, we focused on personal stories of participants- their strategies and solutions are to be reported in later studies. (11)

Data analysis

We summarized survey data with descriptive statistics and applied thematic analysis to interview data (12). From an initial codebook established by previous research (11), a team of 4 coders (RCP, CA, EB, and DM) further reviewed and coded transcripts, applying and expanding the codebook through inductive thematic analysis until the team reached consensus. The coders used Atlas.TI qualitative analysis software version 9 to read two transcripts weekly until all 25 transcripts were analyzed, iterating on our codes and their definitions. Two coders were female (DM & EB), one was male (CA), and one was non-binary (RCP). Two coders identify as Hispanic/Latino (CA & RCP), one as Asian American (DM) and one as White (EB).

Table 1: Interview Questions

Type	Questions
Part 1: Personal Stories	1. Tell us about a time where you or someone you know, had a conversation with a doctor that could have gone better where you felt treated unfairly, not heard, disrespected, or made uncomfortable?
	2. What specific things contributed to things not going well?

Results

Participants

Twenty-five participants completed interviews (P1-P25).Table 2 summarizes participants' demographics and day-to-day experiences of discrimination. Given that we were able to sample for individuals who uniquely belonged to both BIPOC and LGBTQ populations, this study also presents insight into the lived experiences of those with intersectional identities. One participant did not report as either group and self-described as "an older Asian woman".

Table 2

Age (Mean = 31, Standard Deviation = 10, Range = 19 - 60)	n=25 (100%)
18-29	15 (60%)
30-50	9 (36%)
50+	1 (4%)
Gender	
Woman	16 (64%)
Man	3 (12%)
Gender-diverse (Trans, non-binary, genderfluid)	6 (24%)
Race	
White	3 (12%)
Black or African American	5 (20%)
American Indian or Alaska Native	1 (4%)
Chinese	3 (12%)
Multi-race	6 (24%)
Asian Indian	4 (16%)
Other	3 (12%)
Ethnicity	
Not of Hispanic, Latino, or Spanish origin	18 (72%)
Latino/a (Mexican, Mexican American, Chican, Puerto Rican, Filipino, etc.)	6 (24%)
Preferred not to disclose	1 (4%)
Education	
Less than High School	1 (4%)
High school graduate	1 (4%)
Some college	4 (16%)
Bachelor's degree	12 (48%)
Graduate/Professional degree	7 (28%)
Which group(s) best describe you?	
Black, Indigenous, and People of Color (BIPOC)	11 (44%)
Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Other (LGBTQ+)	3 (12%)
BIPOC & LGBTQ	10 (40%)
Other: “Asian Woman”	1 (4%)

Overview of themes

Participants described the reactions and long-term consequences from biased interactions with healthcare providers (“discrimination events”). We identified two themes that reflect this: (1) **Reaction To Bias** and (2) The Aftermath. **Reaction to Bias** describes how patients immediately respond to discrimination events, **The Aftermath** describes patients' actions and thoughts that occur in the long term after discrimination events.

A. Reactions To Bias

Within this theme, we identified four subthemes that describe different ways participants responded: **Fight, Flight, Excusal**, and **Workarounds**.

1. Fight entails immediate self-advocacy during a discrimination event, at the risk of being seen as a "rabble-rouser" (P16). P15 describes being condescended to by their providers for seeking STI medication.

"Specifically, I had a pharmacist who... was just very curt with me and then I had a nurse who said, "If you were my son, I would lecture you on ways that you could be safe." and I responded with, "Well I'm glad I'm not your son."(…) she was standing above me, hands on her hips… literally lecturing me as if she was my mother." Directly confronting bias in this way is often emotionally taxing, risky, and learned over a long period of time. P21 describes their ability to self-advocate as being self-taught in opposition to their upbringing: *"...It's taken me how many years of my life to be able to speak up against somebody in a position of power because I was taught not to do that."*

2. Flight entails tolerating the discrimination event, passively disengaging and in some cases putting in extra effort to be seen as personable and pleasant in the hopes of pleasing the healthcare provider. For example, P1 recounts an experience trying to order STI tests when seeing a new primary care provider while their usual PCP was on vacation. While their usual PCP was aware of their sexual orientation and often ordered tests for P1, they were uncomfortable outing themselves to the new provider:

"(The provider) actually didn't order any tests. I was just like, "you know, it's OK." ...I told him that I would just basically wait it out and (if) any symptoms came up… I would order a test then, but at the end... he [had not] ordered any tests for me…. I didn't really want to be there. And I felt like I was begging for these tests."

3. Excusal entails dismissing the provider's behavior or denying that a transgression has occurred due to implicit bias. Several participants explained that rather than exhibiting discrimination, maybe the healthcare provider *"had a bad day*" (P2, P3, P11, P20) and that their unpleasantness was due to the stress and difficulty of healthcare work, rather than implicit bias. For example, P03, an older Asian woman, told us:

“It's like they can overlook things, you know. See, I'm the type that if you do one thing wrong, I always find the good in other people. It’s, like, oh, maybe they had a bad day… You know, I always think of excuses for other people first, If I get mistreated. But if they've mistreated me like (with) not just the tone of voice, but like the body language, and if it's more than once or twice, then I get upset. But the beginning, I always say “Everyone has a bad day. You know, nobody's perfect, right?”. I always say that for other people, for myself.”

4. Workarounds describe other ways participants navigate bias, enacting subtle ways to get the provider to reconsider. P7, a young man and student athlete, when not given pain medication for an injury, was advised by a mentor to “ask for [the provider] to write down the reason why they're denying it for you…. (M)ost of the time they'll give it to you... it’s a way of defeating some implicit bias.” P19, a woman of color, explains that their husband, a white man, would often act as an intermediary between them and the provider.

“...my husband (was) pissed off and bent out of shape. He was the one who basically spoke up for me. He was the one who said, "No, no, no, no, we need to get these tests done." ...The funniest thing is, I told the exact same thing to a doctor, but they don't listen to me. I'm the patient but you're going to listen to my husband? He's not in my body.”

B. The Aftermath

The Aftermath describes the longer-term consequences of experiencing implicit bias in healthcare. Within this theme, we identified six subthemes that capture a range of responses related to coping: **Delay or Avoidance**, **Changing Healthcare providers**, **Self-medication**, **Covering**, **Health-related Consequences**, and **Mistrust in Healthcare Institutions**.

1. Delay or Avoidance describes deliberately trying to not seek future care out of avoidance of further problems. P11 recounts a dental visit during which their local anesthetic did not take effect while their wisdom teeth were removed. Throughout the procedure, P11 repeatedly attempted to tell their care team that they were in extreme pain, but the care team repeatedly dismissed them. P11 did not seek dental care again until it was life-threatening, years later.

“...it was so traumatic that I didn't go to the dentist again for six years. And so I actually went to the dentist again because I had... a previous cavity from my teen years and it had broken... [Y]ou could you die from a bursting abscess, you know, and so I had to. I had to go to like essentially an emergency situation… I didn't feel heard and the end result was so like, ah, that I was like, “I'm never going to the dentist again unless I absolutely have to.”

2. Changing Healthcare Providers entails attempting to find other providers that provide better care and rapport, and considerations participants made when looking for healthcare providers in the future. For example, P14 describes changing providers multiple times to seek a diagnosis for their chronic pain, only for them to be seen as seeking opiates:

"I ended up switching doctors quite a few times, because I was running into barriers. I felt like no one would help me. So I went to a new clinic and I met with a new doctor... I didn't ask for pain medication. I actually don't even tolerate opioids, so that's not a good option for me... I almost felt as if they were suspicious. Like I was doctor shopping when in reality I was just trying to get someone who would actually work with me and give me the next step."

3. Self-medication describes instances where the participant sought alternative treatment than the one indicated by the provider. For example, P02 said.

"And the only reason that I got better was because I had brought antibiotics from the Philippines and I called a doctor relative in the Philippines and he told me what to take and like how to take it. Probably not the healthiest thing, but I would not have gotten better."

4. Covering describes the way patients change their behavior and appearance to be seen as more amenable, in some cases going at great lengths to appear professional, learning and using clinical language and jargon, and adopting mannerisms and affectations to make clinicians feel more socially comfortable. Patients will often do this in the hopes that by acting this way, they can be seen more as more credible and trustworthy. For example, P16 describes dressing professionally in order to be heard.

"...I'll even wear, because I'm an executive, so I'll… make sure that I'm like suited that day. You know, like head to toe.... Let me put on my professional attire. Sadly, it still doesn't work. Most [of the] time but it's part of that's part of the process. I actually have to prepare myself in that way. Like, and be selective about what I choose to wear that day. Yeah. Like I wouldn't, like I want to go in like my leggings. You know, like everybody else."

5. Health-related Consequences describes poor health outcomes that were worsened or complicated by the provider's implicit bias. Patients recounted times they were not taken seriously, leading to misdiagnosis. P21 describes multiple attempts to try to convince providers to order MRI scans due to grievous leg pain. After multiple misdiagnoses, the source of the pain was discovered due to an MRI scan, but at that point P21's condition had worsened considerably, they would need to undergo expensive surgery.

“*And I think, actually, if they had listened to me beforehand, I probably wouldn't have been as injured as I ended up… I think that further impeded my body so that I had even more damage. Like, I think the miniscule tears could have been like more severe and the strain on my bones were certainly not something that would have happened if I was treated properly initially... that ended up with me required to have surgery…I had to go back go back to work*”

6. Mistrust In Healthcare Institutions documents damage to faith in healthcare institutions and providers. Mistrust often leads to later action-oriented Aftermath responses, like Delay or Avoidance, or Changing Healthcare Providers. As P21 stated after their repeated attempts to be seen for their chronic conditions:

“...I think I'm always on guard… I am scared. I kind of have to watch my back... I can't just trust them.”

Discussion

Previous studies have shown healthcare experiences associated with perceived racial/ethnic discrimination among patients are poorly understood (13). Our findings add the critical voice of marginalized patients that extends our understanding of implicit bias in healthcare settings. In addition, our thematic analysis provides a possible explanation to ways bias can exacerbate health disparities. Patients often have to reconcile with experiencing bias, which may leave individuals with less energy or resources to seek effective healthcare (6) (14) (15) (16). While some patients may feel emboldened to confront bias, this study makes more explicit the ways patients may choose not to risk confrontation, excuse the provider, or find less confrontational ways of navigating bias. Our findings extend current literature that states implicit bias worsens disparities and may worsen health problems downstream.

The Ambiguity Of Healthcare Bias: A Delayed Harm with Long-Lasting Scars

While prior studies have looked into how different aspects of patient experiences can lead to perceived discrimination, our results present an exploratory deeper look into how patients react to and internalize struggles caused by provider bias. (13) Our themes corroborate with what current literature has only gently touched upon: perceived discrimination is often felt *after* the initial discrimination event because of the ambiguity of bias in healthcare. Due to the cognitive toll of navigating a complex and stressful healthcare system, (scheduling and finding a provider, being rushed from appointment to appointment, coordinating and following up with the care team, etc.) patients will often realize that discrimination and bias has occurred a only period of reflection. Our theme of **Excusal** typifies this period of reflection and surfacing of perceived discrimination: patients will assume that social friction between their provider is commonplace or that the provider "*had a bad day*", only to later realize that a transgression has occurred.

For example, P08, an international student not accustomed to care in the United States, described seeing a gynecologist for a checkup at their college's student center. During their appointment, P08 describe the doctor as making racial remarks, "not acting professionally", and carrying out the appointment in ways that made P08 extremely uncomfortable. P08 stated *"I didn't really know what was the right thing for doctors to be doing at the time, I didn't say anything. I just assumed that, "Okay, maybe this is like normal procedure." And I think that it was one of those things where, because of the way that I looked and my background and me not being as familiar with a lot of like the Western customs, I felt like they took advantage of the fact that I didn't know much about what was supposed to be normal."*

This incident would have longer term consequences for P08's care, an example on how **The Aftermath** can play out for weeks after a discrimination event. Not only was P08 troubled by the experience, they would only seek female gynecologists thereafter, an example of **Seeking Other Providers**, and their doctor would later be removed from their position due to severe allegations from other students. Regarding how the incident impacted them, P08 stated "*I definitely was really young, then. And it's been like some time and I've had like time to kind of heal and process. But yeah, it was definitely a bit shocking. And it kind of rubbed me the wrong way about doctors in general, which is why, like I think it's really important to have these conversations and see how we can... increase awareness… and compassion and make sure that… [doctors] aren't taking advantage of situations where people feel vulnerable."* Despite P08's resultant **Mistrust Of Healthcare Institutions** (namely doctors), they were able to move on from the experience.

Our themes that describe the internal struggles of those experiencing bias in healthcare resemble the findings of Fitzgerald and Swan, who cataloged and built a working framework to understand how victims of sexual harassment both internalize and weigh consequences of speaking out against transgressors.

In “Why Didn’t She Just Report Him? The Psychological and Legal Implications of Women's Responses to Sexual Harassment” (17), Fitzgerald et al explored paradigms of assertiveness and cognitive-behavioral stress to understand the outcomes and consequences of victims of sexual harassment. We see clear similarities in how study participants reacted to implicit bias; our definition of ***Flight*** is analogous to Fitzgerald et al’s definition of ***endurance****,* which they define as tolerating a situation because it is unavoidable, one is afraid, or one does not know what else to do. In both instances, the individual chooses not to engage, often because the personal cost to do so is too high. ***Excusal*** can also be seen as a combination and extension of two of Fitzgerald’s constructs, ***denial*** and ***reattributation***. ***Denial****, a deliberate decision to ignore the situation, to pretend it is not happening, or that one does not care*, aligns with how participants described dismissing potential discrimination events*.* ***Reattribution***, *reinterpreting the situation in such a way that it was not defined as harassmen*t, bears a strong parallel to patients seeing their providers as having “bad days”. There is also similarity between our theme of ***Fight*** and the actions of individuals who exhibit ***assertiveness***: responses that clearly communicate that harassment is unwelcome. The parallels between our **Reactions to Bias** and Fitzgerald’s constructs suggest that implicit bias in healthcare may be largely underreported: a key finding of “Why Didn’t She Just Report Him” is that individuals will very rarely speak out correction against transgressions using established institutional and organizational relief structures, due to the high personal cost of time and energy needed to report harassers.

The Cost Of Speaking Out: Would it Even be Worth it? Rigid Adherence to Structure, Medical Gaslighting , And Power Differences

The broader research applications for our findings are not only what is *not reported*: from our interviews we present three ways barriers prevent marginalized persons from reporting bias.

Breaking Through Institutional Inflexibility

One of our strongest findings is a deeper understanding of the factors that prevent patients from speaking out against bias in healthcare settings, as it happens and afterwards in the long-term. Provider and institutional inflexibility can mask bias, acting as a barrier against reporting. Patients can feel unheard as a result of this adherence to structure, leading them to believe that efforts to report their problems are falling on deaf ears.

P15, a queer veteran, describes a continued struggle to receive a form of STI medication with their pharmacist. As part of institutional practice, P15 would have to answer a series of screening questions every three months. They describe trying to build a rapport with the pharmacist, even starting on friendly terms with the provider. However, the pharmacist's demeanor would over time be described as "condescending" and "sterile", a process that consistently put P15 ill-at-ease.

"*I just stopped really engaging with them… anymore …And just letting them say whatever they wanted to me.... my perspective was, I'm going to have to see her for an hour every three months, and we were she's asking me these very intimate questions about myself and I am answering her questions also trying to build a connection... I just realized after a while, that it was not worth it to continually try to get her to see how her standardized questioning could be altered*."

The personal cost of trying to get a provider to break from routine and reevaluate was so high that P15, a usually staunch and outspoken self-advocate, chose not to engage and endure the questions for the entirety of their treatment.

Participants often employ **Workarounds** to get the care they need when providers and their routines are acting as barriers when patients have exhausted all other options to work within the healthcare system to circumvent those barriers. P7, who was able to get their doctor to reconsider giving them pain medication for their sports injury, details how peers use similar techniques to subtly confront bias:

"*I got a friend of mine who went through something similar… They were... African American... they said...their mom wanted to get this procedure done, but the doctor wouldn't let them. And they asked the doctor, "Can you please write the reason why you won't let me get the procedure on my chart, just for the insurance?" or something like that. And the doctor, at that moment, was... reluctant and then changed his mind... it's not a direct result but it feels like a really direct result. And so, I see a lot of people on Twitter* *talk about the same thing where I asked my doctor, "Can you write down the reason why?" And then they [were] allowed...to get the procedure…"*

Medical Gaslighting

Gaslighting, the act of instilling self-doubt as a means to delegitimize another's viewpoint is another barrier that can manifest to marginalized persons seeking care. Providers engaging in medical gaslighting will use their expertise to cast doubt on patients' understandings of their own bodies. P14, an administrative healthcare worker, describes repeatedly trying to convey a specific bone pain. Despite their degree in biology, they were frequently seen as overreaching, or that their apparent knowledge was not applicable. They were frequently dismissed.

"It was tough and I think the biggest part for me is I ended up self-doubting myself a lot... you start second guessing yourself. When you really shouldn't be. I'm not a physician, but I would think that if someone says something as extreme as I feel as if my bones are touching, there would be something a little more than just a distraction."

P14 would try multiple times to convey the severity and specificity of their pain:

"Man, you know, I felt as if I tried to and I tried to do that by repeatedly going back and saying "This isn't working, can I have another option?" or calling the nurse line but I almost feel as if it almost wasn't worth it, since they didn't care. It's almost like "What makes it worth it to try to communicate and go back again and communicate your needs?" I don't know it."

P22, a trans person, describes not being taken seriously due to being transgender:

"I*t's a pretty commonly known thing in the trans community where you go in to a doctor and they blame everything on you being trans. You go in and... "Oh, you know. You've got a broken arm." Hence, the example, like, "Oh, maybe your arm was weakened because of osteoporosis from taking the estrogen." And you're like, "No. My arm is broken because I slammed into a wooden fence at 20 miles an hour." And it's.... I mean, it's common enough that it's a meme within the community*."

While providers do have the ability to discern the severity of health issues, they can also misattribute problems while casting doubt on patients' understanding of their own bodies.

Power Differences and Misplaced Paternalism

Marginalized populations often feel the power difference between provider and patient as an obstacle to continued rapport and discussion. P06 describes an instance in which their psychiatrist immediately, and bluntly refused to prescribe anti-anxiety medications because of P06's legal recreational drug use. *"I did ask if it was in the policy, he told me no. And I asked him, "I think I would want to see another psychiatrist." And he told me, "You know, we work for the same company. They're going to honor what I say... they're not gonna prescribe it. You know, they're not going to go against another doctor in the organization.""* While there were possible legitimate reasons to not prescribe anti-anxiety medication, none of this was conveyed to P06. Their provider immediately used their position as a healthcare professional to immediately shut down the conversation about medication with P06.

P12, a woman of color, describes not being taken seriously, their questions about health frequently dismissed. *"[T]he first thing that comes to mind is [that the provider does it] to prevent further discussion. It's like the doctor cut short the conversation. And he was like, "Oh, the nurse will take care of you," ...that just seemed very dismissive and rude… it's like my concerns are not being addressed… especially if it's [being directed at] a patient who is new to the healthcare system or not as experienced with like terminology..., it just deters them from having agency... and being responsible for their own body..."* In some instances, the power providers have over patients is used to force the conversation to be one-way, damaging provider-patient rapport and trust.

The effects of bias on care and the vast amount of personal resources required to speak out against it ultimately lead to a culture of patients not trying to "rock the boat" (P01, P16), electing to take the stress of navigating bias in healthcare internally. This, in turn, can lead to the learned long-term actions described in **The Aftermath**.

When Bias Goes Unchecked, Every Day Is A Bad Day

During the Covid-19 pandemic, health inequality in the United States was on full display, with underserved ethnic and racial minorities suffering higher numbers of hospitalizations, severe illness, and fatalities when compared to communities of privilege. It was against this backdrop that the Black Lives Matter movement gained nationwide prominence, prompting widespread discussion and discourse on inequality and how it manifests and perpetuates itself in American governmental institutions. This was not lost on our participants. As P18 stated on accountability:

> *"[P]eople can listen, people can take surveys. But if there's no action that is derived from that, then what's the point?... [I]t definitely has to go hand in hand. You know, some sort of accountability…. you know, with police brutality, for instance, you know what that looks like. You can report it. You can talk about it. But what is there is there's no actual weight in that information…. You know, like I like to think that these places weren't intentionally trying to... hurt me in any way or hurt people like me. We are further marginalizing me and my experiences."*

It is of note that the terminology of "having a bad day" also has a notable, extreme, and recent connotation with recent tragedy. When asked if the 2021 Georgia Spa shootings appeared to be racially motivated, a police spokesperson responded, "*[H]e understood the gravity of it. And he was pretty much fed up and kind of at the end of his rope. And* ***yesterday was a really bad day for him and this is what he did."*** (18) While everyone has their bad days, it is this language of **excusal** that allows hard-to-detect implicit bias to go unchecked and underreported. Until further institutional mechanisms, provider training, and technology in healthcare is utilized to close this gap, every day will be a bad day for persons of marginalized communities.

Limitations and strengths

Due to COVID-19 restrictions, we were only able to recruit through virtual means, potentially skewing our sample to younger people who use social media and those with more comfortable with technology. Furthermore, participants were required to participate over Zoom (e.g., device compatible with Zoom software with a microphone, stable internet connection), which possibly selected for individuals more comfortable with teleconferencing software and social media. Due to the restrictions of carrying out remote qualitative research during a global pandemic, the is the potential for sample bias in our population and further research should be conducted with the goal of obtaining even more representative samples. Conversely, the time in which this study was conducted captures the personal stories of participants during a time of social change: this study provides psychosocial and cultural context towards participants' feelings on implicit bias during a time in which health inequity was a much-discussed social issue. This study also explored the lived experiences of people intersectional identities (both BIPOC and

LGBTQ+) regarding health bias, providing a wealth of insights to further learn from and explore in later studies.

Conclusion

These findings fill an important gap in our understanding of the reactions of patients who face implicit bias in healthcare and its long-term consequences, holding implications for research and practice. By presenting these findings, we hope to provide means to achieve a deeper understanding of the perspectives of racially and gender diverse individuals. Our next steps include providing thematic analysis from participant’s proposed solutions aimed at calling attention to implicit bias and correct institutional bias. Additionally, we are currently working on the creation of a technology probe to bridge the communication gap between provider and patient to provide more opportunities for implicit bias intervention and multi-cultural competency.

In an era where healthcare is becoming more and more data-driven, it is crucial to also listen to the personal perspectives and contexts of communities that receive that care. Insight can not only come from lab results and data points, but from the lived experiences of patients, who can provide a wealth of information about their own health. Patient-provider communication is a two-way street, and when patients are marginalized, gaslit, or ignored, that road to successful treatment can instead become a wall to surmount. These barriers further worsen health disparities and lead to worse health outcomes. With that in mind, we hope that our findings further bridge gaps in understanding and allow healthcare professionals to engage in conversations with historically marginalized persons to create a better healthcare system for all.

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