

Addressing Bias among Medical Care Teams on the Wards: A Perspective from Asian Medical Students in the United States

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The Experience

As Asian American and Pacific Islander (AAPI) medical students who were preparing to enter clinical rotations in the United States, we heard general warnings from certain faculty mentors about difficult exams, demanding shifts, and burnout. More specifically, we were also told to be wary of another stressor our mentors had experienced as AAPIs: being mistaken for each other. For example, we heard stories of an AAPI female medical student mistaken for another AAPI female student on a four-person team. This persistent mix-up led one student to consider dyeing her hair or wearing glasses. At the end of the rotation, the two students realized they had received evaluations meant for the other student because of this continued mix-up, which caused significant stress.

These are not isolated incidents. We have faced similar events during our own training in different hospitals across different states. Moreover, harmful AAPI biases are not a novel issue. A recent study published in the *Journal of the American Medical Association (JAMA) Network Open*, AAPI medical residents reported the highest percentage of any race/ethnic subgroup (99%) of being confused for another team member of the same race/ethnicity within a year.¹ As AAPI students, we not only face the challenges of medical school, but we also worry about unconscious and conscious biases in the clinical setting that may impact our evaluations and careers.

Bias refers to the “implicit stereotypes and prejudices,” often negative, that individuals may hold toward other groups based on factors like race, gender, age, and occupation.² There has been an increased focus on the healthcare system’s role in addressing systemic bias and discrimination leading to poorer outcomes and experiences for minority patients.³ Other studies have assessed patient’s bias towards physicians and medical students.⁴ Yet, the

bias perpetrated within the medical team is frequently missed. As AAPI students, we have a unique perspective on this important and prevalent issue.

One day, one of us was asked by a resident if we spoke Korean as we approached a Korean-speaking patient. Upon realizing that we spoke Chinese, the resident expressed disappointment, saying, “That’s such a shame. It’d be so much easier if you spoke Korean.” This conversation could have been approached differently: asking the entire team if anyone spoke Korean rather than targeting the sole AAPI medical student. Incidents like these can also affect team dynamics by leaving a negative impression on a student for something outside of their control – speaking a particular language based on the assumption they may be Korean.

When considering bias among medical care teams, the issue is complicated for medical students: we are less inclined to speak up and advocate for ourselves given our position in the medicine hierarchy.⁵ For AAPI students, this manifests not just as receiving the wrong evaluations, but also being viewed from the lens of racial stereotypes: receiving feedback from faculty on the wards that we are “too quiet,” for example. These experiences pose an important question: how can we address the bias within our clinical teams towards medical students? From our perspective, education and representation are potential avenues for change.

To begin, educators can be equipped with resources to understand the complex cultural backgrounds of AAPI students to cultivate a safe environment. Educator bystander intervention workshops build skills for faculty to intervene if a patient or another team member make biased comments that create an uncomfortable environment. Implicit bias trainings could benefit both students and educators alike by alerting both parties to the unconscious societal biases that may influence how one evaluates

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another person's performance. Bias is present from students toward faculty and from faculty toward students in evaluations^{5,6}, which emphasizes the need to offer interventions toward students as well.

Another way for microaggressions and discrimination to be recognized and addressed is through AAPI experiences to be incorporated into medical school curriculum.⁷ As AAPI medical students, we have attended many lectures regarding race as a factor for healthcare disparities. From our personal experience, stories and statistics of AAPIs are sometimes not mentioned alongside that of other race/ethnic groups; despite being the fastest-growing racial group in America, AAPIs have funding, structural, and social barriers to research participation.⁸ Thus, we encourage these educational trainings and lectures to include our voices and data. Representation also comes in the form of mentorship and structural change to diversify faculty to include AAPI individuals. A 2012 study found that AAPIs represented 3.52% of chairpersons, and 0% of deans in the U.S.⁹ Hence, we endorse a hiring toolkit for recruiting, supporting, and retaining faculty and staff from marginalized backgrounds.

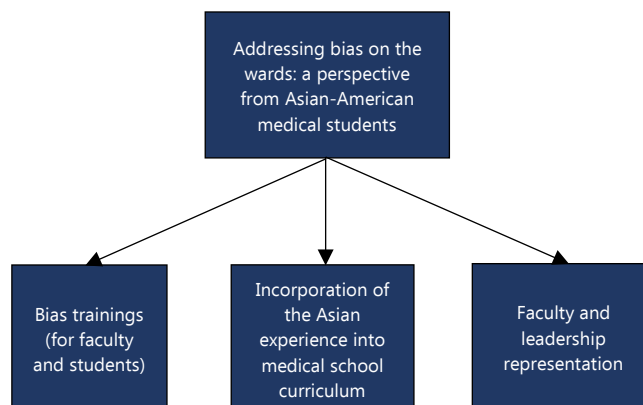
An example of these recommendations in practice, at one of our medical schools at the University of Michigan, we have advocated for bystander trainings to be offered to more faculty, staff, and students. We worked to add readings to an optional curriculum for incoming medical students related to the topic of bias toward AAPI students in medicine. Finally, we worked to help establish an AAPI faculty-staff-student support group across our health system to facilitate further conversation on these topics. While there remains more work to do at both Michigan and other institutions, these small steps have already led to progress.

Addressing general mistreatment of trainees includes addressing the biases medical colleagues perpetrate among each other. As conversations regarding systemic racism increase at bedside and

on the wards, it would be a blind spot to not do so. Just as Morbidity and Mortality conferences are seen as critical for ensuring high-quality patient care, so are discussions around how we can better support our hospital colleagues and medical students. Through interventions including implicit bias trainings, incorporation of health disparities in the AAPI population into medical school curriculum, and adequate leadership representation, we can create a more positive learning environment for AAPI students (*Figure 1*). Our hope is that this extends to the bias that trainees of other identities face as well.

As we look forward in our career, there is no better way to make us better educators and care providers than having exemplary models. Knowing our names is just one of many steps that mentors and supervisors in clinical settings can take to have medical students feel included. Now is the opportunity to set the precedent for addressing bias within clinical teams and positively shape the next generation of physicians.

Figure 1. Three Steps to Address Implicit Bias on the Clinical Wards.



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