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Perceptions of Implicit Bias in New York City Healthcare System During COVID-19

Kiesha Jackson
Walden University

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Walden University

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Kiesha Jackson

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Walden University
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Abstract

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by

Kiesha Jackson

MPA, Walden University, 2020

MA, Mountain State University, 2008

BS, Mountain State University, 2006

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

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February 2022

Abstract

Implicit bias has been identified as a significant problem that hinders effective healthcare delivery. The purpose of this qualitative exploratory phenomenological study was to examine whether implicit bias influenced healthcare services for African Americans with comorbidities aged 30 and over living in New York City during the COVID-19 pandemic. Current studies show healthcare disparities, revealing barriers with healthcare delivery; however, they do not disclose a patient's lived experience qualitatively, which constituted a gap in the literature. The frameworks of the behavioral model of health services use, and social construction and policy design guided this study. Research questions addressed (a) whether a significant correlation exists between implicit bias and the New York City healthcare delivery system; and (b) how communication abilities, comorbidities, and other medical conditions influence services and whether current policies are effective in mitigating healthcare inequities. A phenomenological design was used to examine qualitative surveys from purposive and snowball samples of 13 participants. The data set revealed participants' lived experiences of a biased encounter. Disparities in healthcare for this African American group were prevalent in the findings. The findings reveal poor access to platforms for complaints and evidence of healthcare inequity. Research results indicate a need for healthcare transparency. Implications for positive social change include modifications to healthcare policy, instrumentation review, improved health equity for African Americans, further understanding of bias in healthcare, and the promotion of healthcare education.

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Dedication

This milestone is dedicated to my comrades who did not make it home, including my Police K9 Military Working Dog, who died in my arms, and to all the disabled veterans who severed their country with pride and honor. I also would like to dedicate this to my scholar son, who dedicated his early years to defending the freedom and democracy of the United States; I'm proud of you, son. I also would like to dedicate this to my other son, who is academically gifted and plays six instruments; I am proud of you, son. I would also like to dedicate this to my scholar daughter, a Walden alumnus; I am proud of you, daughter. I would also like to dedicate this to my talented and academically gifted grandchildren; thank you for being patient with your nanna. I would also like to dedicate this milestone to the rest of my family and friends for their support. This study is also dedicated to the countless number of people who have lost their lives to the COVID-19 pandemic and those who have experienced healthcare inequity. The road has been long, but I am proof that disabled veterans can thrive, succeed, and become powerful change agents while influencing social change. Never give up on your hopes and dreams, and always believe that you can.

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First and foremost, I would like to acknowledge and thank GOD. I would also like to acknowledge the United States of America for its steadfast efforts to ensure freedom and democracy for all. Additionally, I would like to acknowledge Walden University for its commitment to disabled military veterans. I would also like to acknowledge the participants of this study; change is inevitable, and it starts with one story at a time. Finally, I would like to extend my sincere gratitude to my dissertation committee and acknowledge them all for their time, patience, feedback, and commitment to this dissertation; thank you!

Table of Contents

List of Tables	vii
List of Figures	viii
Chapter 1: Introduction to the Study.....	1
Introduction.....	1
Background	6
Problem Statement	9
Purpose Statement.....	11
Research Questions.....	14
Theoretical Foundation	16
Behavioral Model of Health Services use.....	16
Social Construction and Policy Design.....	17
Theory Justification	18
Nature of the Study	19
Definition of Terms.....	21
Assumptions.....	23
Scope and Delimitations	24
Limitations	26
Significance.....	28
Significance of Social Change	29
Summary	30
Chapter 2: Literature Review	32

Introduction.....	32
Literature Search Strategy.....	34
Theoretical Foundation	35
Behavioral Model of Health Services use.....	35
Social Construction Theory and Policy Design	39
Table 1	41
Literature Review Related to Key Variables and Concepts.....	43
Implicit Bias History	43
Perceived Implicit Bias in Healthcare.....	46
Implicit Bias Testing.....	49
Policymaking and Public Involvement	51
Algorithms Used as Determining Factors.....	54
Implicit Bias in Hospitals.....	56
Impact During the COVID-19 Pandemic	58
Military Veterans and Implicit Bias.....	61
Military Disability Rates and Implicit Bias	64
Workplace Burnout a Factor in Healthcare	68
Civil Rights Laws and Implicit Bias.....	69
Implications of Implicit Bias	70
The Gap in Implicit Bias Research	74
Clinical Paradigm Theory in Leadership and Communication.....	75
Psychodynamic Approach to Leadership in Healthcare	79

Servant Leadership in Healthcare	81
Systems Thinking in Healthcare	84
Ethical Responsibility in Healthcare.....	84
Qualitative Components of a Study	86
Summary and Conclusion.....	89
Chapter 3: Research Method.....	92
Introduction.....	92
Research Design and Rationale	94
Research Questions.....	94
Phenomenological Approach	96
Generic Approach Explored	97
Design and Rationale Summarized.....	99
Role of the Researcher	100
Methodology	101
Participant Logic.....	101
Triangulation.....	105
Participant Selection Logic	106
Instrumentation	106
Weaknesses in Qualitative Questionnaires/Surveys	109
Collecting Information and Recording Data.....	109
Data Collection Process	109
Recording Data	111

Procedures for Recruitment, Participation, and Data Collection	112
Recruiting Participants	112
Administering Procedures	113
Data Analysis Plan	114
Thematic Data Analysis	114
Instrumentation and Tools: NVivo	116
Data Collection	117
Threats to Validity	119
Issues of Trustworthiness and Credibility: Internal Validity	119
Transferability: External Validity	121
Dependability: The Qualitative Counterpart to Reliability	123
Confirmability: The Qualitative Counterpart to Objectivity	124
Ethical Procedures	124
Summary and Conclusion	126
Chapter 4: Results	128
Introduction	128
Setting	130
Demographics	131
Data Collection	132
Geographical Population-Based	132
Maintaining Reflexivity	133
Data Analysis	134

Conceptualizing and Interpreting Emerging Themes	134
Data Familiarization for Saturation	136
Coding and Developing Themes From Emerging Data.....	136
Using NVivo Software.....	137
Developing the Final Analysis.....	139
Evidence of Trustworthiness.....	139
Establishing Credibility	140
Transferability of Results.....	140
Dependability from Emerging Data.....	141
Confirmability Through Reliable Strategies.....	141
Results.....	142
Table 2	144
Research Question 1	145
Research Question 2	150
Research Question 3	154
Research Question 4	161
Participant Recommendations	167
Summary	169
Chapter 5: Discussion, Conclusions, and Recommendations.....	171
Introduction.....	171
Interpretation of the Findings.....	172
Figure 1	176

Applying Thematic Coding.....	178
Limitations of the Study.....	182
Recommendations.....	182
Implications Positive Social Change	186
Table 3.	188
Conclusion	189
References.....	192
Appendix A: Semistructured Interview Online Survey Guide	239
Appendix B: Inclusion, Research and Survey Questions in Alignment	241
Appendix C: Copy of Online Research Survey	245
Appendix D: Raw Survey Data Word Count.....	255

List of Tables

Table 1. Assumptions of the Theory of Social Construction and Policy Design	41
Table 2. Dominant Themes and Subthemes	144
Table 3. Examples of Possible Outcomes that can lead to Social Change.....	188

List of Figures

Figure 1. Key Terms	176
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Chapter 1: Introduction to the Study

Introduction

There is a lack of research exploring perceived implicit bias in the United States healthcare system (Arnett et al., 2016; Bonnie et al., 2015; Brooks, 2020; Krishan et al., 2020; Stepanikova & Oates, 2017). Peer-reviewed studies, such as Krishan et al., 2020 and Raharja et al. (2020), have shown that implicit bias impacts minority groups, further contributing to health-related disparities, including health inequities and a significant number of deaths and illnesses. The purpose of this study was to evaluate the extent to which implicit bias influences healthcare services for African American adults aged 30 and over with comorbidities residing in New York City during the pandemic of coronavirus disease (COVID-19).

The objective of the study was to understand the perception of African Americans who have experienced healthcare-related implicit bias through the lens of the participant while evaluating the extent of the problem, thereby weighing if current policy changes are warranted. The rationale for this study was to promote African American involvement in the healthcare policy and provide education on the seriousness of significant disparities of this underrepresented population when it comes to public policy. Participants who met the criteria were provided a qualitative survey to express their lived experiences, perceptions of implicit bias, and how healthcare policy plays a role in their health. As such, there is an expectation that policymakers and researchers should understand the correlation of the history of problems, social determinants, healthcare policy, and its effects on society to solve problems associated with healthcare.

Pollack et al. (2018) contended that public policy outlines principles that influence a pathway to action, establish political governance, and, most importantly, set legal boundaries. These same principles also apply to policies for both the private and public sector organizations, which must abide by federal laws; however, the private sector policies do not hold the force of the decree (Pollack et al., 2018). Furthermore, to assist in the construction of a policy, it is implied that there should be an understanding of social determinants impacting the specific community and an understanding of the concerns of that community (Centers for Disease Control and Prevention, 2019b; Pollack et al., 2018).

Public policy, which is legally binding, has three classifications: legislation, regulation, and litigation (Pollack et al., 2018); Legislation (statutory law) is drawn by an assembly of officials (Pollack et al., 2018). Regulations circulated by the federal, state, and local administrative governing agencies include particular policies that are outlined in legislation (Pollack et al., 2018). In contrast, litigation represents public policy employing judicial options (Pollack et al., 2018). Public policy is further discussed in Chapter 2.

With this investigative research I aimed to explore a problem that is inherently grounded in public policy. According to preliminary research, African Americans are more likely to experience implicit bias than most racial/ethnic groups. However, it is essential to note that research demonstrates that anyone can be subjected to implicit bias (Payne & Gawronski, 2010). Ben et al. (2017) explained implicit bias as social behavior and a cognitive process that induces judgment. More specifically, implicit bias is an

unconscious stereotype of negative beliefs and attitudes toward people of different cultures, races, and ethnicities (Ben et al., 2017). According to the Centers for Disease Control and Prevention (CDC), negative bias behavior can hinder a person's quality of life (CDC, 2020a).

While FitzGerald and Hurst, (2017) demonstrated that anyone could be subjected to bias, a disproportionate number of disparities significantly affect the African American racial/ethnic group (Ben et al. 2017; Krishnan et al. 2020; Stepanikova & Oates, 2017); most importantly, healthcare policy was rarely addressed by these studies. Very little qualitative research specifically addressed African American experiences of bias in the healthcare delivery system during pandemics, particularly the COVID-19 pandemic, thereby leaving a gap in research. Also, according to preliminary research, there is a disconnect between patients and healthcare workers (Williamson, 2020).

The importance of this study is rooted in recent data; for example, Krishnan et al. (2020) confirmed that there had been an overwhelmingly disproportionate rate of African American deaths throughout the history of documented pandemics and epidemics in the U.S., inciting bias as a contributing factor. Therefore, this is not a new problem yet a phenomenon that continues to need attention. In addition to a history of healthcare disparities for African Americans, there have also been healthcare atrocities that are well-known to the community, such as the infamous Tuskegee study (Frakt, 2020).

Furthermore, researchers noted that it is difficult to accurately account for all such healthcare inequities committed against African Americans during past pandemics and epidemics because records were not adequately kept, and healthcare policy did not

require these notations (Krishnan et al., 2020). Many times, this ethnic group was even denied services because of biases (Krishnan et al., 2020). Implicit bias in healthcare has now reached the forefront of social concerns, and this phenomenon has continued to be demonstrated during the COVID-19 pandemic, signaling the need for healthcare policy reviews (CDC, 2020a). Failure to further explore the implications of implicit bias may extend its longevity, according to the CDC (2020d).

In 2020 the World Health Organization (WHO) publicly declared COVID-19 as an emerging virus and a threat to humanity (WHO, 2020b). Meanwhile, the CDC (2020f) has mandated American citizens wear masks and social distance to stop the spread of the virus. The U.S. healthcare system was critically overwhelmed with patients and dead bodies “piling up” with nowhere to place them (Carr et al., 2020 as cited in Young et al., 2020). More specifically, the CDC (2020b) reported a disproportionate number of African Americans dying from COVID-19. Like past epidemics, healthcare workers are relied upon to render service without discriminatory practices (CDC, 2021b). My research focused on patients aged 30 and over who used the U.S. Department of Veterans Affairs health services and the general population healthcare systems in New York City.

To further narrow the research scope, the purpose of this study was to evaluate the extent to which implicit bias influences the healthcare services for African Americans with comorbidities, specifically during the COVID-19 pandemic, and the correlation of this phenomenon to healthcare-related public policy. The interview questions created for this study were exploratory semistructured and open-ended. They were designed to explore (a) whether a significant correlation exists between implicit bias and the New

York City healthcare delivery system; and (b) whether communication abilities, comorbidities, healthcare policy, and other medical conditions influenced this relationship (see Appendix A). Hence, the main objective was not to test the healthcare system's adequacy but to explore and understand the problem of implicit bias in healthcare through the lenses of the patients to recognize if policy changes are warranted.

The completed surveys from this study were briefly hand-coded -after familiarization-then downloaded from Microsoft Excel and uploaded to the NVivo application for data analysis and coding. When thematic saturation and common themes were discovered, all research inquiries ceased ending the collection of surveys; the descriptive coding results and summary of themes, words, and phrases were then included in the findings. Additionally, emerging objectives shifted this paradigm, providing an understanding of the phenomena in correlation with policy. As such, the social implications of this study are that it may help influence movement toward a new paradigm of healthcare and health equity.

This chapter presents the problem statement, the purpose of the study, research questions, the theoretical foundation, and the nature of the study. I also discussed this study's assumptions, scope and delimitations, and limitations. Key terms used in this study are defined in this chapter as well. This chapter begins with the background of the study, which provided the basis for conducting this research while highlighting implicit healthcare bias in the healthcare system. This chapter concludes by explaining the significance of social change. It is important to reiterate that the phenomenon identified had not been thoroughly qualitatively explored for the identified target group. Hence, the

findings of this study may build on current scholarship. Much of Chapter 2 focuses on the history of bias, healthcare policy, COVID-19 pandemic, and the social constructs of communication and leadership. In this exploratory phenomenological qualitative investigation, the study's constructs enabled me to present meaningful findings. The following chapters explore informative contextual content, including the findings of this study.

Background

Implicit bias in healthcare is the act of subconsciously displaying stereotyping, profiling, unintentionally assessing an individual without evidence and can either be positive or negative, according to FitzGerald et al. (2019). There is an expectation that a patient or a potential patient seeking healthcare services would receive a fair opportunity to obtain care that is not based on skin color, culture, age, gender, sexuality, or other human characteristics (FitzGerald & Hurst, 2017). However, for example, Wyatt (2013) found that African Americans were less likely to receive equal treatment for pain than White Americans.

Being denied the fundamental human right to adequate healthcare within the U.S., specifically during a pandemic, can be viewed as multifactual, as implied by Bonnie et al. (2015). Bonnie et al. further described the problem of implicit bias, suggesting it aligns with discrimination. Likewise, the CDC (2021b) advised that African Americans are at increased risk due to discrimination in the healthcare system, which is a significant problem. It is important to note that the U.S. has a long history of racial/ethnic disparities (Laster Pirtle, 2020). COVID-19 has consistently exposed healthcare system disparities,

which is a stark reminder of past healthcare inequalities against minority ethnic/racial groups and those aligned with socioeconomic factors.

According to a recent study, commercial algorithms contain racial bias; however, they are currently used to measure risk factors through assessment and aid healthcare workers in decision-making (Obermeyer et al., 2019). Implying its ineffectiveness, Obermeyer et al. (2019) suggested further exploration of the use of algorithms. Supporting the idea of bias in healthcare, Ben et al. (2017) argued that racism and bias are prevalent within healthcare, specifically when treating patients of a particular ethnic background. Racism is a common form of bias discovered in the healthcare system, as reported in a cross-sectional survey study presented by Nong et al. (2020). Additionally, Hall et al. (2015) conducted a study that indicated most providers of healthcare practice implicit bias by displaying different attitudes towards the patients based on race and ethnicity. The researchers also found a need for further transparency resulting from the study's findings (Hall et al., 2015).

The CDC (2020b) reported racial and ethnic disparities in healthcare, citing various underlying medical and nonmedical related risk-markers like patients' socioeconomic status that puts African Americans at high risk compared to racial and ethnic groups. Additionally, almost a year later, the CDC (2021b) noted that African Americans are 2.8 times more likely to be admitted to the hospital due to complications from COVID-19 and three times more likely to die than people who racially identify as White. Likewise, it is crucial to reiterate that many health-related disparities relative to

the impact of a pandemic on ethnic minorities are caused by underlining medical conditions (CDC, 2020b).

Additionally, according to the U.S. Census Bureau, in 2020, African Americans (non-Hispanic) made up 13.4% of the U.S. population; however, they constituted 23% of COVID-19 deaths. More specifically, although New York City's African American community is 24% of the population (U.S. Census Bureau, 2020), almost 28% of the approximate 2,472 disclosed deaths for the city were among African Americans in 2020 (NYC Health Department, 2020). These statistics indicate a disproportionately high impact on the African American community compared to the White population, which totals approximately 32% of the city's population but was 27% of its COVID-19 deaths (NYC Health Department, 2020).

Elias & Paradies, 2021 argued an "example of the invisibility of racism is the recent disparity in significantly higher mortality rate among African Americans during the novel coronavirus disease (COVID-19) pandemic" (Elias & Paradies, 2021 para. 13). The significantly high rates reported by the (NYC Health Department, 2020) disparities for the African American community. According to Stepanikova and Oates (2016), perceived bias exists in healthcare, which further justifies examining patient knowledge regarding their perspective on their experiences with healthcare and its correlation to healthcare policy. These factors also indicate a gap in research that had not been previously explored, which are the lived experiences of African Americans with comorbidities or other underlining conditions who had experienced what they perceived as a biased encounter during a healthcare visit during the COVID-19 pandemic.

Relatively few research studies were found examining the effects and implications of implicit bias during a pandemic affecting African Americans with comorbidities. However, sufficient research-based evidence indicated that implicit bias continues in healthcare and that there is insufficient attention to healthcare policy in that regard (Gopal et al., 2021). This section was presented to justify the need for this phenomenological qualitative research investigating implicit bias in healthcare.

Problem Statement

The problem of implicit bias/bias in the New York City healthcare system may negatively impact African Americans with underlying health conditions, causing health inequity and furthering the decline of patient assurance. This study focused on African Americans with comorbidities aged 30 and over living in New York City during the COVID-19 viral pandemic. This study explored and described the participants' lived experience through their lenses. Current studies revealed a significant number of health disparities with the African American community; thus, revealing a gap in research regarding a qualitative exploration of their lived experiences. Studies have not sought qualitative data for their datasets, which could have attributed to possible researcher biases that resulted in gaps in past studies. These factors indicated a need to research the problem further to spread awareness that can create social change, influence current policies, decrease healthcare disparities, and build a new paradigm of healthcare delivery.

In March of 2020, COVID-19 was declared a pandemic by the WHO (2020b). According to the WHO, the current coronavirus, with origins stemming from the SARS-CoV-2 virus, has devastated the world, causing death and uncertainties for most

racial/ethnic and socioeconomic classifications (CDC, 2020e; WHO, 2020b). COVID-19 exacerbated complications from preexisting health conditions and comorbidities as emerging health conditions developed from the virus (CDC, 2020a); an estimated 61,978,983 had tested positive within the first year, resulting in an estimated 1,459,033 deaths in 201 countries, land areas, and territories (WHO, 2020a). The pandemic has indiscriminately impacted the U.S., totaling an estimated 22,965,957 cases and an estimated 383,351 deaths within the first year of the pandemic (CDC, 2021a). Moreover, as of June 13, 2021, there have been approximately 175,306,598 confirmed cases and 3,792,777 deaths globally from COVID-19 (WHO, 2021). As such, the CDC (2020f) noted that there may be several variables regarding COVID-19 outcomes.

While these numbers provide insight into a significant pandemic problem, they do not specifically identify an implicit bias experience. FitzGerald and Hurst (2017) argued implicit bias is an unconscious and unintentional preconceived notion that modifies behavior. Consequently, according to a recent study, implicit bias had disproportionately negatively affected African Americans (Martinez-Kaigi, 2020). Explicitly, African Americans who visit medical facilities for services can be subjected to implicit bias (Martinez-Kaigi, 2020). It is important to note that this study was not epidemiologically based; however, it exclusively focused on understanding implicit healthcare bias. To further support the rationalization for my study, Block et al. (2020) reported evidence from a poll that indicated racial inequities in healthcare, specifically during the COVID-19 pandemic.

Further evidence of the problem indicated that African Americans are disproportionately and negatively affected by COVID-19 (see Galaviz et al., 2020). The Association for Psychological Science revealed that recent efforts in the fight for justice and equality in the U.S. in the form of demonstrations are long overdue, citing inequities in educational institutions, the job market, politics, socioeconomic classes, and in scientific research (Association for Psychological Science, 2020). These inequities relate to the underpinnings of implicit bias in healthcare according to Smedley et al. (2003). In short, the problem of implicit bias impacts various groups as established by research studies; however, it was unknown how patients perceived these biased experiences during the COVID-19 pandemic, which prompted this study. These biases can be about gender, sexuality, comorbidity, or race/ethnicity (Smedley et al., 2003). The gap in research called for a qualitative phenomenological investigation; therefore, I obtained qualitative data for analysis to explore the problem.

Purpose Statement

The purpose of this study was to explore and describe the extent to which implicit bias influenced healthcare services for African American adults aged 30 and over with comorbidities and living in New York City during the COVID-19 pandemic. By presenting the lived experiences through the lenses of the participants, new policies supporting health equity could result in a possible improvement in the quality of life for this target group. The research questions were also designed to support the purpose of this study by examining (a) whether a significant correlation exists between implicit bias, policy, and the New York City healthcare delivery system; and (b) whether

communication abilities, comorbidities, healthcare policy, and other medical conditions influence this relationship. Additionally, the further objective was to explore implicit bias in the U.S. healthcare system. Specifically highlighting the New York City healthcare delivery system and incidents of perceived implicit biased encounters and how these encounters may have impacted the communication process between New York City residents and healthcare providers. Thus, furthering the purpose was to explore whether current healthcare policy was equitable. Healthcare equity is explained further in Chapters 4 and 5.

Furthermore, although data are continuously emerging, few qualitative studies revealed a lived experience of an implicit bias encounter in healthcare. Although evidence from current studies revealed a disconnection between some African Americans and the healthcare system, inequality in healthcare needed a qualitative study that specifically explored an individual experience. For this reason, in this study, I explored perceptions of healthcare encounters, in which I focused on whether comorbidity factors influenced perceived bias, as previously stated. In addition, I explored healthcare communication and leadership to understand the interaction between patients and healthcare professionals by applying Andersen's (1968) behavioral model of health services use (BMHS).

To this effect, Sfantou et al. (2017) asserted that leadership styles are critical to delivering quality care. In essence, when creating policy, a reasonable leader would consider factors of quality of care for all. To that effect, the further objective of this qualitative study was to draw attention to the disparity in the healthcare system and

understand the basis of the disparity and how it correlates to current policy, which will help to fill existing gaps in the current literature. Participants included in this study identified as residents of the U.S. and met the criteria for participating in this study.

To understand the correlation between implicit bias in healthcare services and policy, it is necessary to understand healthcare history regarding usage, healthcare outcomes, and measuring tools used, as Brown (2020) asserted. According to preliminary research, communication and leadership are of foremost importance for understanding healthcare policy and what may be needed to ensure equitable services (see Babrow et al., 2000; Brown, 2020; Kumar et al., 2014); therefore, a review of these factors is also included in this study. Sfantou et al. (2017) established that leadership styles are essential to the quality of healthcare provided and creating new policies would benefit decision-making. However, current research studies leave significant gaps in understanding bias (see Noonan et al., 2016).

Due to COVID-19, all the qualitative data were collected over the internet. A secured email system was used to correspond with the participants. The NVivo application helped code the participants' responses to the survey questions, which were designed to elicit real-life experiences. When thematic saturation was achieved as common themes were formulated, all research inquiries from participants ceased, and I proceeded with coding for the descriptive data. The intent of this study was not to develop theory but solely to understand the views of a specific group of people. Again, I found very little to no research on this specific problem, thus identifying a research gap. Andersen's BMHS provided the theoretical base for the study. From an epidemiological

standpoint, a critical strength of the BMHS is its capacity to help conceptualize inequitable experiences. To that effect, Ingram and Schneider's (1993) social construction and policy design (SCPD) helped rationalize healthcare policy's possible needs by examining why these inequities are happening.

Research Questions

I chose a phenomenological methodology for this research topic because it was most suitable to explore the phenomena in-depth. Preliminary research helped identify a significant gap in studies on healthcare-related implicit bias, which guided me in constructing the research questions to align with the research purpose (see Agee, 2009). Guided by Andersen's (1968) BMHS and Ingram and Schneider's (1993) SCPD, the research questions were constructed to explore perceived implicit bias encounters through a theoretical framework. The objective of these research questions was to provide further clarity and evaluate the extent to which implicit bias influences the healthcare services for African American adults aged 30 and over with comorbidities living in New York City during the COVID-19 pandemic.

I designed the research questions to provide data that explored (a) whether a significant correlation exists between implicit bias, policy, and the New York City healthcare delivery system; and (b) whether communication abilities, comorbidities, and other medical conditions are factors. Additionally, I explored how and why implicit bias in the U.S. healthcare system has disproportionately impacted a particular racial/ethnic group of New York City residents and if current policy is working. The following research questions were the focus of this research study:

RQ1: To what extent do patients who identified with having comorbidities or underlying medical conditions and who visited healthcare facilities during the COVID-19 pandemic perceive that they experienced implicit bias?

RQ2: To what extent do patients perceive that their underlying medical conditions affected the quality of care received and how they were perceived by the medical professional because of these conditions during their healthcare visits?

RQ3: Given the impact of COVID-19, how do patients perceive healthcare-related implicit bias encounters, and how did these encounters impact their quality of life?

RQ4: How do patients describe challenges with communicating with healthcare workers, and to what extent does healthcare policy affect health equity?

Despite healthcare reform and current policies to control racial disparities, healthcare inequity still exists, causing African Americans to suffer disproportionately (see CDC, 2020f). According to research studies, variables that contribute to disparities include socioeconomic status and race/ethnicity (Raharja et al., 2020). The questions were designed to satisfy data saturation using a small sample of 8-20 participants 13 of whom were chosen for this study because they met the inclusion criteria. For clarification, data saturation is the determination that enough data has been collected, and there is no further discovery of themes to be found in the information (Creswell & Plano Clark, 2018; Garrett et al., 2012).

Theoretical Foundation

Behavioral Model of Health Services use

Because the research questions used in this study were predominantly theory-driven, Andersen's (1968) BMHS was employed to analyze and make sense of the data used to construct the findings. This model allowed for a broad perspective and aligned with a phenomenological methodology that helped me explore healthcare services and policy. It fit with the population, the healthcare system, and healthcare usage, as explained in a study conducted by Tolera et al. (2020). The BMHS also helped me examine the relationship and the communication process between the patient and the healthcare system, thereby helping to uncover what led patients to seek medical healthcare services from a particular facility and whether they were aware of the facility policies. Moreover, this methodological approach provided a clear, concise framework in the emergence of understanding the variables, the research process, the stakeholders and helped to determine outcomes (see Andersen & Newman, 1990).

Additionally, my research considered the fourth phase from the original model, *Health Services Utilization* by Andersen and Newman (1990), which included enabling factors such as socio-culture, however, was not implemented into this study. Ultimately, Andersen and Newman's study helped guide the research process by providing a map into the behavioral process and understanding healthcare policy. As such, Sabbah et al. (2019) successfully applied the BMHS to a theoretical study that examined racial discrimination in the dental healthcare system, resulting in policy changes. The model

also helped the researchers understand healthcare outcomes, focusing on individuals' decisions in using specific dental services (Sabbah et al., 2019).

The BMHS model guided my research, which also helped in understanding the factors affecting the patients' healthcare service choices. The model aligned with the problems presented in this study's research questions and helped rationalize healthcare policies (see Andersen & Newman, 1990). For this reason, the BMHS was used as a primary theoretical framework. Andersen's (1968) BMHS also aligned with the context of my research as it also provided a clear, concise cognitive framework that resulted in the emergence of understanding communication, healthcare leadership, health policy, and African American patient's perspectives. It also helped to address whether policy changes were warranted (see Andersen, 1968; Babrow, 1992).

Social Construction and Policy Design

Ingram and Schneider's SCPD, an adaption of social construction theory (SCT), was developed to address political policy regarding social interactions of an under-representative group to address inequities (Ingram et al., 2007; Ingram & Schneider, 1993, as cited in Pierce et al., 2014). For example, some fundamental drivers include racism, sexism, poverty, education, and healthcare equity (Ingram et al., 2007; Ingram & Schneider, 1993, as cited in Pierce et al., 2014). The design aims to understand better how and why public policies are not working to solve societal issues. The SCPD is beneficial in constructing equitable policy, review of policy and help solve problematic healthcare issues. Moreover, it helps determine why some people are more favorable in

being appropriately interjected into political policy decision-making while others are not (Ingram et al., 2007, p. 93; Ingram & Schneider, 1993, as cited in Pierce et al., 2014).

Central to the theory of SCPD is the assertion that there is an unequal playing field directly affecting healthcare policy, leaving a considerable gap as to why equitable services are beneficial to some groups yet, not all further marginalize those who fall into an under-represented group (Ingram & Schneider, 1993; Pierce et al., 2014). The model was adopted as a lens to help examine whether the current policy meets the target group's basic equitable healthcare needs regarding implicit bias complaints incidents through exploring the lived experience of the participants in my study (see Ingram & Schneider, 1993, as cited in Pierce et al., 2014). Specifically, my research utilized an exploratory approach to illustrate the lived experience of implicit bias while highlighting disparities and the possible need for under-represented groups' participation in policymaking. Thematic analysis was also initiated in this study to examine the phenomenon. The SCPD is further discussed in Chapter 2.

Theory Justification

Using these theoretical approaches to explore the phenomenon offered a unique perspective and distinction between how current policy is correlated with the participants' lived experiences. Exploring these factors concerning public policy and healthcare experiences, an illustration of perspectives, comorbidities, cause and effect of negative experiences, the correlation of policy needs and stakeholder participation, and communication, leadership, and accountability may positively impact this under-representative target group (see Babrow et al., 2000; Brown, 2000; Kumar et al., 2014).

Implementing these theories to analyze the data helped to understand the phenomenon and why there needs to be some form of policy change. It is essential to note that purposive and snowball sampling was also warranted to recruit the appropriate participants that had fit into the equation, which is discussed below.

Nature of the Study

The study design encompassed a well-constructed exploratory phenomenological framework that helped me to understand the phenomenon of implicit bias associated with stereotypes, attitudes, and perceptions toward people and how the correlation of healthcare policy affects them. Through action research, as outlined by Creswell and Plano Clark (2011), the participants in the study shared their lived experience of negative interactions during healthcare visits (see Creswell and Plano Clark, 2011). In conducting this exploratory phenomenological qualitative study, the findings from the data provided more than one perspective; the study was also completed in a committed, timely, and robust manner (see Creswell, 2014). The qualitative design helped explore the phenomenon to obtain a rich understanding of implicit bias through the lenses of the selected participants and their lived experiences. Using this design enabled me to explore the phenomenon by analyzing the participants' experience and presenting the psychological perspectives and meanings of these ascribed testimonies, which helped to recognize if current healthcare policy is working (see Merriam & Tisdell, 2016).

Specifically, using a phenomenological approach helped enable common grouping themes interpreted collectively within the findings (see Merriam & Tisdell, 2016); the commonalities sought for this study were derived from the collected survey

responses. This research encompassed a methodological phenomenological approach for vigorous research examining perceived implicit bias. To that effect, the purpose was to evaluate the impact of implicit bias in healthcare delivery and understand African Americans' lived experiences; therefore, the phenomenological methodological approach supported the action research in its totality.

Yin (1994) asserted that an exploratory approach to inquiry is designed to seek understanding of a phenomenon, specifically being valuable to a broad problem, is appropriate for providing answers to research questions; in that aspect, the exploratory approach congruently helped explain the phenomenon through the participants' lenses during my research. The homogeneous purposive (non-probability) sampling technique was used to recruit the sample units. Thus, considering the criteria to ensure saturation was valid and fulfilled helped gather representative data for the comparability results (see Creswell & Plano Clark, 2018).

Additionally, snowball sampling was applied to recruit samples from specific social media websites approved by the Walden University Institutional Review Board (IRB). Reflexivity was a consideration throughout the design of this study. In aligning the structure, the research questions, gathering and analyzing data, and adhering to ethical research standards were considered (see Lincoln & Guba, 1985; Johnson et al., 2020). Percy et al. (2015) described that inductive analysis of collected data should occur during the research process. Therefore, Percy et al.'s integral methods were used in my research to satisfy saturation, reliability, and validity in obtaining findings of this relatively under-

researched problem; consequently, the findings addressed a knowledge gap that helped to understand the phenomena further.

This study was voluntary; hence, the participants were provided the opportunity to terminate their involvement during the research process. Participants were not obligated to answer any research questions. The participant's confidential information is being kept in a secure password-protected computer that I own; this information will be stored for approximately five years upon completion of the study (also discussed in Chapter 3). Confidentiality was also a priority during this study. If the participant decided if they wanted to withdraw from the study, they were informed that there would be no repercussions, and all their information would be discarded appropriately; however, no participants withdrew from this study.

Definition of Terms

Comorbidities: This medical term is described as a person that has more than one medical condition or diseases. (Gillespie, 2021)

Disabled American Veterans (DAV): Created by the United States Congress, the DAV organization offers disabled veterans services. Its mission is to provide services to veterans of the U.S. military and their families (DAV, n.d.).

Health equity: This term provides that every person has the right to live a healthy life. While health inequities focus more on barriers for example socioeconomic status which can be challenging in obtaining health equity and prosperity (CDC, 2019a).

Implicit bias: The term implicit bias is broad in that several branches focus on negative characteristics of a group of people; for example, people can display implicit

prejudice, implicit stereotype, implicit racial bias unknowingly (FitzGerald et al., 2019). Thereby, implicit biases are described as stereotypically driven unconscious associations characteristic of a group. These biases can ultimately be perceived and lead to discrimination whether they are intentionally proven or not (FitzGerald et al., 2019).

Posttraumatic stress disorder (PTSD): PTSD is characterized by specific mental imbalances, psychiatric disorders, and symptoms because of an unfortunate traumatic event of experience. PTSD may not appear suddenly and may show signs of overtime. According to the American Psychiatric Association, this disorder can be severe and may last for a lifetime or be temporary with or without therapy (APA, 2013).

Social determinants of health: It focuses explicitly on disproportionately affecting minority groups, such as various racial and ethnic minority groups. The individuals associated with these groups are subject to conditions that negatively affect their health, like their living conditions or work environment, and pose a wide range of other health ailments such as COVID-19; these conditions are classified as social Determinants of health (CDC, 2019b).

The Health Insurance Portability and Accountability Act (HIPAA): was enacted to protect the patients' rights of policy and provide the patient the power to access their medical records (U.S. Department of Veterans Affairs, 2014).

U.S. Government Accountability Office (GAO): The GAO is a legislative sector of government that conducts research, auditing, evaluations, and investigations and is nonpartisan and works directly for congress (GAO, n.d.).

U.S. Department of Veterans Affairs (VA): Also referred to as the *Department of Veterans Affairs* and *Veterans Affairs (VA)*. The VA is an exclusive federal agency that provides access to healthcare for veterans who qualify for assistance. The VA also offers training, counselling, and educational services (VA, n.d.).

Veterans Health Administration (VHA): Also referred to as the VA, is the most extensive integrated healthcare system in the U.S., offering healthcare needs for veterans in their [1,293 health care facilities](#), also consisting of 171 VA Medical Centers and 1,112 outpatient facilities that provide healthcare services for a various number of complexities through their sites, which includes, VHA outpatient clinics, to over 9 million Veterans registered in the VA healthcare program (VA, 2013).

Assumptions

This phenomenological qualitative study was assumed to yield insight conducive to current reported literature indicating extreme healthcare inequities impacting African American U.S. citizens when attempting to obtain equitable healthcare services, and it did. I also assumed that the research design chosen for the study was appropriate and aligned with the problem, purpose, and research questions; the research designed appropriately helped to yield conclusive, meaningful results. Additionally, it was expected that there was a high probability of respondents who sought medical treatment during the COVID-19 pandemic and met the criteria of this study, and there was. There was also an assumption that the participants may not provide enough information or answer all the qualitatively designed open-ended questions; this assumption was valid as some respondents skipped some of the questions.

Additional assumptions included collecting reliable, trustworthy data from willing volunteers without coercion, bias, or ulterior motives; all participants who volunteered were willing, and there were no problems with trustworthiness. The research questions were constructed with no biased intentions. No incriminating questions that may have influenced incorrect responses from the participants were presented on the survey. Furthermore, it was assumed that no researcher biases would yield inconclusive data and negative implications as Walden University's guidelines and research protocol guided this study; this was not an issue as I followed appropriate research protocol. Lastly, it is expected that the research findings from this study will help shrink gaps, lend to scholarship, and influence social change and healthcare policy.

Scope and Delimitations

This study's scope focused on one racial/ethnic group identified as African American U.S. citizens with comorbidities who had experienced perceived implicit bias while interacting with healthcare professionals. In addition, the scope was limited to African Americans aged 30 and over from the New York City area. According to prior peer-reviewed journals and information from the CDC and the WHO, a disproportionate number of African Americans reported experiences of racial bias within the healthcare system, however, not specifically addressing the factors. A significant delimitation was the likelihood of restricted access to in-person samples due to the U.S.'s current COVID-19 pandemic climate; this was not a problem during recruitment. The sample population was exclusive in abundance and readily available through the internet. The scope of secondary or additional data could have been collected by phone or video calling, which

is aligned with the constructs of this qualitative study design and would have been sufficient for data collection and analysis as the last resort; however, these methods were not needed to collect data. All communication was conducted through an IRB-approved email, which included a link to the qualitative survey.

The versatility of qualitative methodologies benefited this research study by allowing for data collection through the internet email system rather than conducting one-on-one in-person interviews. As such, a delimitation could have been the sample population and the strategy's effectiveness but was not. Also, honest feedback is challenging in seeking truthfulness, as there is no way to substantiate a participant's lived experience (Hydock, 2017). The factors mentioned are assumptions and were considered during the research process; it was expected that the scope of delimitations would not hinder the gathering of data, nor the analysis process, and it did not.

Transferability is correlated with trustworthiness and provides a viable criterion for conducting ethical research, thus producing evidence that the research findings can successfully be applied to the specific population or issue (Lincoln & Guba, 1985). As such, in this case, the population was African Americans with comorbidities. Hence, the analysis of data and the research findings of this study supported transferability continuously. Lincoln and Guba (1985) outlined transferability, suggesting that the researcher provide thick descriptive data during the collection process for final analysis. The way I structured the research questions may have positively influenced trustworthiness and transferability in this study; however, there is no guarantee of trustworthiness in any one qualitative study (see Creswell, 2014). Additionally, providing

supportive data to improve transferability would be difficult due to the minimal number of samples used in this study (see Matthay & Glymour, 2020).

Limitations

Homogenous purposive sampling limitations were not present as sampling errors due to a possible number of participants. Verifying the participants' information for truthfulness and biases were implemented throughout the data analysis process (see Creswell, 2014); no discrepancies were discovered. Additionally, snowball sampling was also employed to ensure recruitment dependability. Because there was minimal interaction with the participants, it was expected that issues with clarity of data collected and any emerging questions that may have developed during the research process would arise; these concerns were not an issue in this study, and there were no plans for follow-up questions, because they were not needed.

Utilizing the homogeneous purposive sampling methods ensured the samples selected shared similar experiences and characteristics. However, other expected limitations were the participants' willingness to volunteer their time or complete the survey in its entirety; nonetheless, the collected data was very detailed, as many of the participants provided a plethora of information. Because this study did not offer awards of monetary payments or incentives, this was an expected limitation; however, this did not have an adverse effect on the collection of data.

Purposive sampling is also prone to researcher unconscious bias due to superfluous generalizations and assumptions during the sample selection process (Creswell & Plano Clark, 2011). Respectively, the findings were not exclusively

generalizable to other African Americans who utilized the healthcare delivery system as each lived experience may differ; this assumption would require further study.

Conversely, the snowball sampling method has minimal limitations (Creswell & Plano Clark, 2011). This method helped gather samples from social media groups without conversing with prospective participants in person. However, the limitations with snowball sampling for this study may have been the lack of access to the internet for some potential participants who may have met the criteria. On the other hand, the theoretical framework chosen helped minimize limitations to validity and credibility. Data collected was assumed to be valid and from reputable, trustworthy, credible sources as aligned with triangulation in research (see Creswell 2014a; Carter et al., 2014). By utilizing inductive analysis accordingly, possible limitations noted above did not hinder the process, outcomes of the data collection process, or the interpretation of the findings.

Since this study was conducted exclusively over the internet through an email system, there was a possibility that an email could be intercepted, causing a compromise in data and privacy. Therefore, to take precautionary measures, all email correspondences and communications took place over a secured and encrypted email system approved by Walden University. This email system did not require additional security; there were no problems communicating over the email system during this study. However, this does not ensure the participants' security from their personal email systems; all participants were informed of the risks. Additionally, the participants were informed that there would be a minimal chance of becoming emotional; some of the questions may trigger unwanted

memories, or some discomfort may arise when answering various research questions. It is essential to note; there was no feedback from the participants of any issues.

Significance

To help elevate the communicative challenges in healthcare, there is an expectation that professionalism would be considered in the communication process; therefore, to meet these challenges of tackling implicit bias, healthcare workers should evaluate the communication methods they use to correspond with their patients (see Babrow et al., 2000; Kumar et al., 2014). Increasing their knowledge of cultural differences may lead to a more conducive relationship with people seeking healthcare services. The significance of this study was validated within data collected from the participants. Retrospectively, the significance was sharing a lived experience of those who had encountered healthcare inequity. The findings revealed a significantly growing problem of bias encounters and the perceptions of bias within the healthcare delivery system. The significance of a study of this magnitude that touches on racial disparities can positively impact the healthcare system. Thus, a deeper understanding was gained from the findings of this study, which also revealed a shockingly significant amount of similarly impactful stories of not being taken seriously by healthcare workers.

Previous studies of implicit bias in healthcare regarding African Americans left gaps in research due to a significant lack of practical qualitative research studies. Therefore, this study's findings are consequential and critically vital to public policy because health equity for African Americans is flawed and impacts mortality rates (see Arnett et al., 2016; CDC, 2020a); this is an ethical dilemma. As such, this study's

findings also indicate the need for further in-depth qualitative research. Further significance during this research process was to understand the healthcare system's problematic paradigms, including healthcare policies from the patient's perspective.

Moreover, implicit bias is an emerging problematic healthcare issue that negatively impacts a specific racial group (Arnett et al., 2016). The findings of this study also validated many of the previous quantitative studies, journals, articles, and publications. Nonetheless, the rationale of this study's findings can be applied to promote the participation of the healthcare policy decision-making process and provide education on the seriousness regarding policy affecting the under-representative African American population.

Additionally, according to my research findings, in hindsight, the problem of bias in healthcare is an ethical dilemma prevalent throughout history (see Arnett et al., 2016). The findings from this study considerably illuminated and empirically uncovered further the disparities African Americans are experiencing during the COVID-19 pandemic. The implications of this study's findings can contribute to the body of knowledge in healthcare, lend to scholarship, and influence a new leadership paradigm. This study's findings also discovered a need for healthcare leadership training as leadership is critical in clinician competence (see Kirkpatrick and Locke 1991; Kumar et al., 2014; Northhouse, 2016; Sadowski et al., 2018; Weintraub and McKee, 2019).

Significance of Social Change

According to my research findings, the significance of social change is essential to healthcare communication and the way healthcare professionals view their patients.

There should be no tolerance for intentional bias or any other type of discriminatory practices within healthcare as implied by the CDC (2020a). The chances for positive change to occur resulting from this study are unquestionable. This study's findings may profoundly affect human behavior and public policy, given the magnitude of this study, even without developing theories or solutions. Thus, social change implications can influence new paradigms within healthcare options (see Roşca, 2020). Also, this study's findings may contribute to academia and scholarship, training, and further understanding of the perception of implicit bias. Moreover, the findings could influence policymaking and policy modification within the healthcare system. Social change is inevitable when healthcare equity is distributed impartially. Overall, these social change implications may positively affect healthcare equity and African Americans' quality of life.

Summary

This chapter introduced implicit bias as a negative phenomenon and a significant problem within the healthcare system, indicating the need to shrink a gap in research. Specifically, through preliminary research, the problem was identified as implicit bias -a healthcare inequality- within the U.S. healthcare system, which negatively impacts a disproportionate number of African Americans, thereby causing healthcare disparities. The purpose of this qualitative study was to investigate implicit bias specifically during the COVID-19 pandemic, examining the harmful effects of health inequity for African Americans through the lenses of the participants while determining the efficiency of healthcare policy. Consequently, this study's findings revealed the participants' lived experience indicating the need for changes within healthcare policy while further

understanding how implicit bias negatively impacts people; the findings may significantly shift these negative paradigms. Additionally, this chapter presented the research methodologies and questions regarding the phenomenon. The potential for positive social change is one of the underlying bases for this study, thereby influencing a policy change to promote health equity within healthcare for African Americans.

Chapter 2 presents the literature review section, which contains research methodologies and findings from prevalent peer-reviewed literature that align with the research questions and the problem statement of this study. Additionally, a comprehensive review of communication and leadership within the healthcare system is presented to close out Chapter 2. The literature review helped conceptualize the research methodology and questions in the study.

Chapter 2: Literature Review

Introduction

This chapter presents a critical analysis of literature related to implicit bias issues, explicitly highlighting the COVID-19 pandemic and specific factors of biases, and including a comprehensive review of leadership, communication, and healthcare policy. The problem is that implicit bias in the New York City healthcare system, which negatively impacts African Americans disproportionately, is causing health inequity. This study focused on this issue occurring during a pandemic. Due to the insufficient amount of scholarship found addressing this phenomenon, it was necessary to explore military veterans' experiences with the Veterans Administration (VA) healthcare system; this was done to gain a more diverse idea of the impact of implicit bias. It is also important to note that many military veterans use the VA healthcare system, which differs from the general population healthcare system. Including the VA system in this study broadened the scope of recruiting participants and may have strengthened the validity of the research findings, as the scope was not limited in that regard.

The purpose of this study was to evaluate the extent to which implicit bias influences the healthcare services for African American adults aged 30 and over with comorbidities living in New York City during the COVID-19 pandemic and to understand if current healthcare policy was sufficient. I designed the research questions to help explain (a) whether a significant correlation exists between implicit bias and the New York City healthcare delivery system; and (b) how communication, comorbidities,

and other medical conditions influence services, thereby exploring whether current policies are working.

The rationale for this study was to promote the improvement of decision-making and developing or reforming public healthcare policy. In this chapter, I discussed leadership as a critical component in the healthcare system. More specifically, this literature review addressed conflicting evidence and methodologies, critically evaluates, and analyzes findings, and examines strengths and weaknesses to recognize the most current research gaps. Conclusively, the literature review provides rationalization of the need for this study and justified the research questions. Thus, this chapter covers a broad perspective of methodologies and analytical outcomes from various research studies and theoretical frameworks.

To understand the correlation between healthcare social interaction of patients' negative experiences of implicit bias and healthcare policy, it is necessary to understand the history of healthcare in terms of historical usage, healthcare outcomes, and measuring tools used. According to preliminary research, understanding the methods and styles of communication and leadership used in organizations and what may be needed to ensure equitable services were explored, and are addressed in this chapter. However, the first significant piece of information presented in this chapter is the theoretical foundation of this study: The BMHS and the SCPD theories also helped me understand the effects of implicit bias in healthcare services and its relationship to healthcare policy. This chapter presents the strategy used to retrieve information, the theoretical foundation, and the literature review.

Literature Search Strategy

Critical analysis of literature and a comprehensive search of several peer-reviewed scholarly studies, articles, and journals provided a plethora of information for this systematic literature review. I accessed published scholarly journals, books, peer-reviewed articles, federal government studies, and statistical information from reputable websites for this literature review. I conducted searches related to the history of implicit bias and discrimination using key terms such as *implicit bias in healthcare*, *COVID-19*, *discrimination in healthcare*, *New York City healthcare*, *implicit bias*, *healthcare policy*, *public policy*, *discrimination*, and *African American health disparities*. The terms *African American disproportionate death rates during a pandemic*, *qualitative studies on implicit bias in healthcare*, *generic studies in healthcare*, *phenomenological studies in healthcare*, *qualitative studies on healthcare*, and *military discrimination in healthcare* were also entered into an internet search engine.

In gathering communication information, the following key terms were entered into an internet search engine: *clinician communication*, *communication theory in medical settings*, *solutions to healthcare problems*, *leadership theory*, and *medical settings*. Unfortunately, very few research studies were found that examined the New York City healthcare system regarding implicit bias during the COVID-19 pandemic. Below are some of the databases that I used to gather literature for this literature review:

- Walden University Research Database
- Google Scholar
- Science Direct

- ProQuest
- Directory of Open Access Journals (DOAJ)
- University of Southern California Libraries (USC)
- Journal of Medical Association
- Wiley Online Library
- SAGE Journals Pub
- BMC Medical Education
- American Psychological Association (APA)
- PubMed
- Department of Veterans Affairs Website Search Engine
- CDC
- WHO

Theoretical Foundation

Behavioral Model of Health Services use

Andersen's (1968) BMHS provides a strategic methodology that addresses behavior in a clinical setting. The BMHS, which is widely used as a conceptual framework, guided this study. Andersen's initial design focused on healthcare utilization; this model helped me understand inequities of use stemming from implicit bias. Tolera et al. (2020) noted that the variables that drive the model include the healthcare system in its totality and the population it services. From a theory driven pragmatic viewpoint, this model pertains to issues on a sociological spectrum, according to Andersen (1995). Therefore, BMHS was conducive to this research study. Moreover, current research

suggested that this model's constructs support possible systemic problems that hinder the clinician/patient relationship; thereby, the model helps to understand implicit bias. Li et al. (2016) posited that the structure of the behavioral model of healthcare is designed to assess patients seeking healthcare services, indicating that clinicians must provide comprehensive services.

More profoundly, Hirshfield (2016) explained that the BMHS's versatility can lead to adequate health care services. While Babitsch et al. (2012) noted using a multilevel model as a behavioral model of health care, BMHS incorporates several variables, including contextual determinants of healthcare needs of and services for the patient. These factors lent to the validity of this study's research questions and justified the overall research. Andersen and Davidson (2001, pp. 3-30) provided the following variables of the BMHS.

Predisposing Factors

These factors include demographic biological characteristics such as age and gender; social determinants like ethnicity, education level, and relationship position; mental factors such as values and health knowledge; and contextual factors such as cultural norms and political perspectives and the demographics of usage of health services.

Enabling Factors

These factors include health insurance status, disposable income, wealth, and the ability to pay for healthcare needs and services. Organizational factors like transportation, proximity to healthcare facilities, travel time, and waiting time for appointments are

enabling variables. Contextual factors are accessible health community resources and provider financial compensation methods. Organization enabling factors include various types of available healthcare facilities, clinician density, management and leadership, locations, personnel, and most importantly, health policies.

Need Factors

These factors include contextual needs like population indices regarding healthcare, characteristics, and environmental needs, which include the conditions of the communities and their environmental factors such as crime-related injury and health-related death rates. The indices of health within the population include epidemiology indicators such as individual personal disability, mortality, and morbidity.

The BMHS is practical; its dynamic structure can influence systemic reform, healthcare policy, and social change when applied to studies to understand a phenomenon (Johnson et al., 2016). Andersen's (1968) BMHS also supported this research in that the model influences social change and behavior, which is one of the primary goals of this study. Incidentally, one such study that is significant to bias utilized this model, whereas researchers successfully implemented the BMHS's components. Johnson et al. (2016) examined predictors concerning healthcare utilization by patients.

Although the researchers focused on the correlation of excessive alcohol consumption, they uncovered important factors utilizing the behavioral model to examine veterans' beliefs and stigma (Johnson et al., 2016). Through logistic regression, the researchers were able to identify significant factors (Johnson et al., 2016). Additionally, using the BMHS, Johnson, et al. (2016) found that 63% of the 126 veterans diagnosed

with a level of PTSD participated in the study that employed veterans more likely to abstain from mental health treatment within the baseline. More notably, 70% of the veteran participants were likely to abstain from utilizing mental health treatments due to the negative stigma and possible implicit bias within mental healthcare (Johnson et al., 2016).

According to the Institute of Medicine (2006), a physiological and relatively reactive exposure to internal or external cues can resemble or symbolize or resemble an aspect of the traumatic event is PTSD (Institute of Medicine, 2006). Likewise, Johnson et al. (2016) concluded that the veteran's negative perception of mental healthcare is a barrier in treatment. The study's gap outlines a lack of understanding regarding clinician-patient trust. Preconceived biased theories and uncertainties, specifically for African Americans seeking healthcare services, allude to the assumption that a defined fear causing stigma leads to the fear of racial discrimination (see Marshall et al., 2019). Other predictors of the veteran utilizing mental health facilities are the lack of social support and unemployment (Hoge et al., 2006; Johnson et al., 2016). Ironically, a similar study by Mittal et al. (2013) examined parallel factors, focusing on combat veterans seeking treatment for PTSD symptoms. These similar factors found that most military veterans are reluctant to seek care in fear of stigma-related biases (Johnson et al., 2016; Mittal et al., 2013).

Li et al., (2016) noted that the BMHS is a conditional and sequential function that addresses socioeconomic factors in healthcare; thus, predisposing factors also include access to healthcare and the patients' willingness to use the health services. The

importance of understanding Andersen's (1968) model aligns with the factors of African Americans obtaining equitable healthcare services during the COVID-19 pandemic; it addresses steps to provide fair and impartial treatment to all patients regardless of demographics or characteristics. Specifically, Andersen's model addresses ethnicity, associated with implicit bias and communication between the patient and the healthcare system (Andersen, 1995).

Social Construction Theory and Policy Design

The secondary theoretical foundation chosen for this research was Ingram and Schneider's (1993) SCPD. The theory of SCPD postulates that a reasonable ideology is that people have the right to equitable healthcare treatment. SCPD illustrates the policy process by incorporating a foundation to highlight a policy's implications that address a targeted population (Ingram & Schneider, 1993). The model was constructed to address "why some groups are advantaged more than others independently of traditional notions of political power and how policy designs can reinforce or alter such advantages" (Ingram & Schneider, 1993, p. 334). SCPD highlights characterizations of these groups by which their healthcare wellbeing is somehow modified or affected by various policies and problematic issues that may need resolution. Notably, Ingram and Schneider found that political leaders, in general, are known to do helpful things for people they perceive as good and challenging things for people they perceive as "bad" (Ingram & Schneider, 1993 p. 341). Very few qualitative studies were found that used this model.

The theoretical foundation of the SCPD was designed to modify behaviors within a healthcare setting, thereby benefitting the stakeholders identified as the targeted

population to satisfy current policy and improve healthcare patients' experience (Ingram & Schneider, 1993). According to Barbehön (2020), the model's framework embeds positivist principles aligned with research policy. Ingram and Schneider (1993) argued that critical policy phenomenon involves the social constructs of a targeted population, further adding the importance of shaping policy design that supports equity in healthcare services. The importance of a viable framework is to understand how social constructs contour policy design; the developers provide an SCPD framework to benefit the healthcare system (Ingram & Schneider, 1993).

Ingram et al. (2007) stated that policies can impact democratic systems, thus influencing involvement, including political affiliations. They further added that these affiliations can result in patient experiences relayed into embedded messages that include their positive or negative experiences forwarded to officials (Ingram et al., 2007 as cited in Pierce et al., 2014). The importance of design policy is critical to how disparities within targeted groups are shaped. Also, algorithms used in hospital by triage healthcare workers constitute a significant factor in policy guidelines and is used to evaluate and assign the criticalness of a patient's ailment (Miller, Peek & Parker, 2020); the use of algorithms is discussed further in this chapter.

Ingram and Schneider (1993) noted that social constructs ultimately influence policymaking and policy choices. Noting, "Types of Target Populations," the developers provide Table1 "Policy Design Impacts on Different Target Populations" in their 1993 literature (Ingram & Schneider, 1993 p.341). These populations are listed as *Advanced*, *Contenders*, *Dependents*, and *Deviant*s within the table and offer explanations of the

captions and the impactful variables defined under political power and social construction noted as two populations structured into the SCPD framework. (Ingram et al., 2007; Ingram & Schneider, 1993 p.341). According to Pierce, SCPD was established based on the following eight assumptions, strategically placed into three categories: *the model of the individual, power, and the political environment* (p.3). The eight assumptions are listed below:

Table 1

Assumptions of the Theory of Social Construction and Policy Design

Model of the individual
<ol style="list-style-type: none"> 1. Actors cannot process all the information relevant to make a decision, and therefore rely on mental heuristics to decide what information to retain. 2. Mental heuristics filter information in a biased manner, thereby resulting in a tendency for individuals to confirm new information that is consistent with preexisting beliefs and reject information that is not. 3. People use social constructions in a subjective manner that is evaluative. 4. Social reality is boundedly relative where individuals perceive generalizable patterns of social constructions within objective conditions.
Power
<ol style="list-style-type: none"> 5. Power is not equally distributed among individuals within a political environment.
Political environment
<ol style="list-style-type: none"> 6. Policy creates future politics that feeds forward to create new policy and politics. 7. Policies send messages to citizens that affect their orientations and participation patterns. 8. Policies are created in an environment of political uncertainty

Note. Reprinted from Social Construction and Policy Design: A Review of Past Applications. By Pierce, J. J., Siddiki, S., Jones, M. D., Schumacher, K., Pattison, A., & Peterson, H. (2014). *Policy Studies Journal*, 42(1), 1–29. Copyright 2014 by *Policy Studies Journal* Attribution for an adapted data table (Table 1, p.5)

The American College of Physicians (ACP) and its various committees ameliorate much of the problems within the healthcare system (Serchen et al., 2021). The utilization of SCPD is justified in that respect because its foundation mirrors the ideologies of the ACP. The principles outlined within the ACP directives and policy framework align with a public policy and administration perspective on promoting healthcare equity to those who identify with people who reasonably believe they have experienced bias within healthcare. About disproportionate disparities pertained to the focus of this study, the foundation of the construct of SCPD was thereby fitting by providing the construction of policy enhancement and design that address interactive social issues within the healthcare dynamic. However, the model is not without criticism citing the failure to embrace a more collective understanding of social construction's relativism (Pierce et al., 2014, as cited in Sabatier, 1999).

Nicholson-Crotty et al. (2021) successfully applied social construction to explore policy focusing on administrative cost when citizens participate and interact with the government by employing a survey experiment. The researchers noted that while administrative programs have a high negative impact, further referring to this as a burden causing adverse outcomes in policymaking (Nicholson-Crotty et al., 2021). However, further noting the public's support and the upside is the favorable increase towards some government programs by exploring the social construct of the stakeholders and the correlation of the levels of administrative burden (Nicholson-Crotty et al., 2021). Ultimately, they found that the effects of the burden regarding the approval of programs had varied, resulting from the social construction of the stakeholder, however offering an

understanding of the social construction role in correlation with burden and government aid support (Nicholson-Crotty et al., 2021).

In short, healthcare policy serves as a format in providing the changes in personal behavior, thereby adhering to the goals of the policy (Ingram & Schneider, 1993; Serchen et al., 2021). Serchen et al. (2021) argued that interacting factors like behavior and social drivers contribute to disparities within the U.S. healthcare system, thereby implying the need for healthcare policy to protect the rights of patients and healthcare workers. Thus, a policy can address concerns and render a guide to ensure health equity is being distributed justly (Serchen et al., 2021). Ultimately, Serchen et al. noted an urgent need for healthcare policy developers as diversity within communities is becoming more prevalent; there is a need to address inequity gaps in healthcare and address the issue of those who have experienced racial or ethnic discrimination (Serchen et al., 2021). Therefore, these factors further justify the use of SCPD used to address the targeted population of this study while providing a framework incorporating designed highlights of healthcare policy implications (Ingram & Schneider, 1993). The findings of this study intend to contribute to the current body of scholarship on the complexity of public policy and healthcare services.

Literature Review Related to Key Variables and Concepts

Implicit Bias History

Krishnan et al. (2020) examined the history of pandemics, discovering bias descriptors of inadequate healthcare treatment towards African Americans. The researchers noted an overwhelming disproportionate rate of deaths stemming from

several pandemics. Specifically, noting the yellow fever epidemic of 1792-1793 and how erroneous assumptions writing healthcare concluded that African Americans were somehow immune to the virus. In contrast, they cited Down's (2012) literature showing that a disproportionate 50,000 African Americans died from the smallpox epidemic from 1862-1867. Surprisingly, the researchers uncovered very little information regarding racial disparities during the 1918 influenza pandemic. However, Krishnan et al. noted the uniqueness in a disproportionate number of positive influenza cases and deaths in the African American community compared to positive cases and fatalities in the White population. Krishnan et al. also noted several rebuttals to related theories, more interestingly citing the Pickens, *God's a nigger* article (1918):

In December 1918, African American columnist William Pickens debunked the claim of a white West Virginian who claimed the "influenza germ had shown that God was partial in favor of black people." Pickens countered that for whites, "when Negroes die faster, it is often described [sic] to their inferiority," but if spared, "well, that proves they are not human-like the rest of us." These critiques highlight differences between pandemic coverage. (Pickens, 1918, as cited in Krishnan et al., 2020, para. 4).

The researchers found a history of racial disparities and inaccurate theories in treating African American patients seeking healthcare services and providing them (Krishnan et al., 2020). However, African American healthcare workers were often overworked as they serviced all races (Krishnan et al., 2020). There was very little acknowledgment of African American healthcare accomplishments during this period

(Krishnan et al., 2020). Similarly, Brooks (2020) argued that significant causes of the 1918 flu pandemic were healthcare racial disparity, further proclaiming that Jim Crow segregation laws, poverty, and discrimination had adversely impacted African American communities. Additionally, Brooks cited that the Center for Disease Control and Prevention reported an approximated number of positive cases of the 1918 flu pandemic as 675,000 (Brooks, 2020 as cited in CDC, n.d.). Medical records of African Americans and statistical data are scarce and possibly inaccurate due to the racial and socioeconomic inequalities of that time (Brooks, 2020; Krishnan et al., 2020).

The legacy of discrimination in healthcare supported critical gaps I found in current research, precisely by the failure to address whose life is more valuable to save in a pandemic. Likewise, implicit bias is a cognitive process and is also referred to as implicit social cognition (Payne & Gawronski, 2010), which is a social behavior and judgment (Ben et al., 2017). McDowell et al. (2020) offer a more sociological explanation of the implicit bias, suggesting an ingrained behavior that can impact and stigmatize profiled groups such as African Americans. Researchers have done very little to generalize a specific population, uncovering whether a person's ethical values and morals can indefinitely be manipulated to control their unconscious thoughts, leading to implicit biases (Smedley et al., 2003).

Smedley et al. (2003) argued that African Americans are the most senior non-indigenous group in the U.S. besides the White population. Erroneously thought of as substandard and non-human, the African American population has endured systemic racism throughout U.S. history (Bonnie et al., 2015). McDowell et al. (2020) suggested

education as one of the more critical factors in curbing stigmatization and eliminating healthcare disparities. It is equally important to note, Bonnie et al. (2015) incite, the act of implicit bias can be interpreted as a form of discrimination. More recent conceptualizations of racism are apparent in the concept of bias regarding an unconscious negative idea of a person because of their birth name or skin color (Rothman, 2018). This paradigm change is the effects of positive social change as incited in a thesis authored by Rothman (2018). In recent reported, the CDC (2020b), and various media outlets suggested a possible surge in implicit bias and discrimination toward racial/ethnic groups, indicating the need for transparency and further understanding as this phenomenon emerges. It is imperative to assess the potential ethical stipulations that propagate bias (Rothman, 2018).

Perceived Implicit Bias in Healthcare

Research studies revealed evidence of implicit bias against people with comorbidities, including demographics factors of gender, age, race/ethnicity, and socioeconomic factors such as education, healthcare coverage, employment status. The COVID-19 virus has shed light on disparate access to healthcare insurance which could influence healthcare visits based on unintentional implicit bias (Miller, Peek, & Parker, 2020). To this effect, implicit bias is a catalyst for discrimination, as suggested by the CDC (2020b); however, various laws were enacted to help curb the impact of bias. For example, the Affordable Care Act (ACA) of 2010 is a government resource that outlines stipulations that insurance companies must follow (Guo et al., 2017). Those with preexisting conditions and comorbidities are protected under the ACA and are expected

to be free from bias, receiving the same healthcare equity as someone without these variables (Guo et al., 2017).

The law was designed to protect Americans from possible healthcare inequities by providing affordable healthcare based on their income (Guo et al., 2017). While this seems ideal, the ACA drove up taxes and other healthcare coverage costs offered by various insurance companies (Guo et al., 2017). The benefits of the ACA provided millions of Americans with healthcare, controlled the rise of healthcare costs for those who meet the income bracket, and made it possible for those with life-threatening diseases to obtain health insurance and the deductible, copayments, prescription drugs are affordable for many people (Guo et al., 2017). Health insurance factors can play a significant part in implicit bias when it comes to seeking care (Guo et al., 2017).

Miller, Peek and Parker (2020). found that implicit bias on many occasions may be unintentional due to the algorithms system used to determine patient outcomes. Medical supply resources and fears are also factored into the likely biases (Miller, Peek & Parker, 2020). Christian (2019) provided the significance of triaging patients specifically during a pandemic like COVID-19 to assess through sorting the information, prioritization based on the facts, and allocating the available resources. The idea of biases being unintentionally perpetuated is a good argument when algorithms base an individual's healthcare needs on financial factors. However, when comorbidities are incorporated within the scope of allocating healthcare resources, healthcare professionals are forced to prioritize based on healthcare policies established to ensure patients are cared for based on the severity of their condition or life expectancy (Christian, 2019).

The uncertainty of the COVID-19 virus has derived critical questions of whose life is more valuable to save, an older adult with chronic comorbidities or a young, healthy child that contracted the COVID-19 virus, as pointed out by Miller, Peek and Parker (2020). The perception of implicit bias can be influenced by ethical decisions medical professionals are forced to make every day (see Rasool et al., 2017). Comorbidities and life expectancy are critical determinants first analyzed by triage medical professionals to determine what patients receive priority (Christian, 2019). Miller, Peek and Parker emphasized that the implications of triaging comorbidities or preexisting chronic conditions can be subjective, whereby implicit bias can be introduced. Triage patients with comorbidities or preexisting chronic conditions can deprioritize marginalized groups.

More importantly, however, Miller, Peek and Parker (2020) suggested that this process introduces uneven allocations of distribution. In contrast, comorbidities should not be considered throughout the allocation process to prevent any perceived implicit bias that may evolve (Miller, Peek & Parker, 2020). Although implicit bias is a severe matter, Salles et al. (2019) found gender bias within the healthcare system a significant problem citing those who identify as females are paid significantly less and are often mistaken for nurses. Consequently, healthcare bias is prevalent on several levels, according to research. A study conducted by Benjamins and Middleton (2019) found that perceived implicit bias plays a vital role in healthcare. Patients felt they had limited time with their doctors to discuss their healthcare concerns, ultimately feeling rushed (Benjamins &

Middleton, 2019). Salles et al. (2019) further supported the idea that implicit bias comes in many forms and can affect everyone.

Implicit Bias Testing

There is a growing awareness of the harmfulness of discrimination in the form of implicit bias (Krishnan et al., 2020). FitzGerald et al. (2019) completed a systematic review of peer-reviewed studies that focused on implicit bias and the usefulness of training and interventions. The researchers specifically sought to gather data from *PUBMED*, *ERIC*, and *PSYCHINFO* search engines and successfully found and reviewed 30 articles. Interestingly, FitzGerald et al. stated that implicit bias can lead to discrimination. The researchers also noted that implicit bias is related to other bias levels like implicit prejudice and implicit stereotypes, in which these thoughts are automatic mentally unconscious attributes (Krishnan et al., 2020). Amid these variables in implicit bias, questions arise to the effect of the validity of the methods currently being used to deter this unconscious process.

FitzGerald et al. (2019) conducted meta-analysis studies to modify implicit bias. Several interventions were developed due to several studies and were also tested for effectiveness. For example, the Implicit Association Test (IAT), which is widely used to measure individuals' bias, has uncovered validity and evidence to enable researchers to continue studying and developing training interventions on these unconscious prejudices Manchanda and Macias-Konstantopoulos (2020). In contrast, and despite evidence of the effectiveness of training sessions and interventions, it can potentially create a more complex situation, hence not being useful (Manchanda & Macias-Konstantopoulos,

2020). FitzGerald et al. tested eight different categories of intervention studies and found effective interventions were the studies that showed a significant reduction in biases. The researchers also noted that a robust conclusion was not obtainable due to the low numbers within each study they examined, citing poorly structured research methods (FitzGerald et al., 2019).

Additionally, out of the 30 studies reviewed by FitzGerald et al. (2019), many test subjects were college students studying psychology, inferring that to be the reason for the unobtainable conclusion. In short, the researchers suggested several areas that need investigation, for example, larger samples and more thorough studies on the effectiveness of interventions, explicitly examining implicit prejudices and implicit stereotypes (FitzGerald et al., 2019). As such, the researchers had examined implicit bias, hoping to uncover how and why it exists, however, only to spark further curiosity and influence additional research.

Similarly, Burgess et al. (2017) sought to discover ways to reduce implicit bias through mindfulness training, implying that healthcare workers can increase competition and decrease cognitive overload such as burnout by engaging in mindfulness practice. The researchers found the meditation training is a sustainable method to increase mindfulness in healthcare workers. The mindfulness approach promotes skills that help deter negative judgment or bias thinking (Burgess et al., 2017). Moreover, the researchers suggested the mindful approach, citing that the method promotes the development of skills and is a practical method that can circumvent thoughts of bias (Burgess et al., 2017).

Policymaking and Public Involvement

Noonan et al. (2016) conducted a review of several research literature reviews specifically examining African American health in the U.S. The researchers focused on social determinants and disproportionate health disparities to improve the health of this targeted group; They looked at several risk factors, including access to healthcare services and the social determinant of racism. Additionally, the researchers noted that African Americans come last when measuring the healthiest Americans citing that this reality is due to inequitable healthcare caused by social and racial inequality (Noonan et al., 2016).

Additionally, Noonan et al. (2016) found a critical need for participation in healthcare policy for this racial and ethnic group. Using the conceptual social-ecological (modified) model to guide the study that examined health disparities and various health-related social determinants helped evaluate the need to frame healthcare interventions and health policy (Noonan et al., 2016). Specifically examining morbidity, mortality, risk factors, social determinants, and health inequalities, the researchers determined that these were the sole factors of African American health (Noonan et al., 2016). The researchers further showed that in 2014 African Americans accounted for 13% of the U.S. population, with New York State being comprised of 3.8 million African Americans, which was the highest population in the country (Noonan et al. 2016 as cited by The United Census Bureau, 2021).

The study observed data from across the U.S and found that when it came to writing policy African Americans have not been included in political nor fiscal political

positions, thereby not participating in much of the healthcare policy decision making (Noonan et al., 2016). Much of these disparities are often overlooked, which place this racial group in an un-represented category during the construction of healthcare policy (Noonan et al., 2016). In this end, the researchers recommended urgent training for healthcare professionals and tackling social determinants may elicit more positive outcomes (Noonan et al., 2016).

Similarly, regarding healthcare policy, Fredriksson and Tritter (2016) observed a distinction between patient and the public, noting that the role of the patient is based on privacy, illness, and access-free choice, for example. In contrast, the researchers noted the public's role as the policy agent (Fredriksson and Tritter, 2016). Fredriksson and Tritter based this on rights and participation, suggesting further that the model on democratic theory is a foundation in support of public involvement in the rising demand for citizen participation in the decision-making process of healthcare policy (Fredriksson & Tritter, 2016). While this study offered further insight into healthcare policy by employing democratic theory, the study did not address how participants can engage in policymaking. Similarly, researchers found a burden regarding the approval of programs had varied, resulting from the social construction of the stakeholder, however offering an understanding of the social construction role in correlation with burden and government aid support (Carter et al., 2020; Nicholson-Crotty et al., 2021). In retrospect, Fredriksson and Tritter pointed out the need for engagement as a significant key factor indicating further research is needed.

Brown (2020) observed healthcare quality governance, exploring the effects of communication and leadership. Brown aimed to examine influencing factors by comparing the main elements. The researcher used thematic analysis to examine the correlation between communication and leadership when it came to healthcare governance and how factors influence it. Ultimately, by exploring through a qualitative lens, Brown successfully gathered data from eight public hospitals, and by using the SCPD, was able to conclude critical practical engagement factors. Brown demonstrated ways to effectively strengthen governance regarding policy and procedures of boards and those in senior management, suggesting healthcare governances are influenced by communication and leadership. Brown found that when it came to governance at the policy decision-making level, the importance of effective engagement and reflexivity regarding good communication and strong, viable leadership tends to facilitate successfully.

To further support this idea, Anderson et al. (2020) argued the need for transparency, explicitly noting a broader health strategy that addresses the COVID-19 pandemic and the possible implication to include public policy. While Carter et al. (2020) noted that the public health and economic impact of COVID-19 is critical, suggesting a systematic review of interventions, thereby mitigating public health risks. In addition, from a public policy perspective, Carter et al. further argued that a comprehensive strategy is promoting public health messages in the efforts to combat COVID-19, thus implying that the benefits for patients with disease and comorbidities are needed.

Algorithms Used as Determining Factors

Through an empirical study, Obermeyer et al. (2019) found that a majority of U.S healthcare systems medical clinicians and technicians use algorithms to determine health decisions and possible outcomes of the utilization of costs as a proxy. Obermeyer et al. discovered significant discriminatory evidence indicating racial bias within the algorithm system. Commercial algorithms that contain racial bias are used to measure risk factors through assessment and aid healthcare workers in decision-making in accordance with healthcare policy (Obermeyer et al., 2019; Miller, Peek & Parker, 2020).

Ben et al. (2017); Benjamins and Middleton (2019) incited that racism and bias are prevalent within healthcare, specifically when treating patients of a particular ethnic background. Unfortunately, African Americans are far less likely to receive the additional care needed to sustain a healthy quality of life because of the bias (Obermeyer et al., 2019). Obermeyer et al. (2019) Researchers also argued that patients other than African Americans are more likely to be awarded the money needed for additional care even though they have equivalent healthcare needs because of these biases. Consequently, racism is a common form of bias discovered within the healthcare system, as reported in a cross-sectional survey study presented by Nong et al. (2020).

Similarly, Hall et al. (2015) conducted a study that indicated providers of healthcare practice implicit bias, thereby displaying different attitudes towards the patients based on race and ethnicity. The researchers also urged the need for transparency, further understanding, and ambiguity of emerging research, however, not advocating the use of algorithms in healthcare determination (Hall et al., 2015).

Algorithms used in healthcare negatively impact critical services and frequently suggest that African Americans are less sickly than White patients with the same level of illness (Hall et al., 2015). Racial bias in algorithms to measure and determine patients who should receive additional healthcare treatment is a fatally flawed system that needs reformulating, as implied by Obermeyer et al. (2019) and Miller, Peek and Parker (2020).

Additionally, Miller, Peek and Parker (2020) pointed out a significant factor in using algorithms that show how healthcare resources are allocated through the severity of chronic comorbidities emphasizing a disproportionate burden of chronic diseases that various cultures face. More specifically, African Americans, Native Americans, Hispanics, and other minority groups are diagnosed with, for example, diabetes, heart disease, and high blood pressure. These groups can systematically be deprioritized using allocating algorithm scoring (Miller, Peek & Parker, 2020). Christian (2019) argued that a critical point of divergence is allocating resources and prioritizing patient care through triage. Furthermore, the algorithm system lessens the opportunity to receive equitable healthcare and priority for these racial/ethnic groups, placing African Americans at the highest risk (Miller, Peek & Parker, 2020).

Interestingly, Anderson et al. (2020) supported this idea arguing that the implications of treatment algorithms, specifically during the COVID-19 pandemic, will cause health disparities like cancer to deteriorate further. Consequently, the use of algorithms helps to determine the fate of the patient's healthcare needs necessitating future health disparities needing additional complex healthcare treatments (Anderson et al., 2020). To that effect, Miller, Peek and Parker (2020) suggested rationalizing the

triage system to prioritize patients with chronic comorbidities and acute diseases, incorporate these ailments into the triage system instead of the algorithms system, which determines the patient's fate lowering the life expectancy of marginalized people who need healthcare services.

The CDC (2020b) reported on racial and ethnic disparities in healthcare, citing various underlying medical and nonmedical related risk-markers like patients' socioeconomic status. Specifically, African Americans are at high risk compared to other racial and ethnic groups needing healthcare services (CDC, 2020b). Essentially, the CDC (2020c) found that comorbid conditions played a role in many deaths. The CDC (2020c) used an algorithm system to track and estimate deaths from COVID-19. Furthermore, the CDC (2021c) noted that African Americans are 2.8x more likely to die due to complications of COVID-19. Likewise, it is crucial to reiterate that many health-related disparities are relative to the impact of a pandemic on ethnic minorities (CDC, 2021b). Relatively few research studies were found examining the effects and implications of implicit bias during a pandemic; however, there is sufficient research-based evidence that implicit bias exists within healthcare and the need for re-evaluating public policy continuously.

Implicit Bias in Hospitals

It is important to reiterate that very few qualitative studies addressed unconscious racially motivated implicit bias in correlation to health disparities during a pandemic. For clarity, it is essential to explore past studies on hospital admissions; therefore, it was necessary to provide more senior information for comparison. Placzek and Madoff

conducted research that examined racial discrimination during the H1N1 pandemic of 2009. Prior patients admitted into various acute care hospitals within Massachusetts, meeting research criteria, were included in the study (Placzek & Madoff, 2009). The researchers focused on patients' socioeconomic status and racial and ethnic groups for influenza-related healthcare outcomes (Placzek & Madoff, 2009). The researchers also used logistic regression models specifically for intensive care patients to identify predictors.

Placzek and Madoff (2009) found 526 (11%) patients admitted to the intensive care unit's ICU out of 4874 H1N1-related hospitalizations from April 26 through September 30, 2009, were admitted based on risk factors. Further outcomes found that patients who identified as White had a higher probability risk factor regarding Intensive Care Unit (ICU) status for the 2009 H1N1 virus than Hispanics (Placzek & Madoff, 2009). The study concluded that 13% of ICU admitted patients in the lowest SES group were White, followed by 43% Blacks and 63% Hispanics (Placzek & Madoff, 2009). The researchers determined that those who met the criteria of less affluent socioeconomic groups (SES) had lower risk factors for admission to the ICU (Placzek & Madoff, 2009).

As this study provided insight into how ICU patients are chosen, it left a gap in research. However, the researchers suggested further studies to address the health-related social determinants of racial/ethnic groups to minimize pandemic-related disparities (Placzek & Madoff, 2009). Exploring how the ICU admittance system impacts patients who do not qualify for an ICU bed would possibly shrink the gap in their research and

show if the risk factor determination policies play a role in the outcomes of patients not being selected into ICU.

Impact During the COVID-19 Pandemic

COVID-19 was declared a pandemic by the WHO in 2020. January 2021, the WHO reported that the COVID-19 pandemic -also referred to as the SARS-CoV-2 virus- had killed over 400,000 people within the U.S. (WHO, 2021). In contrast, to the estimated 22,965,957 cases and an estimated 383,351 deaths within the first year in the U.S. (CDC, 2021a), these numbers also reflect people with comorbidities, healthy children, and adults (CDC, 2021b). Additionally, The WHO estimated 61,978,983 had tested positive within 2020, resulting in an estimated 1,459,033 deaths worldwide (WHO, 2021). As of June 13, 2021, there were approximately 175,306,598 confirmed cases and 3,792,777 deaths globally from COVID-19 (WHO, 2021). These high rates are not going unnoticed by researchers; for example, Elias and Paradies (2021) argued, “disparate mortality depicts underlying health inequities that disproportionately impact upon African Americans” (para. 13). In hindsight, given that the U.S. rates and studies indicated significant problems, a disproportionate number of people afflicted with disparities within the overrepresented group were contracting COVID-19 in clusters (CDC 2021c). In hindsight, African Americans were overrepresented when it came to being inflicted with COVID-19; however, they were underrepresented in health equity (see CDC 2020a; CDC, 2021). To that regard, implicit bias exists within the healthcare system, explicitly impacting African Americans (FitzGerald et al., 2019).

COVID-19 is an emerging threat (CDC, 2020b; WHO, 2020a). Krishan et al. (2020) found that COVID-19 has taken a disproportionate toll on minority communities and has magnified atrocities and disparities, specifically on those seeking care. The researchers analyzed the 1918 influenza virus that struck many victims -without bias- to understand better past and present pandemics (Krishan et al., 2020). The researchers uncovered a significant gap in research, signaling a demand for further investigation, and implied that it is rare for researchers to include race when reporting on past pandemics and epidemics (Krishan et al., 2020). Krishan et al. also discovered that the U.S. has a significantly long history of racial, ethnic, socioeconomic, and sociopolitical disparities. Current events of COVID-19 further illuminate racial biases, noting that in 1918 one million deaths occurred due to the influenza pandemic (Krishan et al., 2020). As stated, the U.S. has a significantly long history of racial bias towards African Americans and history of socioeconomic disparities (Arnett et al., 2016; Bonnie et al., 2015; Brooks, 2020; Krishan et al., 2020). Additionally, Krishan et al. (2020) and Pepin and Weber (2019) implied that racial bias is structural racism.

Likewise, 50,000 African Americans in 1862-1867 reportedly perished from Smallpox (Krishan et al., 2020). In 1792-1793 the yellow fever epidemic caused confusion resulting in deaths due to conflicting medical information reporting that African Americans were possibly immune to the disease (Krishan et al., 2020). The broader context of a study of this magnitude is the contemporaneous constructs of healthcare equity, highlighting implicit bias. Similarly, Mulchan et al. (2021) found that due to the recent influx of healthcare usage for COVID-19 treatment, there has been a

strain on healthcare resources and letting facilities staffed, which may induce implicit provider bias.

Kim et al. (2020) contended that minorities are less likely to obtain a referral for specialty care, possibly resulting from a primary care doctor's unavailability. Similarly, Mulchan et al. (2021) conducted a study that examined how implicit bias in pediatric healthcare facilities is handled. The researcher that there are problems with stereotypes and preconceived notions about African Americans could hinder equitable medical care and exacerbate disparities (Mulchan et al., 2021). They concluded by reporting that healthcare staff is encouraged to self-assess, recognize any implicit bias in themselves and construct, develop and promote strategies identified to reduce the impact of health equity through implicit bias (Mulchan et al., 2021). Although this study specifically focused on pediatric facilities, it showed how healthcare leadership handled implicit bias.

Louis-Jean et al. (2020) proclaimed that the COVID-19 virus originated in Wuhan, China, before spreading worldwide. The researchers found that pre-existing health ailments had contributed to the extreme disparities resulting from the COVID-19 pandemic (Louis-Jean et al., 2020). Additionally, the researchers reported that African Americans are 44% more likely to die from a stroke, 23% to suffer from obesity, 20% likely to suffer from asthma, 72% like to develop diabetes or be born with it, and 25% more likely to develop heart disease compared to people who identify as White (Louis-Jean et al., 2020). Among the reported cases of COVID-19 African Americans are overrepresented in positive cases and mortality rates (Louis-Jean et al., 2020; Maness et al., 2020; Martinez et al., 2020). Maness et al. (2020) suggested that systematic racism

(discriminatory racial motives and bias practices) influences and encourages social determinants of health. As such, technological advancements present themselves as positive strides contributing to medical improvement that ultimately saves lives, there remains an underpinning detriment of implicit bias (Pepin et al., 2019). More specifically, there is much evidence of implicit racial bias in the healthcare field that disproportionately impacts the African American community (Mulchan et al., 2021).

As discussed in Chapter 1 of my study, according to the U.S. Census Bureau, in 2020, African Americans (non-Hispanic) made up 13.4% of the U.S. population; however, this population comprised 23% of COVID-19 Deaths. In that regard and for this study, New York City's African American community is comprised of 24% of the city's population (U.S. Census Bureau 2020). More surprisingly, roughly 28% of these rates approximated 2,472 disclosed deaths were among African Americans, which amounts to nearly 24% of the city's population (NYC Health Department, 2020). These figures indicate a disproportionately distinguishable high impact compared to the White population, which totals roughly 32% of the city's residents but 27% of its COVID-19 fatalities (NYC Health Department, 2020). These statistics identify a critical gap and adds to the validity of my study.

Military Veterans and Implicit Bias

Tanielian et al. (2008), through a qualitative randomized controlled trial, found the U.S. military has one of the largest healthcare systems, comprising 360 clinics to service 9.6 million beneficiaries and 56 medical facilities. Later, Tanielian et al. (2016) found several barriers that suggested possible bias was one of the barriers and reasons

why veterans are reluctant to seek mental health services. Although this is an extensive healthcare system, no recent studies were found that specifically examined the veteran community during the more recent pandemic; however, there were studies found that demonstrated possible biases within the VA healthcare system.

For example, in 2012, Burk and Espinoza suggested a problem with systemic bias and racism within the military; to what extent is unknown (Burk and Espinoza, 2012). However, Spont et al. (2017) determined that ethnicity and race play a significant role in ongoing mental health and follow-through treatment. The study highlighted veterans with PTSD within a clinical setting at a VA treatment facility (Spont et al., 2017). The study's objective was to identify the causes of retention for pharmacotherapy and an individual of military veterans receiving treatment (Spont et al., 2017).

More specifically, Spont et al. (2017) set out to determine how race and ethnicity were factors in retention and in what way patients viewed and rated their mental health clinicians. The researchers recruited veteran participants of White, Latino, and African American nationalities (Spont et al., 2017). By using the logistic regression technique, the researchers, through the study, determined that treatment beliefs and mental health provider ratings were factors for treatment retention (Spont et al., 2017). The veterans of African American origin who sought treatment for PTSD had a higher rate of not retaining therapy if the provider's therapy was ineffective compared to Latino and White veterans (Spont et al., 2017).

Similarly, Foyne et al. (2015) conducted multiple linear regression to measure racial and sex discrimination differences. Very little research examined discrimination

within the military (Foynes et al., 2015; Kehle-Forbes et al., 2017). Over a decade, Foynes et al. (2015) examined 471 military Marines recruits from the boot camp baseline (Foynes et al., 2015). The sample comprised 12.7% of ethnic men, 34% of white men, 15.1% of ethnic women, and 37.6% of White women (Foynes et al., 2015). The results found that racial discrimination had impacted a large majority of the participants, resulting in self-esteem issues and physical health problems years later (Foynes et al., 2015). In contrast, the results of sex bias discrimination found that sex discrimination was not a significant factor in regressions (Foynes et al., 2015). The researchers concluded that racial discrimination was more prevalent than sex discrimination in the military (Foynes et al., 2015). Although this study provides vital information, it was limited to measuring the number of cases rather than exploring why the participants perceived discriminatory encounters, which left a gap in their research. This study is essential because it showed that discrimination could dwell in even the strictest environments.

Stepanikova and Oates (2017) conducted a quantitative study to measure racial discrimination in healthcare. Through multiple regression analysis, the researchers found that Asians, Native Americans, Black, and Hispanic people experienced perceived discrimination in the healthcare system than those identified as White (Stepanikova & Oates, 2017). While the perception of discrimination was identified in the study results, only Native Americans and Black people were more likely to report incidents (Stepanikova & Oates, 2017). Ultimately, the researchers found that perceptions of ethnic/cultural/racial privilege compared to Whites were likely uncommon if the patient identified as Native American or a Black person (Stepanikova & Oates, 2017).

Stepanikova and Oates did not emphasize or give examples of why other cultures reported experiencing perceived discrimination incidents. The information presented by the researchers is vital; however, the research did not specifically explain the lived experience of the participants in the study, which leaves a gap indicating further research through qualitative methods.

The DSM-5 outlines risk factors associated with PTSD, highlighting that the person experiencing signs or symptoms of PTSD does not have to be present when or where the traumatic experience occurred. Therefore, a clinician must refrain from discriminatory practices and bias assumptions, concluding that it could not have impacted them in any way if the patient were not there (Cunningham et al., 2018). Even more so, as Miller, Monahan, Phillips et al. (2020) pointed out, a veteran may not show signs of distress is not a sign of the absence of it or any suicidal ideation. Keeping in mind, the DSM-5 noted that an individual does not have to be directly associated or even witness the traumatic event with their own eyes to be diagnosed with PTSD, contrary to previous editions. Knowing healthcare policy is critical and may inherently help curb implicit bias or stigma that may hinder proper treatment (Krishnan et al., 2020). Whereby, the relevance is justifiably clear, indicating further research is needed to investigate further ultimately these factors provide validity for further examining implicit racial bias in healthcare.

Military Disability Rates and Implicit Bias

Wong et al. (2019) reported that the U.S. military healthcare system is an equal-access system that provides qualified healthcare to military veterans. Amara (2017)

argued that due to recent changes in operations and policy, the VHA's responsibilities had increased, posing significant challenges. Thus, being awarded disability compensation from the VA is a vigorous process, according to the most recent information on the VA website (VA, n.d.). Additionally, the VA website stated that the first step in receiving a service-connected disability rating is applying for services by submitting a claim form (VA, n.d.). Disability ratings range from 0% up to 100%; the percentage derived from the medical examination determines the monetary compensation and disability services the veteran will qualify for (VA, n.d.). The burden of proof of physical and mental injury often must be written in the veterans' medical service record, thus creating a platform for implicit bias as implied by (Amara, 2017). However, no studies were found where ethnicity or race was a factor in the VA disability determination process, or the amounts awarded based on ethnicity and race.

However, applying for mental health disability treatment and compensation is slightly different from filing award determination for physical injuries (VHA n.d.). There is often no emotional tracking related to medical data if the veteran has never visited or received treatment while serving in the military (Armenta et al., 2018). For instance, sexual assault victims often do not visit a military medical facility due to fear of bias or stigma (Parnell et al., 2018); therefore, the assault is not documented in the medical records (VA, n.d.). Proving mental trauma to receive a disability rating can be challenging (Armenta et al., 2018). If there is no record of service connection, clinicians most times will not award a disability rating if there is no hard evidence (see VA n.d.).

However, stigma and implicit bias can cause an improper medical diagnosis that could lead to being denied a disability service-connection rating (Pappas, 2020). Therefore, the VA has an appeal process, but it does not guarantee that the disability judgement will change (VA n.d.). Boss et al. (2019) observed recent studies conducted by various research agencies, which found that a significant number of veterans had been drastically impacted by a traumatic experience while serving in the military. Research has demonstrated the existence of implicit bias during the COVID-19 pandemic. However, no studies examined the possible effects of this more recent pandemic on VA disability compensation awards.

Hausmann et al. (2020) conducted a study that found differential treatment within the VA healthcare facilities, specifically communicating with African Americans. The researchers found that African Americans were less likely to encounter a respectful, friendly tone of voice from a VA clinician than any other race or ethnicity. Profoundly, Hausmann et al. (2020) discovered that many African Americans perceived that VA healthcare workers engaged in negative stereotypical assumptions when communicating with them, often implying that African Americans exaggerate and fake physical and mental conditions. Additionally, the study revealed that the participants felt belittled and that their health concerns were not appropriately addressed (Hausmann et al., 2020).

Cuevas et al. (2016) similarly found that African American patients felt a sense of perceived discrimination from clinicians when respect were poorly conveyed, and health concerns were discredited. These implicit biases can cause mistrust, often leaving the patient to feel discriminated against, leading to stigma (Cuevas et al., 2016). When

applying for disability with the VA, African Americans are subject to screenings and interviews by the clinic before determining and awarding benefits to the veteran with the disability rating (VA, n.d.). However, as alluded by Cuevas et al. (2016) and Hausmann et al. (2020), communication factors, implicit biases, and perceived discrimination can interfere with a healthcare visit.

Black et al. (2018) conducted a study to measure how military veterans suffering from PTSD symptoms view the disability rating system and their treatment. The researchers examined the medical records of 307 veterans (Black et al., 2018). The study looked at veterans attempting to receive disability compensation and continuing treatment after the disability award compared to veterans who were active in treatment before receiving a disability rating. Additionally, the researchers stated a concern from VA clinicians that veterans currently receiving mental health treatment while applying for disability compensation may exacerbate symptoms and impact the applicant (Black et al., 2018).

Black et al. (2018) constructed a measurement scale that all participants completed. The results revealed that the participants believed they had a better chance of a disability rating if they received treatment before being awarded compensation. Mittal et al. (2013) concluded that healthcare veterans' negative perceptions are barriers to treatment. As such, while very few qualitative studies focused on implicit bias in the U.S. -civilian population- healthcare system, there were noticeable and parallel similarities with the VA healthcare system (Kehle-Forbes et al., 2017). In the end, although useful

and informative, very few examined implicit bias in the VA healthcare system qualitatively.

Workplace Burnout a Factor in Healthcare

Burgess et al. (2017) found that case workload can be a challenge and play a significant factor in workplace burnout. Specifically, dealing with interpersonal interactions such as veteran mental health patients or dedicating an unscrupulous number of hours handling people can lead to workplace burnout (Kok et al., 2016). A quantitative study of 488 clinicians from mental health services was surveyed to determine work-related job satisfaction and burnout (Kok et al., 2016). The researchers implied that burnout results from occupational wear and tear, affecting job quality performance (Kok et al., 2016). As a result of job burnout, mental health professionals' physical and psychological health can diminish over time, causing emotional exhaustion (Kok et al., 2016; Lipschitz et al., 2017). If not addressed and left untreated, the consequences can be detrimental (Kok et al., 2016). The researchers explain that alcohol consumption, depression, and other mental health ailments can arise due to burnout (Kok et al., 2016).

The research study was administered and completed at the Walter Reed Army Institute of Research (WRAIR) upon the Institutional Review Board's (IRB) approval (Kok et al., 2016); the research is entitled "Behavioral Health and Treatment Study" (Kok et al., 2016). Kok et al. (2016) recruited a host of mental health professionals working for the military Department of Defense (DoD). The study participants completed a series of statements on a 5-point ordinal scale to assess burnout by measurement (Kok et al., 2016). Besides measuring the number of working hours and caseload, the participants

were asked to rate confidence in treating mental health patients with various classifications, such as PTSD and TBI (Kok et al., 2016). To analyze the data collected, contingency tables to evaluate or compare the participants' characteristics who reported burnout feelings were used (Kok et al., 2016).

The researchers determined that approximately 21% (weighted) of the participants confirmed elevated burnouts using logistic regression. Additionally, 67% of respondents had reported a high job satisfaction level, 10% reported low levels of job satisfaction. In comparison, 25% of the burnout category respondents reported low job satisfaction levels. All in all, the researcher determined that self-reporting burnout is prevalent. Kok et al. (2016) produced findings that suggested healthcare professionals educated on workplace burnout encourage self-reporting and be aware of interventions to provide training. This study's results suggested a correlation between clinician burnout and possible implicit bias causes (Kok et al., 2016). The significance of this study correlates with my research because it showered a possible cause for communicative challenges.

Civil Rights Laws and Implicit Bias

Pepin and Weber (2019) argued that civil rights laws on the state level effectively help curb the discrimination within healthcare; however, these laws cannot solve racial disparities but contribute to achieving health equity (Pepin & Weber, 2019). As such, these laws contemporaneously and historically played a significant role in one's civil rights to acquiring or partaking in services provided within the healthcare system (Pepin & Weber, 2019). Additionally, civil rights on the federal level provide the minimum standard for states to create their laws to equally serve as protection against discrimination in any

form (Pepin & Weber, 2019). Although implicit bias was not mentioned in Pepin and Weber's (2019) literature, they noted the importance of combatting all types of discrimination contributing to healthcare disparities. Further noting, the laws in place are often underenforced (Pepin & Weber, 2019).

However, the healthcare system must adhere to anti-discrimination laws to mitigate these deficiencies (Pepin & Weber, 2019). Implicit biases can manifest racial disparities, generally impacting the patient's quality of care, sometimes resulting in death (Pepin & Weber, 2019). Most prominently, the unfortunate fact remains; there is a significant gap in research addressing implicit bias -specifically concerning people with comorbidities- in healthcare, impacting African Americans' quality of care and quality of life.

Implications of Implicit Bias

The implications of implicit bias in healthcare can be damaging, as Galaviz et al. (2020) implied. However, according to current research studies, the prospects of social change within healthcare are promising as various awareness strides are currently increasing (see Pepin & Weber, 2019). As such, Wyatt (2013) found that African Americans were less likely to receive adequate healthcare equity than White Americans when receiving pain treatment, thus denying the fundamental human right to adequate care. Within the U.S., specifically during a pandemic, this lack of healthcare equity can be viewed as multifactorial; consequently, implicit bias understanding entails being cognizant of its dimensions (Ben et al., 2017). Additionally, awareness of how body

language is perceived, how thoughts are interpreted, how words are relayed helps diminish or control unconscious bias actions (Galaviz et al., 2020).

Smedley et al. (2003) contended that socioeconomic status correlates with racial disparities that reflect adequate healthcare access and further argued this as a significant detrimental predictor in access to quality care. Additionally, Galaviz et al. (2020) conducted a recent study discovering that the African American community was overrepresented in COVID-19 positive cases, noting that the racial group disproportionately had a significant number of deaths resulting from the virus. The researchers also noted that the current pandemic would worsen as cases will likely increase (Galaviz et al., 2020). Equitable efforts are needed to increase awareness of disparities hindering the healthcare system, causing deaths resulting from COVID-19 (Cunningham & Wigfall, 2020). Galaviz et al. (2020) also recommended implementing further research, preventative bias interventions concerning racial disparities, and testing these interventions for validity and effectiveness.

Similarly, Yancy (2020) emphasized that the COVID-19 virus is comparable to the 1918 Spanish Flu epidemic. Further stating the risk factors, for example, comorbidities, diabetes, cardiovascular diseases, and obesity, play a significant role in outcomes of the COVID-19 virus (Yancy, 2020). Individuals associated with phenotype risk factors, and those inflicted with comorbidities, were advised, and encouraged to assiduously take measures in preventing the spread of the virus (Yancy, 2020); adhering to safety measures will flatten the curve (Yancy, 2020). Yancy pointed out that egregious healthcare disparities are evident; for example, in Chicago, the infection rates include

70% African Americans' deaths while this group comprises only 30% of its citizens. Additionally, in Louisiana, where African Americans comprise 32.2% of the state's population, 70.5% of African Americans who were infected died from the virus's complications (Pratt, 2020; Yancy, 2020). Yancy also argued that the most effective method of flattening the curve is social distancing.

While these numbers show racial disparities specifically within a pandemic, the CDC (2020b) implied that although numbers were significantly high during the COVID-19 outbreak, there are racial disparities overall. Furthermore, Kim (2020) found additional evidence supporting the disproportionate disparities of health equity within the African American community during the COVID-19 pandemic, noting racial discrimination as one of the causes. In retrospect, while this is evidence of healthcare service workers and technicians possibly displaying implicit bias, the importance of health literacy is increasingly critical. Equitable justice in healthcare relies on a standard of non-bias care as the caveat; therefore, implicit bias is not acceptable (Binkley & Kemp, 2020). Neither consciousness exemption should cause ill will or harm to a patient (Binkley & Kemp, 2020).

Paakkari and Okan (2020) explained the importance of understanding health literacy, particularly during the COVID-19 pandemic. Further, Paakkari and Okan described the pandemic as an acute respiratory syndrome coronavirus 2 (SARS-Co-2) and provided measures to refrain from contracting the virus. Additionally, health communication education and understanding research for specific measures may help flatten the curve while benefiting health literacy (Paakkari & Okan 2020). The

emergency of the COVID-19 virus happened rapidly with minimal warning and impacted society, leaving a devastating reality of the need for health literacy, as implied by (Paakkari & Okan 2020)

Furthermore, implications of understanding communicable and noncommunicable diseases may positively or negatively impact society (see Paakkari & Okan, 2020). Explicitly, most people behave responsibly with solidarity, creating an environment that inherently decreases the risk of contracting COVID-19 Paakkari & Okan (2020). The underestimated issues stemming from a detrimental lack of health literacy by the public can contribute to the adverse effects of implicit bias towards those merely unaware of the positive aspects of following state and federal guidelines.

The CDC (2020a) asserted that people are afforded an equal opportunity to be healthy through the right to health equity. Health equity and equality mean that everyone should have equal access to healthcare programs, resources, and information such as policies and support, reducing health disparities (CDC, 2020a). Additionally, the CDC (2019a) provided a list that explained various social determinants that affect racial and ethnic groups. One of the determinants in healthcare describes a composition of disproportionate access to quality healthcare, which, in short, increases the risk of contracting COVID-19 (CDC, 2020a). Although this is vital information provided by the CDC, the last report found confronting discrimination based on race and ethnicity was in 2012.

However, Cordes and Castro (2020) identified a high-risk area for COVID-19. These areas were noted as COVID-19 cluster areas where people contracted the virus as

it spread through the community (Cordes & Castro, 2020). The researchers were able to analyze the positive rates of the infected. They concluded that clusters in high-income-educated, White areas had low testing favorable rates than clusters with a high positive rate, which included communities of disproportionately African Americans -including Hispanic ethnicity- populations, citing the lack of healthcare insurance (Cordes and Castro 2020). Correlations were apparent in which the rates showed an inverse association between the two races/ethnicities (Cordes & Castro, 2020). The CDC (2021b) mirrors these findings within their daily rate tracker, indicating that African Americans are 2.8x more likely to die due to the recent pandemic complications. As some studies reviewed within this chapter demonstrated that the healthcare industry is making strides to deter and combat biased encounters, further research must continue.

The Gap in Implicit Bias Research

Much of the current literature I reviewed in this chapter indicated that bias is a multifactorial hinderance in healthcare. A significant gap in research indicated additional qualitative studies are needed to explore how African Americans with comorbidities who seek healthcare perceive implicit bias encounters when interacting with healthcare workers, how they feel about their lived experiences, and how it affects them. Inequality in healthcare delivery and policymaking within the U.S. healthcare system, specifically during pandemics, has not been thoroughly addressed (see Kim, 2020). According to preliminary research, there is an actual disconnection between some patients and healthcare workers. There is a possibility that the findings from my research can influence federal health policy and incite a new paradigm of healthcare public policy.

Addressing this gap may provide understanding as well as awareness of the problem. Profoundly, due to the broad nature of racial discrimination, for this study, the focus was based on a lived experience of participants who identified as African American U.S. citizens and met the study's inclusion criteria during the COVID-19 pandemic. To reiterate, there were very few studies found that explored implicit bias within healthcare qualitatively.

Although there were recent quantitative studies that measured racial disparities like, for example, disproportionate mortality rates of positive COVID-19 cases in the African American compared to a predominantly White community. Conversely, several peer-reviewed journals discussed health equity, which aligns with leadership and healthcare communication. For this reason, the following section provides an in-depth review of various leadership and communication styles used in healthcare and business; it is essential to reiterate that the purpose of this study was to evaluate and understand, not develop a training tool that addresses the problem. While studies -not reviewed in this research- uncovered significant problems with implicit bias, the gaps were apparent in that racial demographics were primarily excluded from many of those studies.

Clinical Paradigm Theory in Leadership and Communication

Kersemaekers et al. (2020) suggested that when medical specialists experience burnout from stress, their leadership skills may negatively impact their patients and hinder their quality of life (Kersemaekers et al., 2020). The researchers conducted a non-randomized mixed methods study consisting of 52 medical specialists that focused on occupational burnout and leadership factors. Kersemaekers et al. set out to test a

leadership course's effectiveness focusing on occupational burnout and leadership. Self-reporting questionnaires that included various work-related, personal, and social questions related to burnout were used to gather data for analysis (Kersemaekers et al., 2020). The participants were recruited from various hospitals through a purposive sampling approach. The researchers provided online surveys for the participants to complete during the study's quantitative phase (Kersemaekers et al., 2020).

The researchers reported that 25 participants attended a structured leadership course that was part of the study that lasted eight weeks; of the 25 participants who completed the course, 17 went on to participate in the qualitative phase of the study, in which they were interviewed about the course (Kersemaekers et al., 2020). Using the SPSS measurement tool, the researchers were able to establish outcomes. The control period's findings concluded with a course completion of 92% of the 52 participants and the intervention period revealed that time was a significant barrier for the participants (Kersemaekers et al., 2020). Overall, the researchers concluded that the leadership course was a valuable tool for reducing occupational burnout and enhancing leadership skills (Kersemaekers et al., 2020). This study plays a significant role in the patient-clinician relationship and how communication and leadership are essential (Kersemaekers et al., 2020). Highlighting a substantial gap, researchers do not address how poor leadership and occupational burnout affect patients. However, these findings can be recognized as an asset for public health policymakers in the end.

Communicative phenomena such as implicit biases are problematic hindrances and can be perceived or developed into discrimination encounters (FitzGerald et al.,

2019). Babrow's (1992) problematic integration theory (PI) is most appropriate for understanding communication regarding the complex variables of implicit bias.

According to research, African Americans face a multitude of uncertainties when deciding to seek healthcare during a pandemic as they may be perceived as ambivalent, tense, anxious, or confused (see McKay et al., 2012). Babrow et al. (2000) posit that people in uncertain situations should process their fears. As such, McKay et al. (2012) argued that inadequate medical treatment due to several factors such as access to healthcare and inconsistent treatment could trigger patient uncertainties.

PI is an asset for communicating effectively (Babrow et al., 1998). The model can cast light on challenges in the communication exchange, thereby creating a more effective strategy to create and analyze public policy (Babrow et al., 1998). For complex studies, integrating approaches that address communication when complex variables like constructing healthcare policy are presented would favorably benefit that body of work (Mayer & Sparrowe, 2013). Granerud's (2008) doctoral thesis explored health issues within communities utilizing the theoretical foundation of *Social Integration Theory* (SI). Although this model slightly differs from PI, the concept aligns with identifying factors associated with mental health and highlighting predictors. Granerud argued that social competence is a disabling factor of health within a community setting and insight that there is a need for the mental health professionals to focus on encouraging patients to embody a feeling of belonging efforts to obtain social integration. The literature by Granerud focused explicitly on the specific problems regarding communication and

leadership. In contrast, SI focuses on a broader scope, as Bhise et al. (2018) also point out in their 2018 study.

In contrast, Ford et al. (1996) utilized the PI model to analyze management and social support networks' uncertainty. However, both these theoretical models can play a vital role in understanding the communication process and assist in constructing healthcare policy that can effectively tackle the issues and disparities. Moreso, especially for underrepresented groups, as implied by Ford et al. The researchers determined that the PI model's social support element was helpful in the study through a log-linear analysis in that it provided positive results. Bhise et al. (2018) noted that measuring diagnostic uncertainty focuses on the clinician and the patient's encounter, outlined within the PI contextual framework. Tai-Seale et al. (2012) argued that, while some people view uncertainty in a negative reflective physiological state, others see it as a natural cognitive function.

Babrow et al. (2000) argued that clinicians should be careful with their rhetoric when communicating with their patients. For example, there may be preconceived notions, biased ideas, and uncertainty when interviewing a veteran for determination or continued services (McKay et al., 2012). Babrow et al. found that PI is functional in physiological brain functions that evaluate the unknown uncertainties that can cause anxiety; however, stress levels are alleviated by effective communication (Babrow et al., 2000). Babrow et al. (2000) and Bhise et al. (2018) also argued that clinicians should help manage patients' uncertainties. Similarly, Newson et al. (2016) implied that uncertainty is a systemic hindrance to avoid within a clinical setting. While PI is a relatively dynamic

framework, not enough research has been conducted on its usefulness for solving possible communication issues and uncertainty in healthcare delivery; thereby, it is difficult to note its weaknesses. However, Mayer and Sparrowe (2013) infer that the PI model is significantly beneficial when addressing the communicative concerns within an organization, specifically when constructing or reviewing healthcare policy.

Psychodynamic Approach to Leadership in Healthcare

Kirkpatrick and Locke (1991) insisted that influential leaders must desire to lead, exemplify drive, and be ambitious in the leadership role. The psychodynamic approach framework begins with a clinical paradigm, explaining the force behind human behavior (Northhouse, 2016). In contrast, it acts as a lens providing insight for an organization when conducting behavioral studies. However, this model is not necessarily concerned with studying one's skills, traits, or behaviors as it focuses more on the leader/follower relationship (Northhouse, 2016). Thereby, the paradigm provides a useful construct in the emergence of how organizations and leaders function (Northhouse, 2016; Kets de Vries & Miller, 1984). This perspective mainly sheds light on the human mind and the motives that drive behavior (Northhouse, 2016). Northhouse (2016) insights that the first concept recognizes that the psychodynamic perspective's role is critical in organizational culture; thus, suggesting the importance of conceptualizing because certain behaviors exist, specifically in organizations.

Kumar et al. (2014) incited that a strategic leader must implement effective leadership and have a strategy for influencing followers. Conversely, there is a rationale regarding an individual's conscious or unconscious human act whereby there is

seemingly an explanation, either logical or illogical (Northhouse, 2016). The second concept insights that inner emotions play a significant role in an individual's stability and "outside conscious awareness" (Northhouse, 2016, p. 296). The third concept revolves around the idea that emotions influence human behavior (Northhouse, 2016, p. 296). In contrast, it dictates the individual's perceptions of situations, thus choosing how to interact and create each experience (Northhouse, 2016, p. 296). Finally, the idea is that each person is a product of their environment (see Northhouse, 2016, p. 296). Early development is influenced by surrounding behaviors, suggesting that children are impressionable and learn behaviors (Northhouse, 2016, p. 296).

Weintraub and McKee (2019) suggested that leaders need to implement a pathway to achieve long and short-term goals that will benefit the follower. The inner theater is one of the core concepts discussed in Northhouse (2016), which provides that response patterns learned early influence adulthood response patterns. Moreover, relationship themes develop throughout the individual's lifespan, according to Weintraub and McKee (2019); this can be inferred within healthcare leadership culture. Further adding, some may display a dysfunctional pattern and react passive-aggressive in defense of their poor decisions (Weintraub and McKee, 2019).

The inner theater asserts that these behaviors are core conflictual relationship themes (CCRTs) according to the developers of the CCRT (Luborsky & Crits-Christoph, 1998, as cited in Høglend, 2020; Tallberg et al., 2020). The developers suggested that people display a behavior pattern described as transference patterns and fundamental relationship themes (Tallberg et al., 2020). Can inadequate leadership trickle down to

healthcare patients? For every action is a reaction, unethical behavioral patterns possible CCRTs may emerge and perhaps be corrected with proper counseling (Tallberg et al., 2020).

As such, team counseling could be ideal within the healthcare system. According to Northhouse (2016), organizational anxieties must be managed, inciting the consequences of the actor displaying regressive social defenses, causing tension within the group or organization. Sub-consciousness actions may be derived from a lifetime of experiences, perhaps stemming as far back as early childhood, as described by Northhouse. If not addressed promptly, the organization may suffer, as poor behavior is seemingly contagious or can have an adverse effect on the team (Northhouse, 2016). Public health leaders (related to the interaction with the public) must communicate effectively (Northhouse, 2016). Communication is fundamental to leadership within public health, as it is detrimental to problem-solving and achieving goals (Kumar et al., 2014). Therefore, one must also network effectively, have stellar advocacy abilities, be diverse in collaborative thinking, and solve organizational problems (see Northhouse, 2016).

Servant Leadership in Healthcare

Der Kinderen et al. (2020) conducted a study that explored servant leadership in mental health care studying the psychological well-being of 312 employees of a mental health facility. The researchers found that workplace outcomes were influenced by servant-style leadership and had a strong association with the employees' psychological well-being (der Kinderen et al., 2020). Such studies lend validity to the importance of

leadership style in the workplace, as der Kinderen et al. implies. Working in healthcare facilities can be complicated and demanding (der Kinderen et al., 2020); therefore, the employees' psychological health is a factor (der Kinderen et al., 2020). In supporting this theory and in earlier literature, Schwartz and Tumbliin (2002); Greenleaf and Spears (2002) implied that the servant leadership approach enhances complex organizations. While servant leadership is continuously being tested for its value and direction, it is beneficial to understand the servant leadership approach concept (see der Kinderen et al., 2020).

Furthermore, in a paradoxical approach, Greenleaf (1977) explained the servant leadership approach as a strategic design that insights the notion that leaders -in this case, healthcare system workers- should exercise empathy and embody solid ethical values. According to Northouse (2016), the ethical theory provides the individual with a framework of principles to guide leaders in the decision-making process and behave morally decent. Attending to the follower's desires or needs, Greenleaf and Spears (2002) suggested leaders should conceptualize factors that affect their followers, such as inequalities, and place the followers' needs over the leaders' secondary desires. Clinicians lead from the front line; therefore, altruism in their leadership style would positively affect the patient (Greenleaf & Spears, 2002). According to Navarandi (2014), leaders need to be cognizant of their approach and strive to help their followers emotionally while promoting their success.

Counterintuitive, the servant leadership approach allows for a proactive leader (Navarandi, 2014); consequently, progress is inevitable and practical communication

between the leader and follower would positively impact outcomes (Northhouse, 2016). Theoretically, the theory would influence the servant leader in that one's principles may play a significant role in decision making. Navarandi (2014) argued that followers' needs, and well-being usually are placed first before the leader's needs. Peterson et al. (2012) conducted a study that examined leadership narcissism and predictors in servant leadership within organizations. The researchers found that top leadership CEOs are likely to be unselfish (Peterson et al. 2012).

The value-based model of servant leadership is dynamic in that this model encourages an interpersonal relationship with the follower (Hunter, 2013). Theoretically, this model offers guidance recommending various antecedents' traits that align with how the follower perceives the leader suggesting positive behavior and receptivity are significant factors and the leader's values and attributes (Hunter, 2013; Northhouse, 2016). Maintaining and building sustainable relationships on the servant leader's part requires specific characteristics such as morals, values, and ethics (Hunter, 2013). Northhouse (2016) argued that the leader should humbly confer while leading and inspiring rather than seeking power.

However, while arguing its altruism, the theoretical framework has limitations of no consensus. While the leadership model is beneficial within healthcare as far as communicating with the patient, it does not address implicit biases (see Northhouse, 2016). As der Kinderen et al. (2020) inferred, a servant leader is more likely to obtain beneficial mental health care outcomes. The idea of healthcare workers embodying no bias, stigma, or discrimination -even if the clinician recognizes these harmful ideologies

through self-assessment- identifying short-coming may help the clinician choose to change their leadership approach when interacting with their patients.

Systems Thinking in Healthcare

Andersson (2018) elucidates the importance of effective communication and its vital role in outcomes. Systems thinking concerning the definition of leadership is a dynamic way to analyze, break down, and build the framework to implement an idea that is inherently related to the public or organization's betterment (Forrester (1956). It examines all components and underlining challenges; leaders should understand the concept (Zurcher et al., 2018). The conceptual understanding of systems thinking can solve management and leadership levels to improve organizational performance (Andersson, 2018). The most significant difference is that leaders tend to have followers, and managers tend to have subordinates, as suggested by Matt Levine (n.d.). Leaders have visions and develop success goals, and managers adhere to achieving or implementing them (Andersson, 2018).

Ethical Responsibility in Healthcare

Limentani (1998) argued that ethics is not optional within the medical field and is a critical healthcare component. Limentani (1998) also stressed the importance of ethical codes, whereby it is the clinician's responsibility to embody moral judgment and adhere to these codes. Any unethical behavior observed should be reported by colleagues (Limentani, 1998). Objectively, the mirroring and idealizing approach is a viable tool, whereas sound leadership cues can inspire other leaders' behavior, as Northhouse (2016) outlined. Additionally, Northhouse points out that the mirroring concept between leader

and follower can grow to be collusive, as followers are eager to use leaders to mirror what they need to observe (Northhouse, 2016). The National Association for Healthcare Quality (2018) suggests that medical professionals have an ethical duty to stakeholders. Also, stakeholders include the clinicians or healthcare professionals, the patients or recipients, colleagues, employers, providers, purchasers, researchers, regulators, and the public (The National Association for Healthcare Quality, 2018).

Consequently, leaders find it hard to resist their followers' affirmation (Northhouse, 2016). Hence, if the leader displays poor behavior, the followers may mimic it as a defense mechanism (Northhouse, 2016); failure to communicate effectively or demonstrate positive leadership could negatively affect healthcare patients (Sulmasy et al., 2017). The ability to adequately address detrimental issues within the community is essential in public health leadership and management. The National Association for Healthcare Quality (2018) suggests that healthcare professionals be transparent, forthright leaders to the medical teams that they lead.

Sulmasy et al. (2017) argued that medical professionals should have empathy, ethical duty, and responsibility to place the patients' needs first. Further implies that, ultimately, medical professionals should be consistent with innovations within the healthcare system (Sulmasy et al., 2017); thus, the healthcare paradigm should align with their values (Northhouse, 2016). Moreover, managers tend to focus more on everyday dealings and problem-solving, maintaining stable environments, and ensuring standard operating procedures are adhered to and are updated (Northhouse, 2016). Conversely,

leaders should focus on sustainability factors to keep the organization afloat (Northhouse, 2016).

Notini (2018) implied the need for healthcare facilities to provide strategic clinical ethics as outlined and supported in the literature of Greenberg et al. (2013). Unequivocally, leaders should stay abreast of new ethical training paradigms by initiating goals and strategic plans to reach those goals (Notini, 2018). Consequently, my research questions harvest the importance of the underpinning overtones of ethics and moral judgment in leadership. Accordingly, referring to Greenberg et al., the researchers define clinical ethics in such a strategic analytical manner; clinical ethics has been explained as: the act of conferring with, seeking clarification about, requesting deliberation concerning, asking [for] guidance/advice about ethical issues, relating to, broadly, patient care and staff support from a bioethicist [or clinical ethics committee]. A consultation may involve (but is not necessarily limited to) the bioethicist [or members of the clinical ethics committee] listening, providing information, facilitating communication, advising, or meeting with one or more persons involved. (Greenberg et al., p. 138).

Qualitative Components of a Study

Although I used an exploratory phenomenological qualitative approach in this study, grounded theory was my first choice. Hence, I did not find a significant amount of relevant literature about implicit bias within healthcare that used grounded theory methodology. However, after careful consideration, I concluded that a phenomenological study was more suitable for exploring the phenomenon of implicit bias in healthcare and the results I wanted to achieve. My aim was not to develop a theory but to explore a lived

experience; it is unknown if using a different framework in my study would have made a difference in the findings of this study. However, to highlight some of the studies from researchers that employed the grounded theory framework, I present examples of its use in this section.

Guided by the grounded theory framework, Kehle-Forbes et al. (2017) conducted a qualitative cohort study of sexually assaulted military women who had applied for disability benefits citing PTSD. The study included a sample of thirty-seven females (Kehle-Forbes et al., 2017). The researchers gathered data by administering semistructured interviews. Kehle-Forbes et al. found that women felt the VA was unwelcome, specifically when it came to their mental health needs—further implying an overwhelming mental health work staff of male professionals, which gave them anxiety (Kehle-Forbes et al., 2017). The participants were paid \$50 for their participation (Kehle-Forbes et al., 2017). The researchers utilized NVivo to manage the data collected using systematic coding (bottom-up).

Further, the study showed that a vast majority of participants were White College-educated females, in which 73% of the women reported a history of MSA (Kehle-Forbes et al., 2017). The researchers reported accurate findings that told a mistrust story through the participants' lens (Kehle-Forbes et al., 2017). It is important to note that military sexual assault is not just a female issue (VA, n.d.); men are also assaulted (VA, n.d.). However, there were no current studies found that examined male-related experiences. Likewise, conducting a qualitative study requires vigorous data collecting and a strategic design based on the research study's problem and purpose (Creswell, 2014). Ellerbe et al.

(2017) sought to identify and understand quality care gaps in veterans' substance abuse treatment programs; data was compiled from the VA Northeast Program Evaluation Center (NEPEC), which identified 97 VA residential treatment programs (Ellerbe et al., 2017). The researchers interviewed residential facility staff from various locations using an interview guide with multiple questioning to gather data for analysis (Ellerbe et al., 2017). The researchers were looking for common barriers, as reported by the participants.

Ellerbe et al. (2017) examined data collected from 59 interviews. For example, questions like facility performance and barriers that may contribute to substandard performance, how the system works, and the screening process, the in-take, and post-discharge process were asked of the participants through semistructured interviews via landline, which took a little over an hour (Ellerbe et al., 2017). The researchers provided the participants instructions on a matrix-like profile report document (Ellerbe et al., 2017). The qualitative data were collected, transcribed, and placed into the ATLAS.ti coding system application (Ellerbe et al., 2017). It was determined that there was a barrier to available resources and inadequate staffing (Ellerbe et al., 2017).

Additionally, the researchers determined that staff and facility program management shared perceptions of the admissions process and the programs' structure (Ellerbe et al., 2017). The study's findings demonstrated the need to enhance treatment programs/facilities and update policy. However, according to research, there was a profound gap in the research as no qualitative data collected showed implicit racial bias, which can be a barrier in life. In short, these findings undoubtedly imply that further study is needed.

Summary and Conclusion

The importance of this study was to bring public awareness by examining the underpinning issues of implicit bias in healthcare that plague the targeted under-represented racial/ethnic group of the African American community. It is only by understanding and knowing the history of disparities in healthcare that we can begin to understand how to address the issues when constructing meaningful public health policy. This chapter explored the foundations for this study reviewed literature about implicit bias, healthcare policy, communication, and leadership in healthcare, objectively and analytically. More importantly, the literature review highlighted the need for transparency in healthcare policy, indicating the need for African American involvement in the healthcare policy decision-making process.

However, few empirical peer-reviewed studies address the phenomenon of implicit bias, lending justification for this research to fill this relatively significant gap. Although sociological reports, medical studies, and peer-reviewed literature have tackled healthcare bias, an overwhelming gap lingers, which fails to deliver the patients' perspectives qualitatively. Finding current peer-reviewed studies that aligned with the problem was indeed challenging. Likewise, researchers have also done very little to qualitatively address healthcare determinants that factor into the healthcare system's disparities toward African Americans and whether implicit bias affects healthcare outcomes during a pandemic creating a deficiency in public policy.

Several themes emerged throughout this chapter—inconsistencies of fair treatment, social determinants, decent access to healthcare, lack of participation in

healthcare policymaking, and a failed healthcare system for many African Americans. Also, another theme that emerged was that African American patients are less likely than other groups to receive the same level of healthcare as Whites. However, the comfortability for expressing their feelings to the clinician was hindered by the uncertainties of implicit bias, highlighting another significant dilemma that leaves additional room for further study. The remarkable aspect of these studies presented within this chapter is that they provide a plethora of information that consistently revealed implicit bias that explicitly affected the African American community, thus indicating a breach in healthcare policy.

Exposing and confronting bias in healthcare is critical to the quality of life for people. Respectively continuing to confront this phenomenon may influence continuous positive healthcare policy changes. The factors associated with implicit racial bias come with potentially deleterious results that can impact patients' quality of life, as the findings of this research study revealed. Collectively, research gaps may shrink through continuous research exploring the patients' innermost deepest thoughts, awareness, understanding, and education. Greater attention to these problematic issues, meaningful policy changes may contribute to positive social change within healthcare, further supporting my research findings.

Chapter 1 provided a glimpse of the research's methodologies, content, and findings of this study. Chapter 2 explored peer-reviewed research literature examining problematic issues in healthcare, thereby identifying the research gap, and justifying this study. Chapter 3 -the next chapter- outlines the research methodologies aligned with the

problem presented, the purpose statement, and the research questions; the chapter also covers procedures that discuss sample sets and study instruments. Specifically, the next chapter describes the rationale, methodology, trustworthiness, and instrumentation used for this study.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore and describe the extent to which implicit bias influenced healthcare services for African American adults aged 30 and over with comorbidities and living in New York City during the COVID-19 pandemic. By presenting the lived experiences through the lenses of the participants, new policies supporting health equity could result in a possible improvement in the quality of life for this target group. Inequalities in healthcare delivery in the U.S. have not been thoroughly explored. The research findings of this study found a disconnect between the participants and healthcare workers. There is a possibility that this research study will influence health public policy and promote a new paradigm for healthcare delivery. Specifically, the purpose of this research study was to understand implicit bias in the New York City healthcare system and the disproportionate impact it has on African Americans, thereby causing disparities and health inequity. This study was focused on this barrier during the COVID-19 pandemic.

In this study, I explored implicit bias in healthcare from the patients' perspective and presented qualitative discoveries in the findings, thereby exposing the participants' experiences. More specifically, I aimed to do the following in this research study. Firstly, I sought to examine patients' adequacy of care during a pandemic to understand the effects of inequity in healthcare. Brewin et al. (2017) averred that constant exposure to chronic prolonged stressors might induce mental health symptoms. Secondly, I also sought in this study to influence policy, encourage positive social change, and shrink the

gaps in current research. The findings presented in this study can positively influence the African American community and has the potential to improve health equity.

Furthermore, this study may draw attention to implicit bias in the healthcare system. Phenomenological constructs guided this study, and the BMHS also contributed to the richness by providing a clear outline. The BMHS helped explain data to understand the dynamic impact of behavior in healthcare and validate the structure of the research questions. Strauss and Corbin (2006) stated that qualitative research methods of data gathering for analysis have significantly increased over time. In collecting reality-based data in the context of a behavioral inquiry, the qualitative findings drawn from descriptive data provided vital information to analyze. I did not aim to develop a theory with this study as it was not required in a phenomenological study, according to Merriam and Tisdell (2016). Additionally, the SCPD theory employed throughout the study was ultimately applied to understand healthcare policy in correlation to the research findings.

Chapter 2 highlighted several factors that contributed to implicit bias, including communication and leadership, which are essential to effective policy decision-making as suggested by Brown (2020); therefore, a review of these elements and factors directly focusing on implicit bias were included in this study. Current research studies fall short of these considerations, leaving significant gaps in understanding the phenomenon. Noonan et al. (2016) argued that healthcare policy participation regarding the target group needs attention when creating or contributing to healthcare policy decision-making. Therefore, careful consideration was applied in the construction of the research questions.

Chapter 1 introduced the methodologies, framework, and a glimpse of the findings. In Chapter 2, I presented a comprehensive examination/review of the scholarly literature related to the research problem. Explicitly, Chapter 2 focused on symptomatology, sociodemographic and biographical variables, and healthcare leadership. Chapter 3 presents the research setting, design and rationale, researcher's role, methodologies, ethical considerations, instrumentation, technical aspects of research methods, and trustworthiness. Additionally, this chapter covers a detailed description of the methodological components and sampling methods used in this study. In brief, this chapter expounds on methodologies used for the emergence of comprehensive findings presented in Chapter 4.

Research Design and Rationale

Research Questions

The purpose of this study was to evaluate and understand the extent to which implicit bias influences the healthcare services for African American adults aged 30 and over with comorbidities living in New York City during the COVID-19 pandemic. I chose a phenomenological exploratory qualitative research design for this research topic because it was most suitable to explore the phenomena. The objective was not to identify the causes of the phenomena but to share the participants' perspectives that may influence healthcare policy modification. The literature review helped identify a significant gap in the study of healthcare-related implicit bias, helping construct the research questions that align with this research's purpose (see Agee, 2009). Additionally,

the BMHS, SCPD, peer-reviewed literature, and the underpinning of the phenomenological design also helped map the research questions.

The rationale for this research was to encourage African American involvement in the healthcare policy decision-making process, improve the quality of life for this under-represented group, provide education on the seriousness of disparities they face, and address public healthcare policy regarding the inequities. Current studies influenced the following semistructured, open-ended questions. Very little research has examined a lived experience of this racial/ethnic group qualitatively regarding these particular issues. Therefore, the following questions aligned with an exploratory qualitative research approach that helped gather rich data to present in the findings:

RQ1: To what extent do patients who identified with having comorbidities or underlying medical conditions and who visited healthcare facilities during the COVID-19 pandemic perceive that they experienced implicit bias?

RQ2: To what extent do patients perceive that their underlying medical conditions affected the quality of care received and how they were perceived by the medical professional because of these conditions during their healthcare visits?

RQ3: Given the impact of COVID-19, how do patients perceive healthcare-related implicit bias encounters, and how did these encounters impact their quality of life?

RQ4: How do patients describe challenges with communicating with healthcare workers, and to what extent does healthcare policy affect health equity?

The phenomenological research approach was aligned with the research questions ensuring no discrepancies in the data. According to Creswell (2007), qualitative research is a practical approach to collecting participants' lived experiences through their lenses. Additionally, qualitative research allowed for collecting deep descriptive data, such as the lived experiences of African Americans seeking healthcare services during a pandemic. The qualitative approach provided a systematic platform for the participants to explain their lived experiences. Conversely, a quantitative approach would not have been suitable because of the design restrictions; it does not allow for collecting a solid narrative of lived experiences but relies on descriptive numerical data to examine the relationships of variables. (Creswell, 2014).

Phenomenological Approach

In identifying common themes of implicit bias, the phenomenological model was used to identify and interpret the health-related social experiences of the participants. Sundler et al. (2019) suggested that phenomenology is a philosophical ritual in the sciences and can be interpreted in several ways through diverse perspectives. Additionally, Sundler et al. suggested a common link between the intentionality of consciousness and the act of lived experiences regarding rationalizing what people experience. As with the objective of this study, the phenomenological approach distinguished and helped to interpret the phenomenon found within the common themes identified in the lived experiences of the participants (see Creswell, 2014).

Neubauer et al. (2019) encouraged phenomenology in research and suggested that the strategy helps the researcher better understand the research questions, aligning them

to investigate challenging issues. The flexibility of the phenomenological approach to this study can ensure the collection of rich data gathered from a small data set; however, it may not guarantee a complete understanding of the problem (Sundler et al., 2019). In short, science-based phenomenologists emphasize shared experiences identifying phenomena (Merriam & Tisdell, 2016). Objectively obtaining the richest data about a phenomenon is exploring the problem through phenomenology. The overall objective of this technique is to explore a phenomenon in-depth to ensure the lived experiences of participants are presented thoroughly and ethically. Grouping of common themes ensures the data are interpreted collectively and accurately in the findings (Merriam & Tisdell, 2016).

Generic Approach Explored

Although the more widely used phenomenological methods guided this study, other approaches had closely aligned that support the constructs of this research. The generic approach to research can be utilized collectively as per the descriptive argument provided by Cooper and Endacott (2007). It is essential to note that generic research is not bound to any philosophical assumptions, unlike phenomenology and grounded theory (Kahlke, 2014; as cited in Holloway & Todres, 2003; Johnson et al., 2001; Morse, 1989; Richards & Morse, 2007). The general flexibility of the pragmatic generic methodology seems ideal, and it is also essential to note that reliability (generalizability) is not a requirement for a generic study, which is a beneficial element to qualitative study (Percy et al., 2015). Cooper and Endacott contended that a generic approach for a study is appropriate for seeking cognitive perceptions of how people view things. The research

problem can also establish rigor and an in-depth understanding of phenomena by utilizing a generic approach (Kahlke, 2014; Merriam & Tisdell, 2016).

Moreover, Cooper and Endacott (2007) argued that in conducting a generic study, the researcher is not required to declare a specific design; therefore, the opportunity to explore methodologies as a generic approach does not bind the research to a particular research method. In that aspect, Kahlke (2014) also argued that researchers sometimes discover that their research questions fail to align with current methodologies. Also, generic methodology leaves room for exploring what is more appropriate in accommodating their epistemological stance and the constructs of their overall research (Kahlke 2014). In contrast, a phenomenological methodology is designed to develop assumptions from phenomena (Merriam & Tisdell, 2016); however, this strategy is not required within the generic methodology (Cooper & Endacott, 2007; Merriam & Tisdell, 2016). Notwithstanding, the phenomenological constructs was more suitable; it has a more systematic focus, allow for an in-depth study, and is more widely used in qualitative research (Merriam & Tisdell, 2016). Even though the two approaches are similar, both methodologies are appropriate for gaining insight into the participants' lived experiences, perceptions, and real-world phenomena (Cooper & Endacott, 2007; Merriam & Tisdell, 2016).

Although generic methodology resonated with many elements of this study, including the research questions which aligned with the criteria for a generic approach, there are significant weaknesses in conducting a generic study; there is very little focus on a particular framework. Another weakness in choosing the generic methodology

would be the justifiability of the study's purpose to establish rigor. For these reasons, to fill current gaps in research, the phenomenological method was most appropriate. In short, although generic methodology was aligned explicitly with this study's purposes, the problem, and the research questions, it was only a consideration. Amidst hindsight, in investigating findings that yield an understanding of the phenomenon, a generic approach provides the constructs to obtain interpretive data that can help describe phenomena (Merriam & Tisdell, 2016).

Design and Rationale Summarized

The study questions were designed to obtain rich information. The NVivo program was used to store and analyze qualitative data. The interview protocol for the qualitative research involved online interview questions sent to the participants through a secured and approved email system. The chosen samples were provided a declaration that all information provided would remain confidential, further discussed within this chapter. Reliability and validity were assured throughout the process. In qualitative research, the researcher is the scientist searching for patterns, phenomena, attitudes, statistics, and common characteristics that yield understanding (Yadav, 2018); therefore, the non-experimental overarching goal is to share the participant's experience in total profundity.

A complete sample set of no more than 20 participants but no less than 8 who met the criteria was chosen to participate in the study. Recruitment and data collected were accomplished through homogenous nonprobability purposive and snowball sampling to ensure a specific sample set provided representative comparable information (see Creswell & Plano Clark, 2018). Creswell (2014) indicates that these sampling models can

provide purpose and validation to a research study. The completed surveys were briefly hand-coded -after familiarization-then downloaded from Microsoft Excel and uploaded to the NVivo application for data analysis and coding then data was stored on a secure computer (see McGrath et al., 2018).

Role of the Researcher

A responsible researcher ensures ethical considerations, trustworthiness, and validity are not compromised. Moral and ethical personal values and professionalism are crucial when interacting with study participants (Creswell & Plano Clark, 2018); for this study, all the participant's personal information was stored and locked on a computer system for these reasons. Prior to this research, I had been extensively trained in mixed-method research design, including research ethics and protocol, from Walden University. Implications for possible implicit research bias over any samples were not a factor. Objectively, it was vital to follow protocol and restrain opinions, coercion, biases, leading statements, and misleading suggestions that could have influenced the participants' genuine feedback (see Creswell & Plano Clark, 2018).

Furthermore, no participants were selected for the study that I had any power over, including co-workers, students, or political party affiliates. Most importantly, I maintained professional standards while interacting with samples and analyzing data for interpretation. Moreover, no professional or personal relations hindered this study; there was no conflict of interest. The semistructured open-ended questions were not designed to incriminate the participants nor cause reprisal. Other than the responses to the questions, all personal data collected will remain confidential.

Most importantly, the participants were not required to surrender any hard copies of personal information. Vanclay et al. (2013) advised researchers to avoid deception and coercion during the interview. It was essential for the participants to understand the process fully; therefore, the participant was allowed to ask questions for clarity of the research process over the email system or via phone call by request (see Kaewkungwal & Adams, 2019). Researchers should maintain professionalism during the research process, and research data should be analyzed for validity and interpreted ethically for discovery. (Creswell, 2014; Tashakkori & Teddlie, 2009).

Methodology

Participant Logic

The target population was U.S. African American citizens residing in the New York City area, 30 years of age or older, and had experienced perceived implicit bias within a healthcare system during the COVID-19 pandemic. This study utilized phenomenological exploratory qualitative methodologies that did not require a search for cause and effect; however, it sought understanding of the social phenomena of African Americans who perceived they had experienced a biased encounter during a healthcare visit. In addition, this research explored communication gaps through qualitative components to gather individual experiences to find a commonality of emerging themes (see Creswell & Plano Clark, 2018). This research was approved by the Walden University IRB and given the approval number 08-19-21-0166402.

An exploratory approach was employed for this study as it aligned with the problem and purpose. Moreover, an exploratory design allowed me to explore

phenomena with very little to no prior research, which required no hypothesis (see Rendle et al., 2019). The basis for conducting this exploratory research was to gain contextual and descriptive insight into the participants' lived experiences to formulate a rich finding (see Rendle et al., 2019). To collect, analyze data, and report the findings of this study, the guidelines of the Standards for Reporting Qualitative Research (SRQR) were also considered in this study. Purposive and snowball non-probability sampling to recruit participants was used in this study; recruiting was open to the public with minimal criteria. According to Creswell and Plano Clark (2011), there are several steps in collecting data. One method includes the sample population selected using a probabilistic scale and the sample site, considering where the research will be conducted (Martínez-Mesa et al., 2016). In contrast, non-probabilistic sampling occurs on an available selective basis, and probabilistic sampling for analysis occurs when randomly chosen participants (Martínez-Mesa et al., 2016). The qualitative data is persuasive, and quantitative data is rigorous (Martínez-Mesa et al., 2016).

The data collected for this study was qualitative. For this reason, procedures were followed per IRB's guidelines to provide the most transparent, trustworthy, ethical, concise, comprehensive findings. Samples were obtained through non-random, non-probability purposive, and snowball sampling by posting a flyer on social media. All potential participants received an email with inclusion criteria questions. To meet eligibility requirements, the participants had to identify with the following inclusion criteria:

- The participant experienced a perceived bias experience during an encounter with a healthcare professional during the COVID-19 pandemic.
- The participant meets the age requirement of 30 years of age or older.
- The participant resided within the New York City area during the COVID-19 pandemic.
- The participant's ethnic/racial group is African American.
- The participant has comorbidities or any underlining medical health conditions.

Data saturation arises within a qualitative synthesis when common themes emerge (Creswell, 2014). The data collection terminated when saturation was complete (see Garrett et al., 2012; Lipworth et al., 2013). Likewise, Saunders et al. (2017) suggested that research questions and framework should align with saturation implementing scope limits, whereby coherency in saturation is not at risk. Data saturation must satisfy a significant number of common themes until there is little else to discover (Garrett et al., 2012; Lipworth et al., 2013). Creswell and Plano Clark (2011) suggested a minimum of 5 samples should be used within a qualitative study; however, a minimum of 8 participants was recruited for this study.

I employed purposive sampling to achieve “representative or comparability results” and snowball sampling in my research (see Plano Clark, & Creswell, 2008, p. 203). As such, Martínez-Mesa et al. (2016) described purposive sampling as useful in research for diverse populations; the goal is to satisfy saturation through strategic analysis of data focusing on robust themes. Martínez-Mesa et al. (2016) contended that snowball

sampling is beneficial when participants are needed for a study. Hence, snowball sampling focuses more on the referral by accessibility to the population being sought (Creswell & Plano Clark, 2011). As a last resort, if saturation issues had occurred or a representative sampling could not have been achieved, snowball sampling would have been aggressively reinforced within this study; however, there were no saturation issues.

In short, purposive and snowball sampling focused specifically on the African American population. Participants were selected based on their responses to preliminary questions on a recruitment flyer over an approved Walden University email system. The inclusion questions accounted for the qualitative strands needed for administering the qualitative survey; however, to be clear, due to COVID-19, data was exclusively collected online. The participant selection criteria were considered for the sample size of approximately 8-20 participants with an expected completion of 100% of the study questions; this expectation was partially accomplished using 13 participants who met the criteria.

The research methodology proposed a concise rationale encompassing a non-experimental approach, which allowed me to conduct interviews qualitatively (see Creswell & Plano Clark, 2011; Palinkas et al., 2015). Ultimately, the choice to implement a phenomenological exploratory qualitative approach was to strengthen the study and obtain the most meaningful outcome (see Creswell & Plano Clark, 2011; Palinkas et al., 2015). Conversely, these approaches were adopted as the lens to examine further whether healthcare policy meets the basic equitable healthcare needs of the target group. Specifically, the study findings helped to illustrate the lived experience of implicit bias

during the participant's healthcare encounters while highlighting disparities and the possible need for these under-represented groups' participation in policymaking.

Triangulation

Patton (1999) contended that utilizing triangulation helps ensure validity.

Triangulation allowed me to use more than one method and multiple sources that helped me to achieve a meaningful, yet comprehensive understanding of phenomena as (see Carter et al. 2014; Patton, 1999). Although four triangulation methods have been developed to help examine validity from multiple sources through a convergence of information gathered, this qualitative study has no boundaries in using a particular method (see Carter et al., 2014). For this reason, triangulation was used in the simplest form to help achieve representative results. Data analysis was not explicitly dedicated exclusively to theory triangulation, data source triangulation, method triangulation, or investigator triangulation, as this was a phenomenological qualitative study. However, data triangulation benefited this study's credibility and validity by helping me to examine the data using multiple techniques, additionally cross-referencing for verification (see Patton, 1999; Carter et al., 2014). Moreover, theory triangulation guided this study; both the BMHS and SCPD helped support the validity of this study in its entirety.

Furthermore, an exploratory approach to understanding a phenomenon is practical when conducting a qualitative study (Creswell & Plano Clark, 2018; Yin, 1994).

Reflexivity and triangulation were used to establish truthfulness and analyze data for credibility and validity to avoid bias while adhering to ethical research standards (see Johnson et al., 2020; Lincoln & Guba, 1985). Percy et al. (2015) described inductive data

analysis as a method to help recognize themes. Hence, the phenomena and concepts drawn from the raw data were used in the data analysis process; thus, triangulation was used to secure validity (see Lincoln & Guba, 1985). To that end, phenomena are continuously emerging due to multiple occurrences (Yadav, 2018). This research study aimed to understand the phenomenon of implicit bias drawn from worldly views and not develop an exclusive theory (see Merriam & Tisdell, 2016).

Participant Selection Logic

Instrumentation

The instrumentation used for data collection included a qualitative survey I developed to obtain contextual information with a consent form attached then sent over an internet email system after I obtained Walden University's IRB approval. The survey was developed on a free online application called Google Forms and does not require permission to use for research studies. Section 1 of the survey contained the informed consent form. Section 2 of the survey contained the inclusion questions (see Appendix B). Lastly, Section 3 of the survey contained 12 open-ended qualitative questions (see Appendix A). A copy of the survey is in Appendix C.

A free online Google software tool called Google Forms was utilized for this study. Google Forms is a software used to create questionnaires, surveys, quizzes, and spreadsheets, part of the Google application suite (Google Forms, n.d.); it is an innovative tool for lecturers, instructors, and researchers (Google Forms, n.d.). The use of the software requires a Google account active (Google Forms, n.d.). The free online software allows the form creator to utilize the templates in the program or design the

forms themselves. Additionally, the software provides a workspace tool that helps creators build forms by offering several options, such as adding multiple-choice bubbles or boxes and linear scales (Google Forms, n.d.). Another powerful and valuable feature in the application is allowing respondents to submit their forms anonymously (Google Forms, n.d.). It also allows the form designer to require an email into a response box (Google Forms, n.d.). However, it is relevant to note, I searched online for qualitative studies of implicit bias that employed this Google application; however, none were found. Since the use of the application is free, no permission is needed by the Google company to use the application or develop the survey (Google Forms, n.d.).

It is crucial to note that participants in a study were not required to establish a personal account to complete the questionnaire survey used in this study. Hence, to cite the benefits of using the Google free online software, I consulted with the most recent APA guidelines to cite the Google Forms website containing very little descriptive information. Much of the information produced in this section is on-hand discovery during the development of the survey, as there were very few descriptions and instructions provided on the Google website; however, the application was easy to use. Accordingly, it is imperative to reiterate; I developed the survey on the free Google Forms website, and it cannot be found or published anywhere else without permission. In short, Google Forms was a welcoming asset that allowed me to develop a qualitative survey for free.

According to preliminary research in chapter 2, there is a disconnection between patients and the healthcare delivery system, creating phenomena. Employing

phenomenological exploratory methods to investigate a phenomenon allows the researcher to consider the highly personal elements of lived experiences while also allowing research to connect a broader perspective (Creswell & Plano Clark, 2018). The data sought through this qualitative survey explored personal challenges, deep feelings, perceptions, and personal health issues that a quantitative survey cannot. There was no audio record, no videotapes, no artifacts, no in-person communication used in this research study.

I developed a flyer that contains a description of the study, criteria, and a contact email. The flyer was distributed on social media, specifically Facebook and LinkedIn. Once a potential participant responded, showing interest, the participant was sent an email thanking them for their interest and further instructions. The email contained details about the study's purpose and included the survey link. The link to the survey contains the informed consent form, inclusion questions, and a 12-question survey.

Validity was established in Chapters 1 and 2; the preliminary research literature helped establish the gaps, conclusively helping construct the research questions. The questions relate to negative encounters, perceptions, health services, and comorbidities; analyzing these components helped provide meaningful outcomes (see Creswell, 2014). Careful consideration was taken during the design process of the survey questions not to cause emotional distress by using demoralizing phrases and refraining from unethical questions. Twelve semistructured open-ended questions probed and incited the participants' most robust thoughts of their lived experience (see Appendix A).

Trustworthiness was considered throughout the research process (see Merriam & Tisdale, 2016).

Weaknesses in Qualitative Questionnaires/Surveys

The coding process usually begins with a detailed description of the data sets (Patton, 2005). Next, the data is analytically interpreted, analyzing various patterns, phenomena, attitudes, and common characteristics for the emergence of themes (Ali & Bhaskar, 2016). For obtaining qualitative descriptive data in-depth interviews, the researcher observes and isolates patterns in behavior, dictates verbal accounts, and looks for characteristics within the subjects. The overarching goal was to explore healthcare utilization experiences to find commonalities; direct observation lends to the validity and reliability of this study (see Bazeley, 2004). However, this study did not include the observation or in-person technique due to the current COVID-19 restrictions; instead, data was gathered from a survey link forwarded to the participants via an email system. The weaknesses with this approach are the complexity of interpreting data, fulfilling data saturation, and collecting inadequate or passive responses (Bazeley, 2004); however, these factors were not an issue in this study.

Collecting Information and Recording Data

Data Collection Process

The purpose of this study was to examine and provide an understanding of the lived experiences of African Americans living with comorbidities who had encountered what they perceived as implicit bias through the healthcare system during the COVID-19 pandemic. Explicitly, the study evaluated the extent to which implicit bias influences the

healthcare services for African American adults aged 30 and over with comorbidities living in New York City. The BMHS and the SCPD elements provided a theoretical approach for the study. Essentially, this research explored communication gaps through qualitative components and various individual experiences to find a commonality of collected data for findings; therefore, participants were encouraged to respond to all questions to the best of their ability (see Creswell & Plano Clark, 2018). The participants responded to most of the questions, allowing me to consider the highly personal elements of a lived experience while also allowing research to connect a broader perspective (see Creswell & Plano Clark, 2018). A total of 13 participants were selected for this study.

The data collection process took place in a controlled environment on a personal computer that requires a password to open. Data collection included administering and collecting semistructured open-ended questions on a qualitative interview guide/survey (see Appendix A). The survey was estimated to take approximately 35 minutes to complete and was sent to the participants using a Walden University-approved internet email system. Inclusion questions are pivotal to a probing qualitative survey to determine if the participants meet the criteria (Patino & Ferreira, 2018); inclusion questions were included on the survey; a total of 19 participants responded with interest in participation, and a total of 13 had met the criteria. An IRB-approved informed consent form was provided on the survey link. No incriminating or possibly emotionally damaging questions were presented on the qualitative survey. The participants were provided a phone number and email on the informed consent form to contact if they had any

questions. A follow-up email was sent with the interpreted results of each of the participants' surveys providing an opportunity to recant or modify their responses.

Recording Data

Data were analyzed and recorded immediately upon receiving survey data from the participants. Walden University's ethical standards protocol guided the research. The flyer, survey, and consent forms can be found in this study's Appendix section. Upon receiving the completed surveys containing the participants' responses to the semistructured, open-ended questions, each survey returned was briefly hand-coded -after familiarization- then transferred into the NVivo application for storage and qualitative data coding. The participants were provided a copy of the completed survey and consent forms. As themes emerged during coding, categories were developed from the data. Each sample was assigned a unique code. The information was entered into the proper category to help uncover patterns and themes aligned with the research questions.

In qualitative methodology, the researcher is the scientist searching patterns, phenomena, attitudes, and common characteristics (Frankfort-Nachmias & Nachimias, 2008). The researcher primarily searches for understanding the participants' environment and behavior in total profundity (Creswell, 2014). Again, data was collected through qualitative surveys, using a Walden University approved semistructured interview guide. There were no one-on-one interviews in person for this study. The survey was constructed to last for approximately 35 minutes. However, it is essential to note that the survey was not time constricted, and the participants were not pressured to complete all

the qualitative questions. Most importantly, each sampling unit was provided the same survey/questionnaire to avoid any possible unconscious or implicit biases.

Procedures for Recruitment, Participation, and Data Collection

Recruiting Participants

Participants for this research were recruited from the general population in New York City. Inclusion questions helped filter the samples to ensure the criteria were not compromised; however, this process was not guaranteed to produce truthful inclusion answers. The internet was the primary source for the distribution of recruitment materials. The recruitment process included two phases. The first phase (recruitment phase) consisted of a recruitment flyer provided on a free social media website that did not require special permission to solicit. Arigo et al. (2018) discovered social media platforms to be a valuable tool in researching health topics and suggested applying ethical principles of autonomy when leveraging this platform is essential.

For the second phase, participants were provided a link containing the study's semistructured interview online survey guide, including the informed consent form (see Appendixes C). The Walden University IRB approved the methods used in this study. Furthermore, no participants were excluded based on gender. The process was discreet, and no stereotypes, no personal experiences that I have encountered, or potentially stigmatizing labels were used in this study. Those who did not meet the demographic criteria were sent a thank you email explaining why they were disqualified from participating in the study. To clarify an example of the criteria, the participants must have

an underlying condition or comorbidities and have interacted with the healthcare system in New York City during the COVID-19 pandemic.

There were no follow-up interviews or additional research questions for the participant. A debriefing email consisting of a respectful greeting, details of the study, contact information if the participant has any questions about the study; there were no concerns relayed to me about the study. Interview checking and exiting the study commenced as an email was sent to the participants thanking them for their time and participation. Furthermore, Martínez-Mesa et al. (2016) described the snowball technique as beneficial when examining specific populations and allows the researcher to inquire about possible referrals at the observer-participant point of interaction. Although snowball sampling was used in this study, it was not a significant part of the recruiting process due to the overwhelming interest and timely responses. Recruiting participants for this study was not a hindrance, and there were no complications.

Administering Procedures

The Walden University guidelines and protocol carefully guided research procedures for this study. The recruitment flyer used in this study included an IRB-approved contact email. An IRB-approved secured email system was used to answer any questions about participation documents and clarify the survey questions. The participants were informed that the survey would take approximately 35 minutes. Data were analyzed until saturation was reached and validity was satisfied. Careful consideration of privacy was a priority as the participants were guaranteed confidentiality. Ethical guidelines were followed so that the participant's privacy or rights

were not violated or compromised; transparency was prioritized throughout the research process. Gelinas et al. (2017) argued that transparency is a critical factor in online recruitment, citing that the researcher should be transparent about the benefits of the study and the potential risk, thus providing the participants with an honest description study.

According to Creswell and Plano Clark (2011), “data collection needs to be administered with as little variation as possible as that bias if not introduced into the process” (p. 179); this ensured that the data was accurately reported (see Creswell & Plano Clark, 2011 p. 179). Each sampling unit was given the same survey/questionnaire to avoid bias. Additionally, a daily journal for memoing was used to note research steps taken to complete the study; and the participant responses containing emerging ideas and themes generated from the surveys were stored in the NVivo tracking and filing system. Ethical procedures must be followed when conducting an experimental or non-experimental design, as incited by Green & Salkind (2011). To that effect, results may be inconclusive if the validity is flawed, and the participants’ reliability is weak (Creswell & Plano Clark, 2011); however, credibility was not flawed in this study as there were no concerns that developed during the research process.

Data Analysis Plan

Thematic Data Analysis

Ali & Bhaskar (2016) suggested that research data provides contextual meaning to a study. Data was organized, analyzed, and stored private computer I own. All transcripts obtained for a systematic review of common themes were recorded using a

thematic analysis approach (coding) to reveal findings through comparable answers addressing the research questions. All conclusive and inconclusive data were entered into NVivo. Analyzing qualitative data requires critical thinking, non-bias perceptions, ambiguity, ethical standards (Creswell, 2014). This research encompassed a plan to securely analyze collected data, organize it, and manage the information (see Merriam & Tisdell, 2016). The phenomenological approach allowed for the constructs of thematic analysis for coding, thus aligning with the overall design (see Merriam & Tisdell, 2016). Additionally, in identifying further analytical classifications from the emergence of data that provided an understanding of the phenomenon, the constructs of thematic sampling were employed in this study (see Creswell & Plano Clark, 2011).

According to Roberts et al. (2019), thematic analysis consists of hermeneutic content designed not explicitly for numerical data but non-numerical data. Heidegger's (1971) *Hermeneutic Circle* was also used as a lens to move inductively from the participants qualitatively coded units to a more extensive representation of categories and themes until saturation was satisfied and no other new information would make a difference in the findings (see Mantzavinos, 2016 as cited in Heidegger, 1971). As such, the thematic analysis uses a process by which themes can be identified; for example, the themes aligned with the theoretical framework, content, and the overall focus, as Xu and Zammit (2020) described (see Xu and Zammit 2020). Data sets include patterns developed from themes (patterns) critical in a complete description of a phenomenon (Cassol et al., 2018). As such, Cassol et al. (2018) provide five stages of analysis:

- familiarization (analyzing all data collected to note ideas and themes).

- identifying a thematic framework (recognizing issues and further investigation)
- indexing (assigning numerical codes to place descriptive text in)
- charting (constructing the data to make sense by creating charts for the subjects)
- mapping and interpretations (create typologies that will help find a link between themes)

Instrumentation and Tools: NVivo

Widely used in qualitative and mixed-method studies, the NVivo software program is beneficial for systematically storing data collected and examining the findings from collected data (Dalkin et al., 2020). The NVivo software program's benefits are overwhelmingly helpful in all aspects of storing and analyzing data, as incited by Dalkin et al. (2020). NVivo allows for unstructured spreadsheets, video, audio, surveys, image data, and various other files to be stored and analyzed (Dalkin et al., 2020; Tang et al., 2017). The NVivo application helps keep the data organized (Dalkin et al., 2020). NVivo also allows importing data/documents directly from a computer and merges documents to NVivo from other Microsoft Corporation programs (Dalkin et al., 2020). *Microsoft Excel* is a standard program that can merge documents to and from NVivo (Dalkin et al., 2020).

After collecting the data from the Google Forms online application, the data were briefly hand-coded -after familiarization- then entered into the NVivo system to code, interpret data, find commonalities, and analyze for accuracy. For example, in testing

theories, a cross-sectional survey is entered into the system to identify a commonality of keywords and phrases, create a summary of nodes, export, import data, develop queries, charts and connect common phenomena to increase the illness (Dalkin et al., 2020; Tang et al., 2017). The NVivo program is widely used to store folders systematically, spreadsheets, video, audio, still photos, files, and store information from narrative surveys and interviews (Tang et al., 2017). In short, in determining coding and interpreting phenomena, the NVivo program was significant in this study and was more accurate than hand-coding, (see Tang et al., 2017). The coding process should begin with a detailed description of the data set and then be analytically interpreted for findings (Tang et al., 2017; Dalkin et al., 2020). In short, when coding data, it is crucial to look for commonalities like keywords or phrases indicating phenomena to establish theories through the qualitative research process (Gibbs & Taylor, 2010); the NVivo program was successfully implemented within this study and helped to interpret the findings.

Data Collection

A semistructured interview guide/survey consisting of open-ended questions was distributed and collected over an approved email system. The qualitative survey took approximately 35 minutes for the participants to complete. Participant confidentiality was a critical factor in the study and was protected at each step. Each participant was required to sign a consent form. Each participant was supplied with an approved copy of the consent form that included details of the study criteria. For this study, participants who met the criteria, and agreed to participate in the research, was assigned a numeric code after signing a Walden University IRB-approved consent form that was forwarded in the

same link as the survey. The participant's data will be stored "for no less than five years upon completion" of the research study as per Walden University's guidelines (The Doctoral Study Guidebook, 2011, p. 11). However, if the participant had chosen to terminate or exit from the study early, no longer wanting to participate, all personal data would have been destroyed indefinitely, as the data would no longer be needed (see The Doctoral Study Guidebook, 2011); Pope et al. (2000) explained exploratory qualitative research study below:

1. the analytical process of textual data collection
2. rigorous data entry and analysis
3. potential inquiry and hypothesis can develop
4. the content analysis takes place inductively for coding by hand or software
5. dependable, robust findings depend on the research's integrity and skills (Pope et al., 2000)

In short, data were collected exclusively over the internet until saturation was satisfied. Since this is a non-experimental study, no experimental instruments or medical treatments were used in this study. The semistructured, open-ended qualitative survey was developed on the free Google Forms software application. Data were collected from online surveys, briefly hand-coded -after familiarization- then entered into the NVivo system to code and store. Data collected for analysis were reviewed for appropriateness and accuracy using coding guidelines. The procedures ensured rich data for analysis; no follow-up questions were presented to the participants. An email with the participant's

interpreted survey responses was forwarded to them for review and final submission to be published. As a last resort, snowball sampling would have been aggressively applied to the study if there had been a low participant response, and saturation could not have been achieved.

Threats to Validity

Issues of Trustworthiness and Credibility: Internal Validity

Trustworthiness was one of the more critical components of collecting data for this research study (see Matthay & Glymour, 2020). Lincoln and Guba (1985) suggested the following concepts that helped establish trustworthiness: credibility, transferability, dependability, and confirmability (see Lincoln & Guba, 1985). These concepts are discussed further in this chapter. This study encompassed all aspects of trustworthiness when conducting qualitative research (see Guba & Lincoln, 1985).

Furthermore, credible constructs must align with trustworthiness, how data is handled, ethical considerations, information is collected from reliable participants, and the data appropriately stored then interpreted into findings (Plano Clark & Ivankova, 2016). A research study is considered credible in academia and scholarship when criteria and logic are substantiated and supported by credible data (Forero et al., 2018). Further, trustworthiness is undoubtedly a similar sentiment for many scholars in alignment with credibility. Trustworthiness is the basis for a validated research scholarship when gathering, analyzing, and implementing qualitative data (Plano Clark & Ivankova, 2016). In a study, there are several components to consider with trustworthiness (Matthay & Glymour, 2020).

When considering concept validity in a scientific scholarship, a construct is regarded as an idea, theory, or concept that the researcher intends to find (Matthay & Glymour, 2020). Credibility can be substantiated through verbal interaction during the one-on-one interview, thereby offering the participant the opportunity to elaborate on any research process issues (Plano Clark & Ivankova, 2016). However, the credibility for this research was obtained through email communication with no complications or discrepancies in data. Additionally, this study's research design was developed to ensure the saturation process was ethical. Triangulation was also applied, and calls with the committee Dissertation Chair were routinely conducted (see Birt et al., 2016; Matthay & Glymour, 2020). Threats to internal validity can harm a study; more specifically, when conducting a study, it is wise to consider regression, ambiguity or ambiguous temporal precedence, history additive and interactive effects, history, attrition, selection, instrumentation, and maturation (Johnson & Christensen, 2017). As noted, Gelinas et al. (2017) suggested that transparency is a significant factor in research studies and recommends honesty when interacting with research participants.

Threats to Internal Validity: Maturation

Maturation regarding time and effect can threaten research's internal validity, mainly when the analysis includes people within an experiment and the time it takes (Golafshani, 2015). Factors that may affect maturation are the study participants becoming restless, irritable, hungry, and losing memory (depending on time), for example (Sensing, 2011). Maturation was considered when distributing data, interacting with participants, and collecting data for this study (see Sensing, 2011). Likewise,

instrumentation in research can be a slippery slope regarding internal reliability threats in that bias can interfere with validity (Golafshani, 2015). Instrumental bias can disrupt the measurement process when changes to the measurement tools (such as a timer stop clock) occur over time (Golafshani, 2015). As such, there were no threats to maturation within this study.

Shadish et al. (2002) noted four types of validity: internal, external, statistical, and construct validity. Testing was not a concern as this was a non-experimental qualitative study, and all validity measures were considered. Matthay and Glymour (2020) implied that a general concern within measurement regarding validity is even if measurement errors are related to constructing validity, these errors must be considered a portion of the variable. However, it is essential to avoid mistakes in the covariation between variables in the end (Golafshani, 2015). Variables can have a causal relationship when two variables may be inaccurate (Petursdottir & Carr, 2018). As provided by Shadish et al. (2002), there are nine threats to validity, which are as follows: attrition, ambiguity, instrumentation, maturation, selection, regression, selection, and testing. Threats to validity were not a concern; this was not an experimental, qualitative study; however, all validity measures were enforced.

Transferability: External Validity

Transferability criteria provided a foundation for quality strategies in obtaining research samples, data saturation, examination or analysis, and generalizability (see Johnson et al., 2020). Additionally, transferability can provide thick, robust descriptions within the findings of a study that provide an understanding that may resonate with the

study's audience in that the finding may align with their own experiences (Merriam & Tisdell, 2016; Schloemer & Schröder-Bäck, 2018; Lincoln & Guba, 1985).

Transferability ensures that trustworthiness is present and provides a viable foundation, evidence that research findings can successfully be applied to the study's specific population (Johnson et al., 2020).

Variation was limited to a cohort of people in that the focus is to enhance the quality of care for African Americans, specifically those living with comorbidities. Additionally, in the context of transferability (external validity), the findings of my study provided unbiased researched-based evidence of the phenomena as precautions were taken to ensure no discrepancies of external validity would occur. The public may relate to the research findings in this study, thereby ensuring transferability and future research scholarship (see Johnson et al., 2020). The questions were ethically constructed to improve the likeliness of a high probability of transferability. However, there was no guarantee that this study would not have produced transferability issues; hence, there were no issues found in the data that suggest the public would not understand these findings.

Threats to External Validity

It is essential to understand the research's external validity (transferability) (Matthay & Glymour, 2020). Threats to external validity include sampling bias, for example (Merriam & Tisdell, 2016). Sampling bias results from an invalid sample representation regarding the target population can misrepresent a study (Schloemer & Schröder-Bäck, 2018). Notably, Matthay and Glymour (2020) implied that a threat to

validity might become prevalent during the interpretation of the research result stage, thereby addressing oversampling examples (Matthay & Glymour, 2020).

Additionally, to correct any threat to external validity, the recalibration technique, thus utilizing algorithms to modify and correct weighting of, for example, age, race, gender regarding the study samples, need to be completed (Matthay & Glymour, 2020). However, it is crucial to avoid errors for the covariation between variables with research studies (Creswell & Plano Clark, 2011). As such, threats to validity were considered throughout this research. To that effect, for this study, threats to validity were not expected, as this study did not include experimental variables, and all IRB protocols were applied as directed; there were no threats to validity during this study.

Dependability: The Qualitative Counterpart to Reliability

Reliability and dependability are two integral elements when gathering qualitative data (Johnson et al., 2020). With triangulation, the researcher implements more than one research component to explain or understand phenomena (Carter et al., 2014). Further benefits are the opportunity to collect data from multiple data sources to help identify inconsistencies, general errors, potential biases, and uncertainties (Golafshani, 2015).

In contrast, an audit trail can be composed of summaries and memos recorded during the study proving the research with documentation of the research process (Merriam & Tisdell, 2016). For this reason, triangulation was utilized in this study to ensure validity is satisfied and descriptive data is comparable. Implementing triangulation within a qualitative study can ensure validity, reliability, and dependability (Carter et al., 2014). In short, to ensure validity, triangulation can involve cross-checking regarding

multiple data sources (Carter et al., 2014; Schloemer, & Schröder-Bäck, 2018) this study employed triangulation to ensure trustworthiness was not compromised.

Confirmability: The Qualitative Counterpart to Objectivity

Another significant trustworthiness component in qualitative research is conformability (Denzin & Lincoln, 1994). A researcher must establish conformability (Lincoln & Guba, 1985; Creswell & Plano Clark, 2011). The researchers must be free from biases within the research findings (Creswell, 2009). Two components can be considered to establish conformability: audit trail and reflexivity; however, to establish its dependability, credibility and dependability must be met (Lincoln & Guba, 1985).

An audit trail is valuable in qualitative research studies concerning the ease of study results (Koch, 1994). The audit trail technique also includes detailing the construction and framework working and data and its presentation. Reflexivity is also a significant aspect of conformability; it is vital in qualitative phenomenological research (Lincoln & Guba, 1985). The reflexivity technique involves interpersonal skills and much to do with ethics when handling the study participants' data together (Lincoln & Guba, 1985). Furthermore, to ensure the conformability of this study, a journal was maintained during data collection and analysis. Establishing trustworthiness and meeting the conformability criteria helped present meaningful, robust findings in this study (see Johnson, Adkins, & Chauvin, 2020).

Ethical Procedures

After the Walden University IRB's approval of this study was granted, the elicitation for study sample units commenced. The confidentiality of participants was a

priority throughout the active research of this study and remains as such. Most importantly, to ensure viable research, ethical considerations were taken by ensuring participants confidentially adheres to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as cited by Nettrour et al. (2018), as well as the Walden University IRB's guidelines and protocols. Additionally, the IRB approved all document content, communication correspondence tools, a recruitment flyer, and social media platforms. Because this study took place exclusively over the internet, there was a possibility that an email could have been intercepted by a computer hacker, causing a breach in data and privacy. However, this did not happen as a secured and encrypted email system provided by Walden University did not require additional security. However, this description did not ensure the participants' security when sending documents; this was not reported as an issue during this study.

Informed consent forms were distributed to each participant via the survey link discussed throughout this chapter. All collected data were stored in a password-locked computer. To ensure ethical procedures were complied with, the aspects of each detail explained in this section were adhered to with no modifications specific guidance and protocol set forth by Walden University's Dissertation Guidebook and the University's IRB. In corresponding with participants, a declaration that this study was voluntary, and they could have withdrawn anytime during the process was explained to each participant and provided on the informed consent form. Vanclay et al. (2013) provides ethical principles in research, as follows:

- Make certain that respect is given.

- Informed consent is provided.
- Audio or video recording requires specific permission.
- Coercion is prohibited.
- Participation is voluntary.
- A participant's right to be excluded from the study or withdraw from the process is explained.
- Full disclosure of resources to include funding or special incentives, and protection of participants (no harm involved) is ensured.
- Undue intrusion is prohibited.
- Cognizant of moral hazard, and care considerations is priority.
- Deception is prohibited.
- Anonymity preservation is priority.
- Participants should have full rights to modify their provided information.
- Confidentiality and data protection is priority.
- Ethical governance and grievance procedures is priority.
- Conflict of interest should be understood.
- Full disclosure of reporting methods and research methodology (Vanclay et al., 2013)

Summary and Conclusion

This chapter presented critical components to this study's framework, methodological approaches to research, instrumentation, tools, and the coding process. Most importantly, this chapter provided a detailed description of the research design and

rationale, the researcher's role, the elements of trustworthiness and ethics, and how they aligned with this study. Additionally, the significance of this study is public awareness, understanding, and education. The dependability of the phenomenological design supported the common meaning of the phenomenon. The significance of trustworthiness supported the theoretical clarification and helped to ensure reliable data that is presented in this study's findings in Chapter 4. Significant considerations constructing this chapter included:

- design choice, framework choice, historical alignment tool,
- ethical considerations, interaction, liability, reliability, viability, commitment,
- honesty, trustworthiness,
- rewards, compensation, funding, budget,
- positive outcomes, findings,
- social history, socioeconomic status, medical ethics,
- proper population, gender, sample size,
- instrumentation, tools for qualitative research,
- Internet, and availability.

In summary, Walden University's IRB approved the data collection from a sample set of participants recruited through a non-random selection process over the internet; the sample consisted of 13 participants. This chapter presented the methodological approaches used in this study and the ethical elements needed to obtain successful research findings. Chapter 4 presents the findings of this study.

Chapter 4: Results

Introduction

The purpose of this qualitative phenomenological study was to examine whether implicit bias influenced healthcare services for African Americans with comorbidities aged 30 and over living in New York City during the COVID-19 pandemic. The objective during the data analysis phase of this study was to examine the perspectives of this population by sharing their lived experiences. More specifically, this study explored the perceptions of implicit bias through analyzing the data set, which included participant accounts of perceived negative encounters described as unwelcoming, uncomfortable, and possibly biased experiences with a healthcare professional. The inquiry's relevant and predominant theme was influenced by recent media reports of substantial disparities within the African American community during the COVID-19 pandemic. Therefore, it was necessary to narrow the scope of research by selecting an area of the U.S. with one of the highest numbers of COVID-19 cases, which was New York.

Additionally, during the proposal process of this study, I conducted a comprehensive and vigorous investigation to identify a gap in current studies that would support this research. I discovered that implicit bias was an ongoing phenomenon that negatively impacted the African American community; however, it had not been thoroughly explored qualitatively. Specifically, the COVID-19 pandemic illuminated the idea that there was a need to tell the stories of the patients. Because the initial scope of research was significantly large, a target group within the New York City area seemed plausible. This area was chosen because it had a high rate of COVID-19 positive cases

and clusters of deaths and prolonged sickness stemming from the pandemic. It is important to note again that the basis of the research was not to cover the stories of those who had tested positive for COVID-19; it was to explore the experiences of African Americans who had sought healthcare during this pandemic, which is explained further in this chapter.

By employing an exploratory qualitative phenomenological design for the research, an in-depth study of the lived experience of the phenomenon from the participant's lenses revealed insight that supports several of the themes that emerged in the literature review. Several questions relating to communicative exchange, comorbidities, and underlying conditions were presented to participants. Each participant was provided the same survey questions to establish a correlation of shared experiences into emerging themes to identify the primary perceptions of these encounters. Applying the framework of Andersen's (1968) BMHS and Ingram and Schneider's (1993) SCPD helped construct a vivid picture of the participant's reality. This chapter presents the setting, demographics, data collection and analysis, trustworthiness, and the results of this study. The interview questions helped answer the following research questions:

RQ1: To what extent do patients who identified with comorbidities or underlying medical conditions and who visited healthcare facilities during the COVID-19 pandemic experience implicit bias?

RQ2: To what extent do patients believe that their underlining medical conditions affect the quality of care received and how they are perceived because of these conditions during their healthcare visits?

RQ3: Given the impact of COVID-19, how do patients perceive healthcare-related implicit bias encounters, and how did these encounters impact their quality of life?

RQ4: How do patients describe challenges with communicating with healthcare workers, and to what extent do they believe challenges affect their overall health equity?

Setting

A Walden University IRB approval was granted to conduct research. Next, I used an IRB-approved flyer to recruit the participants for this study. The IRB also approved social media for recruiting; the flyer and an approved correspondence post were displayed on Facebook and LinkedIn. Correspondence with participants took place over a Walden University-assigned secure email system. It is important to note that the setting for this dissertation was exclusively completed over the internet; there was no video conferencing, phone communication, or in-person interviews with any of the participants. Ultimately, participants chosen for this study were selected because they satisfied the criteria.

In addition, I used purposive and snowball sampling to recruit participants. Data was solicited that included the participants' lived experiences their responses. Potential participants who responded to the social media post via email were sent a link to the survey. Upon completing the survey, the participants who had satisfied the inclusion criteria were sent an email thanking them for their interest and asked if they would like to

refer potential participants to the study. The potential participants who did not qualify for the study were emailed thanking them for their interest.

I sought to recruit 8-20 participants to answer 12 qualitative open-ended survey questions for the research study. A total of 19 participants were sent a link to the study. However, out of the 19 participants, only 13 met the criteria based on their answers to the inclusion questions. Some surveys returned contained little to no information. Potential participants who did not answer any of the questions were excluded even though they had met the inclusion criteria. No conditions, stipulations, personal or organizational conditions influenced any participants of this study.

Demographics

The participants who agreed to participate in this study met the criteria outlined on the research flyer, media post, and survey. To be considered for this study, the participants had to be African American, age 30 or over, and have experienced a perceived negative bias encounter with the healthcare system while living in New York during the COVID19 pandemic. These demographics were explicitly chosen to narrow the scope of the research. Focusing on a COVID-19 high-impact area like New York, there was an anticipated high probability of obtaining the richest data. As a result, an abundance of meaningful data was collected within three weeks. Males and females were not separately categorized, nor was the gender question asked before, during, or after the survey, as this was not essential to gather data for this study.

Data Collection

Geographical Population-Based

I employed phenomenological elements to gather in-depth data from participants to describe their lived experiences, ultimately producing shared themes that helped me understand the phenomenon. I employed purposive and snowball sampling to collect data from New York City residents. The flyer used to recruit potential participants provided the criteria needed for selection. Approximately 25 people responded to the flyer within three weeks. Out of the 25 inquiries, 19 people took the survey, but only 13 met the criteria.

All potential participants were sent an IRB-approved letter describing confidentiality factors, ethical commitment, the IRB approval number, the objective of the study, and its overall goal. The 19 people who showed interest were sent an email invitation with the survey link. The interview protocol was designed to encourage rich data in answers to 12 semistructured, open-ended questions on the phenomenon. The participants were also advised that the email survey would take approximately a minimum of 35 minutes to complete. All 19 respondents returned the surveys within the time frame requested. The flyer remained on social media until data saturation was achieved. Although the flyer, consent form, and survey listed the criteria, six respondents bypassed this information and requested a survey as stated in the previous section. Respondents who did not meet the criteria were sent an email stating that their surveys would not be used in the study because they did not meet the criteria noted on the flyer, social media post, or the first section of the survey.

I had no in-person contact with the participants. The participants were not encouraged to illustrate a particular narrative when answering the questions presented in the qualitative survey. The given responses by the participants were expected to be an accurate interpretation of their own words as described on the informed consent agreement presented to the participants and signed by the participants on the survey. The completed surveys were briefly hand-coded -after familiarization- then downloaded from Microsoft Excel and uploaded to the NVivo application for data analysis and coding. Each participant was assigned an identifier code to ensure the survey answers could be measured appropriately and protect each participant's identity. The selected participants were referred to as Participant 1, Participant 2, and so forth in chronological order going up to 13. However, in the results section, the participant's responses are not listed in particular order. There was no unusually occurrence during this study's data collection and analysis phase.

Maintaining Reflexivity

In maintaining reflexivity, I used a journal to document information concerning experiences I shared with the participants; this process was employed to ensure control of bias, thereby providing a fresh analysis of the research responses. I used interview checking to ensure proper interpretation. Each participant was emailed a copy of their survey responses and asked to verify the data for accuracy and if the data was a genuine and complete reflection of their responses. After completing the data analysis process to ensure proper interpretation, each participant was emailed a copy of their survey

responses and asked to verify the data for accuracy and if the data was a genuine and complete reflection of their responses.

There were minimal unusual circumstances during the data collection process; however, some of the potential participants who answered the survey questions were excluded from the study because they did not meet all the required criteria as stated in the previous section. Again, the individuals who filled out the survey were notified that their survey could not be used because they did not meet the criteria. Follow-up questions were not asked of the participants. Participants were able to skip the questions they did not want to answer. After receiving the surveys, they were all edited to correct typos and extreme grammatical errors. Participants then had an opportunity to review their grammatically edited survey and make changes that they felt were necessary.

Data Analysis

Conceptualizing and Interpreting Emerging Themes

In analyzing the phenomenological data survey responses for cognitive perceptions of bias and its impact on the participants, Heidegger's (1971) hermeneutic circle was used as a lens to move inductively through the participant's coded units. This process helped rationalize more prominent representations of categories and themes until saturation had been satisfied. First, upon collecting each survey via email, each participant was sent a thank you letter in response. The completed surveys were briefly hand-coded -after familiarization- then downloaded from Microsoft Excel and uploaded to the NVivo application for data analysis and coding. Holistically, it was necessary to analyze each response to the research questions, searching for commonalities to ensure

saturation. It was also necessary to understand the philosophical process of engaging in Husserl's bracketing for phenomenology in which the researcher avoids any personal judgment.

Moreover, Husserl's (1906) preliminary action helps avoid any possible bias; bracketing is also an asset to understanding an individual's experiences. So, by applying bracketing to explore a phenomenon of local epoche, the data may become more comprehensive. However, it is important to note Husserl's (1906) bracketing technique does not allow for assumptions of specific phenomena, in this case, the study of bias within healthcare (see Heidegger, 1971). Furthermore, in phenomenological reduction (suspending personal judgment), there is little opportunity for external influence when analyzing data. Nonetheless, employing local epoche was unnecessary as the elements coincide, ensuring plausible rigor, so bracketing or local epoche were not employed to analyze the data; this study did not use a Husserlian framework.

However, it was necessary to implement the philosophical underpinnings of Heidegger's (1971) hermeneutic circle as a lens for a deep rich understanding of the data (see Heidegger, 1971). Almost opposite of bracketing, which explores the data, journaling was necessary to capture possible biases before and while exploring collected data. The philosophical theory of the hermeneutic circle was used to understand the phenomenon by not suspending judgment but capturing biases in a journal to make sense of the researcher's thoughts. Each participant received a follow-up email containing their interpreted survey responses for further explanation and edit. To suppress any preconceptions or preunderstanding of the phenomenon would not be feasible; there was

room for updated versions of the explicit phenomenon and information from the collected data. While analyzing the responses using the hermeneutic circle through a phenomenological vertical, horizontal, and circular method, it was necessary to analyze piece by piece and then repeat the process several more times as new themes emerged.

Data Familiarization for Saturation

During this process, significant biases, assumptions, and even the interpretations of data were continuously noted in the journal. There was a continuous loop of new information for understanding the phenomenon. However, saturation was satisfied when no further information could be discovered during the data collection process, ending the discovery of new information. The familiarization of emerging data was necessary to generate codes to develop themes during inductive analysis. The process allotted the ability to produce the rich data included in this research report. The importance of emerging themes was a critical element; therefore, the raw emerging data was first-hand-coded to establish the more prominent similarities from each survey.

Coding and Developing Themes From Emerging Data

More specifically, it was necessary to isolate the disproportionate responses from each survey collected that were meaningless to the study. Identifying these responses was also done using a horizontalization technique that Patton (2005) described as isolating unnecessary jargon that has nothing to do with the study (see Patton, 2005). Whereby having this information horizontalized (isolated) with the elements of the responses as each held the same weight so that each perspective is considered when clustering the

data. It is important to note that the data was first-hand-coded to gain a general sense of what the participants had experienced since their data had to be translated.

Additionally, by also implementing the data analysis strategies of Braun and Clarke (2006) for the thematic coding process, reviewing the participant's responses through familiarization of the content within the survey responses helped generate initial codes so that themes could be developed (see Clarke, 2006). Several themes emerged throughout this process. The more prevalent themes used in this study were, for example, mistrust, racial discrimination, bias assumptions, worsening conditions, quality of care, mistreatment, healthcare insurance, and not being taken seriously were some of the themes and subthemes identified during the coding process.

Using NVivo Software

After hand-coding, the NVivo software provided the ability to cluster this data into the appropriate categories by coding elements from each participant and notable themes to interpret the findings. The more prominent themes that stood out were, for example, racial discrimination, underlying health conditions, bias based on assumptions of demographics like social class, not being believed, and the assumption of poor communication. Subthemes were also necessary, comprising of rich and thick responses. The survey responses were also structured in a hierarchical framework; the data was strategically placed analyzed several times to ensure proper placement for interpretation of findings. Several categories were included within the NVivo software system to help code the data. Overlapping data were identified throughout the analysis of emerging themes. Moreover, codes were categorized appropriately to coincide with the raw data

collected, such as implicit bias based on comorbidities and bias-based perception. These identified themes, codes, and categories were analyzed to ensure alignment with the research questions.

Again, upon grouping the codes into the appropriate categories, all information was further analyzed to identify the relationship of themes. The categories that were not significantly emphasized were placed into subthemes to ensure clarity. Upon further examination for clarity, subcategories were implemented to ensure the data was correctly coded. The data analysis process was completed and placed into a hierarchical datasheet for thematic construction.

In short, the participants' responses were analyzed to become familiar with the information provided in each of the surveys. Notes were configured as a reference point during the coding process. While reviewing the research questions, the survey questions were used to generate the initial codes to help create themes and patterns. This information was used to dissect each survey response and place them into categories. The completed surveys were briefly hand-coded -after familiarization-then downloaded from Microsoft Excel and uploaded to the NVivo application for data analysis and coding. Because the software-generated codes were broad, narrowing the categories and codes down to relevant the research significantly was necessary. Upon completing this process, various themes from emerging data were created based on the commonalities during the coding process. Additionally, while reviewing the various responses, it was found that much of the information provided was similar enough to cause overlapping of data when

categorizing into the themes and subtheme; therefore, the coded data sets were identified as significant to the relevancy of the research questions.

Developing the Final Analysis

The data was further analyzed to ensure commonalities were strategically placed into the proper categories. By examining the relationship of themes, adjusting codes into the correct categories, the data analysis process was simple in that the data was structured in such a way to ensure proper thematic analysis of data analysis finalization to answer the research questions. Each theme correlated within the research questions, reviewing the developed themes several times as necessary. Emerging patterns developed as each survey was included in the initial coding process. It is also important to note that several overlapping responses indicated that some of the questions provided on the survey were too similar. Therefore, it was necessary to produce subthemes within the various categories that highlighted the research questions as stated in the previous sections of this chapter. Much of the participant responses were summarized in the next section; however, the more detailed descriptive accounts of the lived experience were quoted to give rich insight through the lenses of the participants. The final analysis of the data was captured into the final research report.

Evidence of Trustworthiness

Ensuring trustworthiness is necessary to establish credibility. transferability, dependability, and confirmability have been considered and applied throughout the research process. The criteria to establish trustworthiness is found within the elements of

credibility, transferability, dependability, and confirmability. Below is the gathered evidence that each element has been considered and satisfied throughout the study:

Establishing Credibility

Credibility or internal validity was established during the interpretation of collected data by transcribing the data as each participant forwarded their survey answers through the secured email system. Each participant was forwarded the interpreted data for interview checking upon completing the analysis. They were asked to confirm any discrepancies in the data. Each participant replied to the email indicating that all the information was correct, and no discrepancies were found. Theoretical triangulation to analyze the data side by side also helped understand the emerging themes. In addition to ensuring credibility, analyzed findings from studies also helped to put the data in perspective. No significant adjustments to the initial strategy discussed in Chapter 3 were necessary.

Transferability of Results

Each participant was chosen because they met the criteria. Analysis commenced after saturation was complete and emerging themes were prominent. By structuring the survey questions to draw out rich descriptive data, the interpretation of the information helped establish transferability. By aligning most of the information discussed in the literature review section, many elements and themes can be applied to the findings in this study. In short, the data was reviewed meticulously to ensure transferability was present.

Dependability from Emerging Data

A thick, detailed description of emerging data continuously replicated throughout data analysis helped establish dependability. The theoretical triangulation technique was also employed to ensure the analysis of data and interpretation of collected data were not compromised. Additionally, by cross-referencing and cross-checking, dependability was established. However, the most prominent evidence to satisfy dependability was established when participants of this study responded to the follow-up emails constructed to ensure their data responses had been interpreted correctly. Additionally, many of the survey responses were supported by findings of recent studies and existing literature that examined healthcare equity problems. By applying Heidegger's circle (1967) helped me to analyze emerging data ensuring techniques were being used appropriately and that all interpreted data was true and correct (see Heidegger, 1967).

Confirmability Through Reliable Strategies

Confirmability was established through carefully analyzing data for accuracy, coding correctly, and ensuring appropriate titles matched the emerging themes through the coding process. Additionally, throughout this research study, detailed descriptions of every step of the process by implementing an audit trail that helped establish confirmability. By implementing an audit trail, details within the emerging data were comprehensible and explained much of the themes to confirm rigor. Moreover, the audit trail supported the study's findings -for possible further research- which were conceptually grounded, each step of the research was noted. Finally, Walden University's

IRB approved all forms, tools, resources, and documents used in this study. Finally, to further establish credibility, interview checking, and triangulation were necessary.

Results

During the initial data analysis process, there was skepticism about whether saturation would have been established due to the COVID-19 pandemics' adverse effects on the sample population; however, there were no problems with saturation. Although 19 surveys were collected, it was clear that no new surveys would influence new themes or categories; therefore, recruitment ended. Six surveys either did not include enough data to correlate a conclusion or theme, or the potential participant did not align with the stipulations outlined in the criteria. The information included in this section contains information and direct quotes from 13 of the participants who met the criteria and provided enough information to satisfy saturation for this study.

Many participants listed high blood pressure, diabetes, and asthma as underlying medical conditions. In contrast, some participants did not disclose any underlying medical conditions. Most of the respondents answered many of the 12 questions, of which all were optional. Each respondent automatically received a copy of the survey. However, those who responded to any of the inclusion questions selecting "no" were sent an email notifying them that they did not meet the criteria and that their survey would be deleted. The printed version of the survey is included in this report (see Appendix C). The inclusion questions are numbered 2-7 in section 2 on the survey link and are attached to this report (see Appendix B).

The categories and themes were developed by thoroughly analyzing the data for commonalities vertically and horizontally. The completed surveys were briefly hand-coded -after familiarization- then downloaded from Microsoft Excel and uploaded to the NVivo application for data analysis and coding. The themes developed through the data analysis were aligned with the factors associated with this study and the research questions. Several themes and subthemes emerged throughout the data analysis; below is a table containing these themes and subthemes, followed by the research questions and the coded data from the survey responses within their respective themes. The dominant themes and subthemes are presented in the following table on the next page (see Table 2):

Table 2*Dominant Themes and Subthemes*

Dominant themes	Subtheme A	Subtheme B	Subtheme C
Theme 1: Underlying medical conditions and repeated visits to a medical facility	Subtheme 1a: Perception of implicit bias assuming neglect of conditions	Subtheme 1b: Not taken seriously	
Theme 2: Quality of care and how I am viewed	Subtheme 2a: Healthcare Insurance	Subtheme 2b: Doctor's visit causes stress, anxiety, and additional medical conditions	
Theme 3: Bias based on assumptions affect my overall quality of life	Subtheme 3a: Racial bias by healthcare workers, staff, and administrators	Subtheme 3b: Bias encounters make medical conditions worse	
Theme 4: Communication and health equity is substandard	Subtheme 4a: Healthcare professionals can be condescending	Subtheme 4b: Bias tones based on assumptions	Subtheme 4c: Mistrust

The completed surveys were briefly hand-coded -after familiarization- then downloaded from Microsoft Excel and uploaded to the NVivo application for data analysis and coding. Hand-coding the raw data set was not as thorough as using the NVivo software application, so there were substantially fewer categories and codes. For this reason, the raw data was entered into the NVivo application for complete coding. NVivo noted 207 codes from surveys. Then, a word-count document was constructed using the raw data from the surveys (see Appendix D).

Research Question 1

RQ1: To what extent do patients who identified with comorbidities or underlying medical conditions and who visited healthcare facilities during the COVID-19 pandemic experience implicit bias?

Below is the dominant theme for RQ1, followed by subthemes in which the survey responses were all summarized, and quotes from the respondents were included to provide a compelling, clear lens into the participants lived experience.

Theme 1: Underlying Medical Conditions and Repeated Visits to a Medical Facility

The initial theme generated the subthemes to explore the extent of healthcare facility visits caused by the participant's comorbidities or underlying medical conditions (pre-existing conditions). Emerging themes within the data indicated that some respondents continually visited healthcare facilities for treatment. Although the words, implicit bias, was not identified as a common theme within the data set, racial discrimination was referenced. The most notable quotes from the data set provided a lens into the participants' lived experiences to examine the correlation of themes within this question. In Assessing the significance of the question, the most detailed emerging themes had provided a glimpse into these experiences; for example, Participant 1 stated, "I was racially discriminated against. Whenever I go to the emergency department with airway problems, I see White people get seen ahead of me with less emergent of an issue."

Participant 3 noted a similar experience stating, "nurse not wanting to help me or overlooking me due to being African American rush to help a White man." The design

and content of the survey questions helped code the data and develop these significant themes with no issues. However, the questions were similar; therefore, responses overlapping had emerged; for example, Participant 13 shared an experience of discrimination that triggered other underlying conditions. This response from the participant is also relevant within other subthemes as the impact of racial discrimination in a medical setting caused further problems. Additionally, Participant 1 shared the following experience:

I frequently go to the emergency department because I have reactive allergic asthma exacerbation attacks. During my episodes of acute asthma attacks, I need breathing treatments hourly. In 2020, I went to the emergency department with wheezing, shortness of breath, and dyspnea. When I arrived at the Emergency Department, the nurse asked the frequently asked questions like have you had a fever, nausea, or loss of taste. I told the lady no and that I could not breathe. The lady took my vitals, and my heart rate was 125, oxygen saturation was 88%. My oxygen saturation was low. I was sent out to the lobby and told to wait; I screamed I can't breathe. The lady looked at me and said that 88% is probably my norm and to wait in the lobby until a room is available. I waited 2 hours in the lobby, and after 2 hours, I passed out because my airway closed. I had to be emergently intubated.

Similarly, Participant 10 stated, "Yes, it appeared others were given more of a priority for similar or less severe conditions." The participants were detailed in responding to the survey questions, and as the stories were compelling, they were similar.

Frequent medical facility visits by the participants for care were confirmed and aligned with the research question. The participants perceived that their inadequate treatment involved a level of implicit bias due to their ethnicity.

Subtheme 1a: Perception of Implicit Bias Assuming Neglect of Conditions. A common theme was that the participants believed that medical facility staff had not properly cared for their underlying conditions. There was also a fear of stigma. Some participants indicated that they had been questioned by medical staff about their medical condition to imply the participant had been neglectful of their health. Several participants discussed healthcare encounters in which they explained how a lack of empathy from doctors had made them feel as if their medical conditions were their own fault. As such, Participant 4 pointed to this neglect from caregivers and stated:

I'm very disturbed every doctor visit I have due to the waiting process being so long and my doctor telling me because of my health issues; I'm never going to lose weight, so she doesn't think dieting would be good for me and to stop trying. I've been working on my health with my doctors, and they don't have any positive feedback. I'm always the first one in at the doctor's office for my appointment and the last one out. The doctor would send meds to a pharmacy that I don't ask for; when I tell them I refuse to take such medication, they still send it against my will.

Also, in response to perceived neglect, Participant 7 stated, "I would include that a psychoanalyst is present in each room during diagnosis due to issues with mental health and it being ignored." Participant 2 suggested that healthcare professionals had neglected

underlying conditions as Participant 4 had also done within a survey response. While Participant 6 explained that he/she was “Denied medications because pain isn’t perceived to be extreme,” specifically when responding to SQ2 that addressed the perception of medical bias due to comorbidities or underlying medical conditions during the COVID-19 pandemic. Also, in response to the survey question addressing RQ1, Participant 10 shared a similar experience during a visit to a healthcare facility stating, “I was made to feel like my medical problems were unimportant” and “I was rushed out the door without a proper evaluation.” Participant 10 also wrote, “I mentioned my history, and it was constantly being misinterpreted as non-severe,” in response to a similar survey question designed to address RQ1.

Throughout history, researchers have discovered that various cultures were susceptible to certain debilitating diseases and medical conditions while others were not (Idossa et al., 2018). Assuming medical professionals are familiar with this information, and according to the survey responses from this study, healthcare workers may predict ailments by looking at a patient and their medical history. Participant 9 shared an account of being inadequately examined, stating, “the doctors didn’t give me a full workup and didn’t explain why I wasn’t given certain meds. They both were very vague about my illness as to why they didn’t approve certain meds,” when responding to a question on the survey which inquired about comorbidities, underlying conditions and the perception of implicit bias.

Subtheme 1b: Not Taken Seriously. Several participants had described how they thought their ailments were not considered urgent or taken seriously. One

respondent recounted an incident where medical staff had them seated in the hospital emergency room for hours while they struggled to breathe due to a chronic condition. Participant 1 stated that their health-related concerns were “not taken seriously,” Further stating, “I feel like health care providers do not listen to me nor take my symptoms seriously.” Participant 13 explained a similar experience regarding medical staff who disregarded their health-related concerns, stating:

I was in the emergency room due to fainting at home. When I arrived at the hospital, the emergency room was packed. I was put in the middle of the floor with a mask on across from someone who had COVID. They asked a few questions and ruled out that I had vertigo; they dismissed my symptoms and sent me home. When I went to my primary care Dr., they said it was anxiety. I feel they rushed my visit in order to try to remove me from the ER. Keep in mind that I was never given a COVID test in the ER to see if I had COVID. They simply diagnosed me with a past diagnosis and rushed me out.

Similarly, Participant 1 shared, “I had to wait for an extended period of time to be seen.” Ultimately alluding to experiencing implicit bias stating that “my discomfort level and distress were not considered.” Participant 10 shared a similar experience and a communicative challenge and noted, “I mentioned my history, and it was constantly being misinterpreted as not severe.” Many participants explained how medical staff misinterpreted much of their verbally stated symptoms and felt their voices were not being heard. Participant 12 stated, “My pain was not taken seriously. A doctor even told me that my pain can’t really be a 10 on a scale, from 1 being very little pain and 10 being

the worst pain of my life.” Participant 10 shared a similar experience, stating, “I was told my condition was not severe and I was not experiencing discomfort, and I was. My symptoms were being downplayed.”

The participants shared similar lived experiences of perceived implicit bias amidst these emerged themes identified during data analysis. Many of the participants noted their conditions in detail. Although all the participants experienced implicit bias during a healthcare visit, several of the participants noted that they experienced implicit bias on more than one occasion. It is important to note that only the more impactful responses from the participants were summarized and used in the final write-up of this study, as many of the questions and responses overlapped or were redundant. However, the overall is to provide a glimpse of experiences from the patient’s perspective. Within the emerging data, the experience of implicit bias was also identified within the dismissal of symptoms by medical professionals. Many of the participants alluded to the idea of racial discrimination and explained in detail that their health concerns were not taken seriously due to their ethnicity.

Research Question 2

To what extent do patients believe that their underlining medical conditions affect the quality of care received and how they are perceived because of these conditions during their healthcare visits? Below is the dominant theme for research question 2, followed by subthemes in which the survey responses were all summarized, and quotes from the respondents were included to provide a clear lens into the participants lived experience.

Theme 2: Quality of Care and How I Am Viewed

Emerging data showed the impact of the quality of care provided within a medical setting. The data set revealed how respondents viewed their lived experience of bias by detailed accounts of these healthcare-related visits concerning healthcare inequities. Additionally, the participants noted the many challenges of not receiving quality care and how it affected their health. Not only did some of the respondents note the perceived racial disparities regarding their lived experiences when seeking medical care, but many of them also noted emerging or exacerbated underlying conditions that were caused by their adverse interaction with a medical professional.

Participant 5 noted, “I believe because many people of my nationality have high blood pressure and diabetes. It is not looked upon with any sense of urgency.” While Participant 13 stated, “My anxiety and depression have become very severe because I am afraid to go to any medical facility and receive the rushed, lack of care, and higher chances of catching covid. I try to avoid medical facilities as much as possible.” Participant 1 shared a similar sentiment concerning an underlying medical condition having something to do with the quality of care received and how the medical professional treated them. Participant 1 responded to one of the survey questions regarding healthcare equity, stating, “I do believe that my pre-existence condition caused some delay in my care.” Participant 8 also gave a detailed description in which Participant 8 shared the following lived experience:

My doctor simply gave me pills to help, while my white friend was given a regimen such as exercises, diet, and instructions on how long to take the pills.

When I asked my doctor what the difference was, he said, oh yeah, you should do those things. Why wasn't I given the same instructions from the beginning?

Likewise, regarding how participants were viewed and mistreated during healthcare visits, Participant 11 reported how their healthcare concerns were dismissed. Participant 11 implied communicative challenges stating, "nurses didn't respond to my calls for help" and "they were ignoring my concerns and complaints." Similarly, Participant 12 stated, "a nurse literally told me that I do not look like my pain is a 10/10. I should not get upset after waiting over an hour for my pain medication when the patients with COVID are dying," in response to a survey question addressing the dismissal of health-related concerns. Additionally, as many of the participants stated in detail that they believe their underlying medical conditions had also played a role in their perception of medical bias encounters; in contrast, in response to this, Participant 7 responded, "Lack of treatment and rude treatment from physicians. I never saw an actual doctor."

Subtheme 2a: Healthcare Insurance. Another emerging theme indicated that some participants were less likely to receive satisfying care from a healthcare facility and were often worried about how medical staff had viewed them because of the type of insurance they provided. Interestingly, Participant 1 shared, "I believe if I were White with good insurance, my symptoms would have been taken seriously." Participant 7 includes, "I have the lowest medical insurance, and I feel like I do not receive the best treatment as well as the fact that I am Black." While Participant 8 reported, "White customers at my doctor's office get treated like royalty, it comes off as I'm just an insurance payment when I'm there." Although data were limited concerning healthcare

insurance and policy knowledge, the few statements that the participants provided on the survey were insightful. Additionally, participants were able to provide a lens into an economic lived experience concerning implicit bias by discussing the level of healthcare insurance.

Subtheme 2b: Doctor’s Visit Causing Stress, Anxiety, and Additional Medical Conditions. Some participants stated that they had experienced anxiety during their visits to their healthcare facilities and hospital emergency rooms, implying that healthcare facilities are stressful environments. After completing these healthcare visits, some respondents stated that some of the experiences caused further anxiety and stress, triggering depression. Participant 1 stated, “Because the nurse did nothing, didn’t listen to me, and didn’t take my symptoms seriously, I have an anoxic brain injury.” Participant 13 also experienced additional medical conditions to worsen and stated:

My anxiety and depression have become very severe because I am afraid to go to any medical facility and receive the rushed treatment, lack of care, and there are higher chances of catching COVID. I try to avoid medical facilities as much as possible.

Participant 9 responded to a similar survey question that addressed the quality of care received when visiting a medical facility to treat underlying medical conditions implying inadequate treatment caused further damage due to poor substandard care. Participant 9 wrote, “I wasn’t able to see or even follow up with the doctors. I was given pain meds, which caused me to have problems with my liver and kidney. I kept having to go to the emergency room.” The extent to which patients believed their underlining

medical conditions affect the quality of care was noted in many participants' responses, indicating an overlapping theme of problems within the quality of care received and how the participants because of their comorbidities or underlying conditions.

Research Question 3

Given the impact of COVID-19, how do patients perceive their implicit bias encounters, and how do these encounters impact their quality of life? Below is the dominant theme for research question 3, followed by subthemes. The survey responses were all summarized, and quotes from the respondents were included to provide a clear lens into the participants' lived experience.

Theme 3: Bias Based on Assumptions Affect My Overall Quality of Life

In analyzing the responses from the data, the quality of life for the respondent is compromised in an adversarial capacity when experiencing what they explained as implicit bias encounters within a healthcare setting. Participant 9 stated that the negative lived experience encountered while seeking healthcare caused other ailments or exacerbated pre-existing conditions. Participant 9 shared, "All of this caused me to have depression and anxiety." As with most of the responses, many of the participants implied that their experiences caused undue stress and other health-related complications.

Participant 13 described how a negative lived experience compromised their quality of life during a healthcare visit stating the following:

It was compromised where I didn't even want to be around family and friends. I pretty much isolated myself in my bedroom and only left my room because I was attending to my grandchild. COVID has impacted my family in a hugely negative

way, with no trust in the health system in fear that we won't receive the same treatment as everyone one else.

Participant 2 shared an incident when seeking healthcare treatment, implying that COVID-19 may have played a role in poor treatment received while waiting to be seen by a doctor. Additionally, Participant 2 shared a "Delay of care due to being placed in isolation. People were afraid to enter the room" during their healthcare visit. Participant 2 also implied that the experience caused unwanted stress and compromised their quality of life. Participant 8 shared a detailed event in which their quality of life was also compromised. Participant 8 wrote:

My quality of life was compromised for a variety of reasons. Obviously, the mental aspects of being home constantly were tough enough but having to do phone/video calls when my White friends seemed to still go into the Drs. Office, I felt slighted.

During a visit to a healthcare facility, Participant 8 reported an incident with medical staff to a healthcare administrator, resulting in the following action: participant 8 wrote, "they denied that happening and would be more cognizant going forward and apologized." Participant 8 went on to explain that the incident had been addressed, and medical staff seemed "cognizant" of the situation and thought that things would get better, "but then it was back to business as usual," Participant 8 stated. Meanwhile, Participant 12 shared, "The way healthcare workers treat people with sickle cell patients. I was treated like I was a drug addict. I was treated like my health needs did not matter."

Participant 11 stated, “I’ve been in their care for months. If my heart is weak, why don’t they give me a laser? And why is my pneumonia not getting better? I don’t understand.”

The overall theme that quality of life for many participants has many similarities in that they share negative experiences. Participant 1 stated, “Due to the lack of immediate care, I suffered an anoxic brain injury because my brain did not receive oxygen for greater than 15 minutes. It has taken me over a year to work on talking, focusing, coordination and vision.” The compromise of the participants’ lives after experiencing implicit bias from a healthcare facility is aligned with the idea that the research questions are valid and can be answered.

Subtheme 3a: Racial Bias by Healthcare Workers, Staff, and Administrators.

Most participants of this study either implied or stated that they would have received better medical treatment if they were not Black. Some participants also implied that multiple visits to healthcare facilities, including emergency rooms, sometimes worsen and cause other problems. However, all the participants believe that they have experienced implicit bias. Participant 8 noted the difference with a White friend who visited the same medical doctor for the same treatment. Participant 8 stated, “I believe if I had been given the same attention and detail as my White friend, I could have achieved my goals of losing weight, diet, and working out. I was only given pills and how many to take a day.”

When asked to discuss formal complaints to leadership about adverse experiences with medical staff on the survey, Participant 1 responded, “I am scared that if I do, I won’t be able to seek treatment at the hospital anymore.” Additionally, Participant 1

stated that they were not familiar with healthcare facility policies as many other participants stated. Participant 3 shared communication issues as well as feelings of implicit bias, stating they had experienced “rudeness” because “the nurse was taking other people before me that came in after me because I’m African American.” The fear of retribution and retaliation was apparent in many of the survey responses as Participant 5 stated, “I did not complain formally due to not knowing who would be interested in hearing my concerns and taking them seriously.”

Participant 6 also shared an experience of what was perceived as racial discrimination by a healthcare provider, stating, “I was told to just get over my emotional trauma and denied referrals.” They added that “I was denied a medical exemption after having an allergic reaction to the pneumonia vaccine,” as their healthcare concerns were dismissed by a healthcare professional. Participant 9 stated, “they didn’t want to treat me because I’m Black. Made me feel like I wasn’t worthy of being cared for,” when describing a biased encounter within a healthcare setting. Participant 11 shares a lived experience while battling a severe illness stating the following:

I went to my primary care doctor’s appointment. I was having difficulty breathing, lost a lot of weight, and felt weak. He prescribed me some medication and said to take the medicine, and I would be okay as he made a lot of jokes. My friend was with me and asked the doctor did he think I might need oxygen and if I was dehydrated. I was so weak and couldn’t breathe. All he did was ask his nurse to bring a cup of water.

Notably, the participants of this study had experienced some forms of implicit bias either with their primary care doctors or when taken to a hospital emergency room.

Participant 11 explained that after receiving inadequate care from a primary doctor:

My friend took me to the emergency room. They put me on oxygen and hooked me to an IV to get fluids in me. I had pneumonia and was badly dehydrated. If my friend hadn't taken me to the hospital emergency room, I wouldn't have made it. My pneumonia is not getting better, and my heart is very weak, and I can't walk now. I have been emergency for a month in the hallway cold, feeling very sick. I don't have covid. Then the hospital sent me to rehabilitation for weeks and didn't allow any visits. I haven't seen any family in months. I got worse, so now I'm back in the hospital. On an IV again to input some nourishment in my body. I seem to be getting worse.

Participant 11 concluded this detailed yet compelling narrative and stated:

I believe because I'm African American, they seem to overlook me and leave me in the corner of the hallway cold when I need some help. I don't know what to, or my does my family; they live out of state. I'm getting sicker, and they seem not to be doing anything to help me.

Additionally, when addressing complaints made to healthcare leadership about negative healthcare experiences, Participant 12 responded to the survey question and wrote "Yes," they had complained to leadership, "but hospital administrators ignored my concern." Then later addressed another research question stating, "I know to complain to customer service and hospital administrators, but if nursing and doctors find out, I will

get ignored more.” Many of the participants’ responses to implicit bias encounters with healthcare professionals are detailed.

Moreover, a particular survey question asks them to explain their perception of racial discrimination during their healthcare visit. However, instead of defining racial discrimination, many of the participants gave in-depth examples of their experiences of discrimination. Moreover, many of the participants alluded that racial discrimination and communication issues fall back on the leadership of the healthcare facility.

In addition, in response to this research question, Participant 5 wrote of an incident involving medication. Participant 5 stated, “I was told that I could get back to the regular treatment at a later date, and just because I have had diabetes prior to 2020, it doesn’t mean that I don’t need my regular medication or treatment.” Ultimately, Participant 5 reported similarly, “It is as if my care is not a priority at this point.” Some participants reported that leadership addressed complaints about what they perceived as racial discrimination encounters. As such, Participant 13 addressed the survey question about leadership and communication:

I have complained, reported to doctors, customer service, front desk as well as to the individual themselves. It’s frustrating that we have come to this extent to make ourselves heard. But instead, when we are forced to report these types of matter, we are frowned upon when doing so. I have seen others (non-Black) complain, yell, toss items, disrespect patients and doctors that get away with doing so, and get seen.

Subtheme 3b: Bias Encounters Make Medical Conditions Worse. Bias

experiences caused many participants to be reluctant to visit a healthcare facility. It is not uncommon that people are hesitant to visit a doctor when sick. Some participants implied that they sometimes do not see a medical professional and stay home only later to find their condition has worsened. Participant 13 explained, “I have experienced discrimination that triggered my depression and anxiety.” As with other participants, these negative experiences cause stress and uncertainty. Participant 1 wrote, “I needed rehab; my anoxic brain injury made me have to relearn a lot of things.” Participant 3 noted, “my pressure got higher due to the stress of being mistreated.”

Additionally, Participant 6 stated, “Being denied pain medication makes me feel worst.” Participant 9 wrote, “All of this,” referencing a negative lived experience in a medical facility, “caused me to have depression and anxiety,” and the additional medical conditions resulting in this negative experience. During a healthcare encounter Participant, 11 stated that “they seemed not to be concerned that my heart was getting weaker,” further insinuating neglect stating, “They would leave in the hallway cold in the corner and didn’t check on me.” Participant 12 shared a similar experience, “I was neglected so badly by the hospital staff that I had to be put on ketamine for pain control and transferred to a higher level of care too. This is not common.”

Given the impact of COVID-19, many of the participants perceived their implicit bias encounters within a healthcare setting were impactful, which caused a compromise within their quality of life. Many participants shared accounts of how these experiences eventually caused an undesirable feeling of stress, anxiety, or both. Even when reporting

these negative encounters to healthcare leadership, many of their concerns were ignored, causing fear of retribution and uncertainty. Participant 7 gave an account of racial discrimination when seeking medical care reporting unfair treatment and stating, “I never received treatment from an actual doctor. I was passed off to nurse practitioners and sent home without pain medication for painful illnesses.” Consequently, the adverse effects of medical treatment neglect are prevalent in these cases, ultimately causing further damage and indiscriminately affecting daily life.

Research Question 4

How do patients describe challenges with communicating with healthcare workers, and to what extent do they believe challenges affect their overall health equity? Below is the dominant theme for RQ2, followed by subthemes. The survey responses were all summarized, and quotes from the respondents were included to provide a clear lens into the participants’ lived experience.

Theme 4: Communication and Health Equity is Substandard

The common theme of communication was that the participants felt that the healthcare practitioners were not listening to their health concerns. Many participants stated that they felt rushed and felt as though they were complaining and did not want to feel like a burden. Stigma seemed to be a concern with several of the participants in that they were concerned about how healthcare workers viewed them, also implying that it was in their best interest not to complain. However, some participants did disclose what initially caused them to visit a healthcare facility emergency room. Although there was an experience of bias, some participants noted that the COVID-19 pandemic may have

caused stress on the medical staff, which contributed to their negative encounter; contrariwise, they also stated that there is a problem with training, professionalism, and leadership. Participant 13 described a confrontational experience in which the following occurred during a healthcare visit:

I think it was because I am Afro-American because though after a few minutes of disputing with the front desk, the DR agreed to take me after all. After speaking with my medical assistant, she stated that my appointment was given to someone else. This caused my anxiety, trust, anger, and depression to deepen because of the extent that I had to express in order to get seen.

Participant 5 noted:

I believe I was in double jeopardy given the fact I had concerns about COVID as well as my underlying condition. It was so difficult to get an appointment in my community. It just seemed like the medical staff was unavailable to care for patients.

Participant 5 also wrote that, “Due to being a diabetic, my healthcare provider has not seemed concerned with me not having regular appointments. It is as if the disease has been there and is not anyone’s greatest concern because of COVID.” Additionally, Participant 6 stated, “Black patients do not receive treatment like other races.” When explaining a communicative challenge, Participant 8 shared:

My white friend and I wanted to see the difference with a phone call back-to-back. When he called, it was yes, when can you come in. When I phoned, it was, well, it would be better if we do a video call ... huh?

When explaining a communicative challenge dismissing a health concern Participant 9 wrote, “In regard to diabetes, I was told to take Metformin and change my diet. It took weeks to get the appointment; then, it was over the phone. The nurses who answered seemed as if they didn’t care like I was being bothersome.” Likewise, Participant 11 responded to a similar question sharing:

My primary doctor never took any test but diagnosed me and prescribed me something for a stomach virus when I came in for my doctor’s appointment. When I went to emergency, they found I had pneumonia and a very slow heartbeat. But no stomach virus.

Participant 12 responded to a similar medical neglect experience stating, “I had to wait over an hour for pain medication; my oxygen requirements increased because of the amount of pain I had.” Participant 12 also perceived a communication challenge that caused additional pain and suffering, stating, “I had to be transferred to a higher level of care; I needed a ketamine gtt.” As such, Participant 13 shared the following experience regarding a communicative challenge during a health-related visit in which the participant explained that their complaints of mistreatment were relayed to “doctors, customer service,” and other medical staff, further implying that these complaints were ignored.

Participant 7 stated, “I was sitting in the waiting room in pain for 4 hours, so I was drawn to tears by the time I made it inside, and the nurse practitioner looked at me as though I was complaining, but I was in pain due to my kidneys.” Consequently, communication is a vital factor in receiving medical care. Many participants explained

the repercussions of experiencing negative verbal responses when interacting with medical professionals. Participants reported additional pain and suffering because of the communication challenge involving a medical visit citing, “I felt abandoned and frightened, and I knew the healthcare professionals were doing their best; however, I still needed that medical interaction.” Participant 5 also recognized the effects of COVID-19 on the workers stating, “I cannot compare the enormous responsibility this pandemic has been on the healthcare system and workers.”

Subtheme 4a: Healthcare Professionals Can Be Condescending. Furthermore, when it came to communication between the healthcare workers, a common theme indicated that some of the staff used a condescending tone when the participant asked a question. The data also indicated that the participants perceived some healthcare workers as condescending to the point that they were insulting and hurtful. Participant 13 shared an experience when attempting to make an appointment for medical treatment, indicating a significant breach of communication. Participant 13 noted, “The treatment over the phone was not professional; the tone was loud. I still proceeded to make my appointment and was given two different set times. I picked the latest due to having to gather paperwork earlier that day.”

When explaining the steps that took place after the appointment was made, Participant 13 wrote:

I packed lunch for my grandchild, parked in front of the facility, and called to check-in for my appointment from the parking lot. When doing this, I was told I did not have an appointment and was told to reschedule. As I proceeded to tell

them they did arrange my appointment, she hung up. So, I decided to walk in person, bypass the entry door, and tell the front desk they were inappropriate for hanging up on me.

Additionally, Participant 13 commented on why racial bias played a role in a negative experience:

I think it was because I am Afro-American because though after a few minutes of disputing with the front desk, the doctor agreed to take me after all. After speaking with the medical assistant, she stated that my appointment was given to someone else. This caused my anxiety, trust, anger, and depression to deepen because of the extent that I had to express to get seen.

Interestingly, condescending tones are prevalent in many survey responses and unsurprisingly overlap with many other themes. As noted in many participants' responses, the perception of bias can also come from someone who condescendingly speaks to others. When explaining an encounter while seeking an appointment for physical therapy, Participant 9 stated, "the physical therapist was very insistent that I not get an appointment in the pool for aqua therapy" as a medical treatment.

Subtheme 4b: Bias Tones Based on Assumptions. The participants often experienced biased tones from healthcare workers of different races/ethnicities other than African Americans. Many of the participants felt as if they were being judged based on their race and comorbidities. Participant 1 stated, "I was looked at by a nurse and told 88% oxygen is probably normal for me. That is not a normal oxygen saturation." Additionally, Participant 2 responded, "I am overweight, and with covid and restrictions,

I had to be placed on precautions. The staff would take their time to come into the room.” Participant 2 further stated, “Nurses with similar ethnicity treated me better than their counterparts,” and “Sometimes my anxiety of not being able to breathe gets overlooked and labeled as drug-seeking.”

Participant 5 stated, “I believe because many people of my nationality have high blood pressure and diabetes. It is not looked upon with any sense of urgency.” Participant 7 responded similarly to the same survey question, stating, “I never received treatment from an actual doctor. I was passed off to nurse practitioners and sent home without pain medication for a painful illness.” Participant 7 stated, “I was suffering from kidney stones and did not receive the proper diagnoses or medication.” Participant 9 shared an experience when addressing a perceived racial discrimination encounter within healthcare, “I wanted aqua therapy, and the therapist was quite adamant about me not going and suggested that my son pay for me to go to the gym. instead.” Participant 12 shared that same sentiment stating:

Medical literature states that African American people’s pain should not be taken seriously and should be the last priority. During my two hospital admissions during the height of COVID, my pain was not taken seriously, and I was their last priority.

Subtheme 4c: Mistrust. The participants in this study provided detailed accounts about their lived experiences during a perceived bias encounter with a healthcare worker. There are trust and communication issues, according to the coded data. In further exploring mistrust, Participant 13 described their reluctance to visit healthcare facilities:

I still have anxiety issues and trust issues when it comes to health care because I am not equally treated. There also needs to be more Spanish speakers and different ethnic backgrounds to help accommodate the patient's needs and make patients feel comfortable attending or being seen at the facility.

Participant 13 also stated that because of receiving unprofessional healthcare, not only was trust an issue, "my anxiety, trust, anger, and depression to deepen." Mistrust was a reoccurring implied point in many of the survey responses. When addressing uncertainty and trust, Participant 7 responded, "I still feel the same and do not wish to even return to the hospital." Many participants explained various challenges and experiences with communicating with healthcare workers, implying that their experiences had adversely compromised their overall health equity. Participant 8 stated, "The healthcare delivery system needs a total overhaul on how it treats all people;" this sentiment was shared by most of the volunteers who participated in this study. Mistrust was prevalent throughout the responses and appeared to impact treatment and future treatments, as respondents reported.

Participant Recommendations

The survey asked participants to explain what changes they thought were needed (recommendations) in healthcare delivery systems. Participant 1 stated, "All people be treated equally and not based on past treatment, whether they can pay the hospital bill." Participant 1 further added, "With the volume of patients coming to the Emergency Department because of covid, I feel like many sick Black people died because their symptoms were ignored." Participant 3 replied, "They should help everyone in the order

that they come in, and color should not matter.” Participant 5 recommended, “healthcare must be accessible to all persons regardless of status.” Participant 5 also added a statement under the last question on the survey -which asked for additional information- stating, “I cannot compare the enormous responsibility this pandemic has been on the healthcare system and workers.”

Additionally, in response to the survey question asking the participants for suggestions on making changes to healthcare policies, Participant 6 replied, “A patient’s health is a priority.” Participant 7 suggested having a “psychoanalyst is present in each room during diagnosis due to issues with mental health and it being ignored.” Participant 8 indicated that “everyone should be created equal, and there has to be a law stating that! Also, doctors should recommend the same directives to each patient, meaning don’t tell one exactly what to do health-wise and another just take this pill.” In addition to this suggestion, Participant 8 also stated, “the healthcare delivery system needs a total overhaul on how it treats all people.”

Participant 9 recommended that changes are needed in the healthcare system, suggesting “all healthcare workers should be trained to not discriminate against people of color,” further stating, “I think it needs to be overhauled. A lot of new things have come about since COVID.” Participant 10 suggested “Listen to the patient and assist regardless of the perceived ability to pay,” and that “The delivery system should work for all.” Participant 11 implies that healthcare workers need humility, thereby stating that they should “show more concern for a human being no matter their or race.” When seeking medical care for “sickle cell,” patients should not be treated poorly, as implied by

Participant 12, in which the participant also stated, “I was treated like I was a drug addict. I was treated like my health needs did not matter.” In analyzing the many challenges extracted from the data, the essence of these recommendations hold validity to possible solutions.

Summary

The purpose of this study was to explore and describe the extent to which the phenomena of implicit bias influences healthcare services for African American adults aged 30 and over with comorbidities living in New York City during the COVID-19 pandemic. This chapter explored the perceptions of implicit bias in healthcare through the lenses of the participants chosen for this study. Also presented in this chapter was the methodology used to explore participants' survey responses. Additionally, the narrative summaries presented in this chapter's results section were constructed based on the survey data findings from 13 participants. One of the goals of conducting this study was to provide insight into the healthcare system for this demographic group by sharing the participant's stories, possibly influencing healthcare policy.

RQ1 focused on the extent to which the participants visited medical facilities and encountered bias during their visit. Some of the participants noted that they had no alternative but to visit a medical treatment facility more often than others due to conditions like, for example, chronic asthma and high blood pressure. Some participants reported biased encounters happening more than once during many of these visits. RQ2 explored the extent to which bias impacted the participant's underlying medical conditions, how these conditions impacted the quality of their healthcare visits, and how

medical professionals perceived them. While healthcare quality was reported as inadequate for many participants, some noted that their medical conditions had worsened.

RQ3 focused on the impact of COVID-19, inequity, and how bias encounters had impacted their quality of life. Many participants reported how their quality of life had been compromised resulting from bias encountered with medical staff, which caused or exacerbated additional pain, suffering, stress, anxiety, and depression during their visit. Research question four (RQ4) explored the participant's challenge of communicating with healthcare workers and healthcare policy knowledge. Much of the responses revealed communicative problems resulting from condescending jargon and blatant disregard for the patient's medical condition. Many of the participants also reported having minimal knowledge of healthcare policy.

The data collected determined the significant themes, for example, compromise of the quality of life and themes addressing a distinct disconnect between the African American community and the healthcare delivery system. Other themes explored were stress, mistrust, and not being taken seriously. The study results uncovered a complex New York City based healthcare system for this demographic group of participants, supporting other studies exploring healthcare bias. Respectively, no discrepancies or biases compromised the research findings, and participant anonymity was prioritized. Finally, the next chapter expounds on critical points discussed within this study; specifically, interpretations of findings, limitations, implications, and recommendations suitable in alignment with the interpreted research questions and responses from this study are presented in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore and describe the extent to which the phenomenon of implicit bias influences healthcare services for African American adults aged 30 and over with comorbidities living in New York City during the COVID-19 pandemic. One of the main objectives was to fill the gap in current literature by explicitly addressing healthcare equity for the African American population. Furthermore, a specific geographical population was sought out, and a sample was recruited for this phenomenological study to narrow the research population. I employed several data collection and analysis methods to construct themes from the emerging data. Additionally, in this exploratory phenomenological study, I examined the participants' lived experiences and the similarities in their stories. These similarities helped me categorize and develop meaningful themes —although some overlapping— that aligned with the research questions.

While analyzing the data, I discovered that some participants had not formally complained of their biased encounter due to a fear of retribution. The key findings that emerged from the data were consistent and supported current literature describing biases within the healthcare system, extending this discipline's knowledge. The data set revealed perceptions of discrimination, harmful conditions in medical facilities, and egregious compromises in the quality of life for many participants. Additionally, the findings revealed that having comorbidities or underlying medical conditions that caused many participants to visit healthcare facilities regularly impacted the quality of healthcare

received. The CDC's (2021c) research and reports align with the findings of my study, citing ethnicity, race, and commonalities factor into bias encounters within healthcare (see CDC, 2021c). My research findings can potentially influence changes in healthcare policy and social change throughout communities. In this chapter, I discuss these findings and provide recommendations.

Interpretation of the Findings

The findings of this study confirmed an ongoing problematic issue with implicit bias in the New York City healthcare delivery system for many African Americans. Not only did the findings demonstrate a complex system in New York City, but the findings were also aligned with many of the studies presented in Chapter 2 in the literature review. The participants involved in this study were anonymous, and the findings from the interviews are presented in this section. Despite increased awareness of bias in healthcare, the study reveals African Americans' perspectives of their lived experience, indicating that changes in healthcare policies are needed.

Moreover, the findings revealed that having comorbidities or underlying medical conditions like asthma, high blood pressure, chronic pain, which caused many participants to visit healthcare facilities regularly, impacted the quality of healthcare that they had received. More specifically, six of the 13 participants noted that they either had diabetes or were borderline diabetic. Three out of the 13 participants noted that they have asthma. Four out of the 13 participants noted high blood pressure. The participants noted high cholesterol, COPD, fatty liver disease, chronic migraine, and sickle cell anemia as comorbidities or underlying medical conditions. While five out of 13 participants were

familiar with healthcare policy, seven were not familiar with healthcare policy; one respondent wrote “N/A” in response to a survey question asking about healthcare policy knowledge. The following research questions were used to explore the problem and purpose of this study and are summarized using the findings of this study:

RQ1: To what extent do patients who identified with comorbidities or underlying medical conditions and who visited healthcare facilities during the COVID-19 pandemic experience implicit bias?

The reasons many of the participants regularly had visited healthcare facilities during the COVID-19 pandemic were due to comorbidities or underlying conditions. Participants also reported several bias encounters during visits to healthcare facilities, specifically hospital emergency rooms. Additionally, the data revealed that implicit bias encounters had placed unwanted burdens on the participants. Participants also described the challenges of being treated poorly during these visits noting the feeling of being “rushed” to clear the emergency room floor.

The findings also revealed that participants felt neglected and often concerned that their symptoms were not being treated properly and their concerns were not taken seriously. Ultimately, the study confirmed that biased encounters had impacted patients seeking healthcare services during the COVID-19 pandemic had experienced bias. However, because the research questions failed to explore whether these bias incidents had increased or decreased during the COVID-19 pandemic, it is unknown whether the pandemic had played a role in the number of bias occurrences for the participants. However, the CDC (2019b, 2020e) noted that socioeconomic status, comorbidities,

ethnicity, and race are risk factors that can negatively impact health. Ultimately the CDC's (2021c) reports are aligned with this study's findings in recognizing a significant problem with inequity in healthcare (see CDC, 2021c).

RQ2: To what extent do patients believe that their underlining medical conditions affect the quality of care received and how they are perceived because of these conditions during their healthcare visits?

Participants reported that they believed their race and medical conditions contributed to the quality of care during visits to healthcare facilities for services. Specifically, participants had described their visits for treatments as neglectful, implying that doctors were not correctly treating their conditions and misdiagnosing their symptoms, referencing the patient's history of visits. Additionally, as reported by the participants, there was no "sense of urgency" to provide treatment due to expectations of underlying conditions that affect African Americans. In addition to physical medical conditions that impacted the quality of care received, debilitating mental health conditions were reported by some participants. Finally, many participants stated that their experience with receiving less than standard care had caused additional physical problems, stress, and anxiety.

RQ3: Given the impact of COVID-19, how do patients perceive healthcare-related implicit bias encounters, and how did these encounters impact their quality of life?

The findings revealed that substandard healthcare quality could impact a person's quality of life. Participants reported several healthcare encounters that had impacted their

quality of life. Thus, the effects from their negative healthcare experience had crossed over into their personal lives, resulting in mood swings and notable changes in personality. These factors had impacted how they treated others. Additionally, some participants revealed that they had not complained about the poor treatment received during their healthcare visits due to fear of stigma and retaliation from medical staff, further causing uncertainty.

Consequently, patients who had not made a formal complaint about their negative healthcare encounters had also reported how the added stress caused a compromise in their overall quality of life. These experiences also exacerbated many of the participants' medical conditions, causing further damage to their preexisting condition. Patients perceived these implicit bias encounters as a hindrance to their quality of life.

RQ4: How do patients describe challenges with communicating with healthcare workers, and to what extent do they believe challenges affect their overall health equity?

The findings implied that the participants viewed their encounters as a breach of effective communication. They also described some of their encounters as disrespectful, citing, medical personnel had been condescending and discourteous. Participants also reported that they believed their implicit biased encounters were discriminatory and assumed that being African American had much to do with how they were spoken to or addressed by medical staff. Additionally, participants described being prejudged based on assumptions due to being African American and that these preconceived notions had caused much of the poor communication with medical staff. One participant had acknowledged the possible additional stress placed on medical staff due to the influx of

patients needing care for COVID-19, causing a breach in respectful and positive communication.

Subsequently, several participants had implied that trust, stigma, and uncertainty cause them to be reluctant to seek emergency medical care and that their communication challenges had negatively impacted their health equity. Figure 1 contains implications of bias encounters in healthcare based on the data set.

Figure 1

Key Terms



The findings of this study may influence changes in healthcare policy and social change throughout communities. This underrepresented group was found to have experienced highly biased confrontations within the healthcare system. Furthermore, when emerging themes appeared during the data analysis process, algorithms, uncertainties, racial discrimination, healthcare policy participation, leadership, and communication became more transparent as I captured a more precise understanding.

Implicit biases are not uncommon in society; however, having a more precise understanding of the impact of receiving substandard or bias-tainted care gave a robust understanding of the need for pragmatism. Another example was found in the Wyatt (2013) study of African Americans, which suggested that this population was less likely to receive equal treatment for pain than White Americans. The idea of being denied the fundamental human right to adequate health care was prevalent throughout my study data, which aligned with Wyatt's research findings (see Wyatt, 2013).

Additionally, Miller, Peek and Parker (2020) pointed out that allocation of resources is administered through algorithms that measure the severity of chronic comorbidities, emphasizing the disproportionate burden of chronic diseases several minority groups face. The researchers also suggested that these populations can be systematically deprioritized due to using allocating algorithm scoring. In comparison, Anderson et al. (2020) argued that the implications of treatment algorithms would cause health disparities like cancer to deteriorate further. These presented examples from the literature review section in Chapter 2 were prevalent and aligned with the evidence provided from this study's findings.

Furthermore, it is essential to highlight that the healthcare algorithm system may have played a vital role in some participants' treatment from healthcare workers. In further analysis of the literature review content, the comparability factors are aligned. The stories from the participants share a stark similarity to many current research findings presented within the literature review chapter suggesting that bias is a problem in

healthcare. The final analysis is that this study confirms recent literature and extends the body of knowledge for this discipline, promoting further investigation.

Applying Thematic Coding

After initial familiarization of the survey responses was completed, initial codes were identified. Themes for categories and subcategories during the analysis of the collected qualitative surveys were developed. Thematic coding was employed to review and interpret the data for findings. The following paragraphs further explain the techniques used to complete this study.

Heidegger's (1971) hermeneutic circle was used as a lens to move inductively from the participant's qualitatively coded units. The Hermeneutic Circle elements helped identify prominent representations of categories and themes until saturation had been satisfied and no other new information would make a difference in the findings. It is important to reiterate that the BMHS and SCPD guided this study. The research questions explored (a) whether a significant correlation exists between implicit bias and the New York City healthcare delivery system. Moreover, (b) how communication abilities, comorbidities, and other medical conditions influence services, thereby helping to rationalize whether current healthcare policies are effective for a specific population. Overall, the BMHS helped me to examine the relationship and the communication process between the patient and the healthcare system. As such, SCPD was employed to understand the participant's knowledge of policy and help to rationalize interactions of this study's participants who sought healthcare services.

The BMHS was used to gain a more transparent understanding of healthcare behaviors then associate these behaviors to the experiences of the targeted group from the patient's perspective. Much of what Andersen discussed within the BMHS was prevalent and had emerged during data analysis. Additionally, to get a more transparent and concise understanding of the problem on a larger spectrum, it was also necessary to employ the SCDP to explore how healthcare professionals' behaviors impacted the patients and influenced healthcare policy. By implementing these models into the study, a more rounded picture had developed while reviewing the findings, which left room for further study ideas.

The findings from this study were consistent with several elements of the theoretical framework of the BMHS. The BMHS holds that behaviors in healthcare are influenced by and include predisposing factors such as demographics; in this study, it was the racial identity of the participants. Also aligned with the BMHS regarding the targeted group for this study are enabling factors such as healthcare policies, leadership, communication, and factors such as comorbidities. Li et al. (2016) stated that the structure of the BMHS was designed to assess patients seeking healthcare services, implying that it is the ethical duty for healthcare systems to provide comprehensive service to their patients; this further validated the reasoning to conduct my research.

In short, Andersen's (1968) BMHS provided a strategic methodology that addressed behavior underpinning in a clinical setting (see Andersen, 1968); thereby, on a sociological level, the BMHS was practical in also identifying stigma as a possible influence in healthcare outcomes. The participants in the study instinctively provided a

plethora of information that aligned with the elements of the BMHS; therefore, the data was much easier to understand from a theoretical, pragmatic standpoint because it focusses on real issues that the participant's data had related. Applying the BMHS to this study to understand the phenomenon offered a lens that provided a more significant and broad view of possible implications if left ignored. Systematic reform of healthcare policies is aligned with the BMHS and the underpinnings of this research.

The importance of understanding Andersen's (1968) model aligns with the factors of African Americans obtaining equitable healthcare services during the COVID-19 pandemic; it addresses all patients regardless of demographics or characteristics. Specifically, Andersen's model addresses ethnicity, associated with implicit bias and communication between patients and healthcare systems (Andersen, 1995). The finding from this study was consistent with several elements of the theoretical framework of the BMHS. The BMHS implies that every person deserves fair and impartial healthcare services; through this lens and further research, the future for healthcare equity for all seems promising.

The importance of healthcare policy design is essential to how inequalities within the African American community are shaped. When exploring the effects of healthcare policy, the SCPD provided a lens that also helped to conceptualize the data. The findings had proven that this theoretical framework had been an asset to understanding the phenomenon from a political and public policy viewpoint. Although this study was not explicitly focused on healthcare policy as the problem, healthcare policy proved to be a significant underpinning dilemma as I was rationalizing the data themes. Like Andersen's

(1965) BMHS, Ingram and Schneider's (1993) SCPD also hold that people have the right to equitable healthcare. The findings of this study were aligned with SCPD in that the theoretic framework highlights the implications of policy. In addressing the issue of implicit bias, the collected data from the participants, reinforced Ingram, and Schneider's (1993) idea that some groups receive preferential treatment over others, further implying that policy design and political power have influenced this notion (see Ingram & Schneider, 1993).

Most of the participants in this study were not familiar with the healthcare policies of the facilities that they had experienced their implicit bias encounters with; this seemed to be consistent with the elements of SCPD and this target population, which brought further understanding of the problem. Therefore, it was necessary to fully understand the correlation of healthcare policy when examining perceptions of implicit bias. Ingram and Schneider (1993) argued the importance of shaping policy design that supports equity in healthcare services and healthcare policies could negatively impact the well-being of people and suggested that political leaders and policymakers can be biased in their views towards certain people. Ultimately, when examining the data and indulging in each theme that emerged, the constructs of SCPD helped me rationalize the responses on a participative policy level. Thus, according to Ingram and Schneider (1993), social constructs ultimately influenced policymakers; this idea further reinforces healthcare policymaking participation.

Limitations of the Study

Limitations to this study included not physically interviewing the participants to probe deeper for richer responses that would have been generated from the interview guide and one-on-one verbal communication. There was also no way to verify the identities of the participants, and scientifically examine the truthfulness of their responses. Creswell (2014) explained homogenous purposive sampling in his literature, which was instrumental in this study. The research samples collected from the surveys were coded; accordingly, measures were taken to control research bias. The generalizability of findings was limited due to the demographical area chosen for this study. The homogeneous purposive sampling methods were employed to seek out the participants' lived experiences to develop themes that help answer the research questions.

The sampling strategies chosen aligned with this phenomenological study; there was minimal interaction with the research participants as the population was recruited from social media, which did not limit the clarity of the emerging data as many of the responses were detailed and rich. Follow-up questions were not necessary during data analysis. The willingness of the participants to complete the survey in its entirety was not a vital factor, as reaching saturation was not a significant issue. The decision not to offer monetary payment or incentives did not impact the study. There was no trustworthiness issue during this study.

Recommendations

This study centered on inequities in healthcare, specifically perceived bias encounters between the healthcare seeker and the healthcare delivery system workers.

Although this study was limited to one geographical area, the results were insightful and provided rich qualitative accounts of bias encounters. I sought to recruit 8-20 participants that aligned with the criteria of this study to explore participant accounts of their implicit bias experiences. As such, 13 participants were qualified to join the study. Data was collected and analyzed from 13 qualitative surveys. After completing the data analysis stage, the results revealed a critical need for healthcare transparency in the New York City healthcare delivery system. The most profound similarity in the collected data was that some participants felt their health-related complaints were "being ignored," which caused further health complications. I then determined that further investigation on a broader scope would produce a more comprehensive lens, further highlighting the problem. Overall, several recommendations emerged after the data analysis was complete; this section summarizes the recommendation based on the research findings.

Der Kinderen et al. (2020) implied that the servant leadership approach would more likely benefit the patient's healthcare outcomes. I recommend that healthcare facilities review their leadership styles for effectiveness to this effect. Moreover, quarterly, or annual leadership training may enhance the communication between healthcare workers and those who seek medical care. Additionally, during this research, I concluded that leadership is essential to communication and are both critical skills needed in healthcare to shrink gaps in implicit bias and increase the effectiveness of healthcare delivery systems. The harmful ideologies of discrimination of any form have been proven to be detrimental and need attention. Although self-assessment and identifying

shortcomings may be helpful, it is not enough. Leadership is a critical component to successful patient healthcare outcomes and increased patient assurance.

Conversely, I had also concluded a correlation between inadequate treatment received from medical workers, the patient's overall health, and their quality of life. Not to exceed this study's boundaries, I recommend implementing healthcare policy modifications that consider all nationalities when constructing community healthcare guidelines to decrease disproportionate disparities. To that effect, there needs to be a way for African Americans to get involved in the decision-making process regarding the specific healthcare needs in their community. Noonan et al. (2016) conducted a study that found there was a lack of African American involvement in policymaking. The researcher also found that African Americans had not been included in many fiscal political positions, hence not participating in healthcare policy decision-making (Noonan et al., 2016). The Noonan et al.'s study supports my findings that more than half of the participants were not familiar with healthcare policy (see Noonan et al., 2016). Therefore, I recommend establishing a healthcare policy that includes cultural-based educational training and campaigns to recruit African Americans as healthcare policymakers.

Additionally, according to this study's findings, I recommend an accessible patient equal opportunity liaison -that carry a disinterested party title- in all healthcare facilities. Patients who experience biased encounters may feel more comfortable talking to a liaison who can act as a mediator on their behalf. Essentially, when negative biases are interpreted as offensive to the receiver, especially in healthcare, there also needs to be

a platform where the healthcare patient can anonymously report the incident without fear of repercussion.

Furthermore, I recommend reviewing the healthcare algorithm scoring system to ensure health equity is not being compromised and medical treatment and resources are not unfairly being administered. When paying for a service, there is an expectation of receiving a reasonable level of healthcare delivery satisfaction no matter the circumstances, demographic, or type of medical insurance. If it is a simple case of deciding who lives or who dies, the algorithm system implemented in the decision-making process in healthcare facilities should be reviewed and enhanced to meet the needs of all patients.

Ultimately, I realized that further research was needed during the data analysis phase of this study; my data set could have been broader regarding demographics and regions. More profoundly, the findings of this research indicated that there is a need for a larger-scale study that will examine healthcare-related negative experiences of a larger demographic. Additionally, with a broader geographical area, the findings may produce more meaningful outcomes. In short, the findings of this study have elucidated several critical elements that were overlooked in past studies. Despite the need for additional research, I comprised eight recommendations based on the findings of this study, which indicate the need for the following:

1. Create campaigns promoting African American involvement in healthcare policymaking.

2. Recruit more African Americans to become healthcare leaders and workers in all aspects of the medical field.
3. Review current healthcare algorithms for biases.
4. Review healthcare policies to ensure that the needs of the specific community are met.
5. Implement healthcare liaisons to act as mediators for patients in healthcare facilities.
6. Implement cultural sensitivity and leadership training within healthcare facilities.
7. Promote African Americans involvement in their healthcare community outreach programs.
8. Continue research in this discipline ensuring minimal limits to generalizability.

Implications Positive Social Change

This study's findings confirmed and were consistent with much of the literature review section in Chapter 2, suggesting a compromise within the healthcare system regarding health equity. Several implications emerged through the findings of this study. One implication is that the results of this study could positively influence social change throughout the healthcare system and communities across the world. Additionally, another implication resulting from this study can result in a more conducive system where communication, leadership, and policy within the healthcare community are considered.

Furthermore, the findings from this study are significant enough to add to the body of current literature regarding healthcare equity, which is a fundamental human right. The findings of this study were supported by meaningful data collected from the participants; these findings shrink a gap in research yet, suggest further exploration of implicit bias in healthcare is needed. Implementing sustainability strategies focusing on building a positive relationship with underrepresented communities could be this study's more profound methodological recommendation to influence positive implications that improve healthcare equity.

Consequently, positive social change implications may influence many outcomes that may benefit the healthcare industry (see Prevention, I. of M. (US) B. on H. P. and D., & Weissman, 1996). Along with my listed recommendations based on the findings of this research, I have also concluded possible outcomes that correlate with social change. In short, based on the findings of this study, by implementing sustainable strategies centered on the community's needs, the Table below -found on the next page- includes examples of possible outcomes that may be obtainable:

Table 3*Examples of Possible Outcomes that can lead to Social Change*

Quality of life possible outcomes	Quality of possible healthcare outcomes	Influence positive social change
Improved family interaction	Reduced health disparities and mortality rates	Leadership positivity and increased work productivity with the implementation of innovative groundbreaking training programs
Improved social interaction	Population health enhancement through improved health equity and an increase of community and cultural engagement	Increased community healthcare policymaking involvement
Healthier lifestyle and extended lifespan	Fewer misdiagnoses, more self-reporting and enhanced communications between patient and the healthcare system	Enhancement of healthcare policy to meet the needs of the community
Improved critical thinking, motivation, and job retention	More visits to primary care doctors and less emergency room visits	Implementation of programs focusing on community social determinants which can lead to increased community resources benefiting all unrepresentative cultures

Conclusion

In conclusion, this study, which explored an underrepresented group, sought to share the lived experiences of individuals who had encountered implicit bias while interacting with a healthcare professional. Consequently, “healthcare is a typical example where institutional racism occurs yet remains invisible” (Elias & Paradies, 2021 para. 13). Hence, the underpinning rationale for this study was to promote African American involvement in healthcare policymaking and provide education on the seriousness of extreme disparities of this under-representative population. This study examined the many similarities of 13 phenomenological qualitative surveys, which provided descriptive stories of participants’ negative healthcare experiences. This study’s findings aligned with the research questions.

The findings presented within this study were compared to current research literature. The comparison was made to construct the appropriate recommendations and determine if the findings would be beneficial in shrinking the gap in research, thus lending to the current body of scholarship. A unique distinction between how current policy aligned with the participants’ lived experience was also reported in this study. The literature reviews in Chapter 2 were significant in this study. Existing research literature provided a lens into the history of discrimination in healthcare, which helped me better understand this study’s findings and produce the recommendations in this chapter.

This study concluded with findings consistent with the existing studies I presented in Chapter 2, which examined bias and various aspects of discrimination in healthcare;

however, researchers had not thoroughly qualitatively shared the descriptive stories of those who had experienced lived encounters within their literature. Moreover, this study's findings indicate that further mental and physical trauma had been placed on one or more participants due to their negative experience in a medical setting; this negative experience had also impacted their quality of life. This study also found a need for the inclusion of African Americans and the healthcare policymaking process. In Chapters 1 and 2, evidence of a complex healthcare system was explored and noted; the findings from this study have confirmed much of the information provided within those chapters, further signifying a need for healthcare policy review and changes.

Most noteworthy from the results is that perceived discriminatory practices within the healthcare system can have severe implications on the patient's health and equity. Therefore, the findings of this research study indicate that further analysis of the problem on a larger geographical and demographic scale is needed. Most importantly, this study highlights many issues that call for an objective assessment of healthcare policy within specific communities. To this end, the objective was to understand the perception of African Americans who have experienced healthcare-related implicit bias through their lenses while evaluating the extent of the problem, thereby weighing if current healthcare policy changes are warranted.

In summary, the problem of implicit bias in the U.S. healthcare system negatively impacts many African Americans with comorbidities and underlying health conditions, thereby causing health-related disparities, health inequity, mistrust, uncertainties, and further patient assurance decline. Hence, health equity for humanity should be a

fundamental right. Further exploring factors concerning public policy, healthcare experiences, an illustration of perspectives, comorbidities, cause and effect of negative experiences, the correlation of policy needs and stakeholder participation, and communication, leadership, and accountability may positively impact this under-representative target group. Ultimately, by exposing encounters of bias through individual testimonies, social change is inevitable if there is an effort to enhance healthcare policies that reflect the reported issues.

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Appendix A: Semistructured Interview Online Survey Guide

- SQ1. What are your most chronic medical conditions, please only list 2? (This Question is OPTIONAL as all these questions on this survey)
- SQ2. To what extent have you experienced what you perceive as medical bias due to your comorbidities or underlining medical conditions during the COVID-19 pandemic, what happened? (Please explain)
- SQ3. To what extent during the COVID-19 pandemic have you experienced what you may perceive as racial discrimination by a healthcare provider, what exactly happened? (Please explain)
- SQ4. Please explain whether you believe a medical professional dismissed your health-related concerns during the COVID-19 pandemic by explaining your experience.
- SQ5. During the COVID-19 pandemic, do you believe your underlying medical conditions have something to do with the quality of care you have received and how the medical professional perceived you, can you explain what happened? (Please explain)
- SQ6. To what extent do you believe your quality of life was compromised due to what you may have perceived as implicit bias or bias from a healthcare provider during the COVID-19 pandemic? (Explain your experience please)
- SQ7. Have you formally complained to healthcare leadership about your negative healthcare experience during COVID-19? (Please explain the experience)

- SQ8. To what extent are you familiar with the policies of the healthcare facility or facilities you have had negative experiences with during the COVID-19 pandemic and what is your experience with these policies?
- SQ9. Can you share a specific communicative challenge you experienced with a healthcare provider during the COVID-19 pandemic?
- SQ10. Describe how you believe any perceived communication challenge caused additional pain and suffering, if any, during the COVID-19 pandemic?
(Please explain what happened)
- SQ11. If you had the opportunity to change, add to or modify the U.S. healthcare delivery system's policies and guidelines, what are two of the most important things you would include based on your experiences?
- SQ12. Would you like to add any additional information about your experiences with the U.S. healthcare delivery system during the COVID-19 pandemic?

Appendix B: Inclusion, Research and Survey Questions in Alignment

The interview questions SQ1-SQ12 will answer the research questions identified as RQ1-RQ4. The questions cover the phenomenon of implicit bias, communication, and healthcare policy. To produce the findings of the study, below are the inclusion questions that are included on the survey link form, followed by the structure research and survey questions for thematic analysis during coding. It is important to note that because of overlapping themes and similar survey responses this initial alignment was slightly modified to align the themes with the research questions.

Inclusion questions

This section consists of qualifying criteria questions supplied on the survey and within the criteria listed in the Informed Consent Form.

1. Were you a New York City resident during the COVID-19 pandemic?
2. Have you encountered a negative experience, what you perceive as implicit bias when interacting with a healthcare provider during the COVID-19 pandemic?
3. Are you aged 30 or over?
4. Do you identify as African American?
5. Do you have comorbidities or any underlying medical health conditions?
6. If you typed “I Consent” on the Informed Consent Form in section 1, consenting to participate in this study, you agree to have your responses published. Your name, email address, or other personal information that identifies you will not be included in the study as you are guaranteed confidentiality. If you answered “YES” to all the inclusion questions, please indicate that you would like to

continue with the survey by selecting “YES” or “NO” if you do not wish to continue. If you do not wish to continue, none of your information will be saved, and this document will be deleted. Do you wish to continue with the survey?

Research and Survey Questions in Alignment

RQ1: To what extent do patients who identified with having comorbidities or underlying medical conditions and who visited healthcare facilities during the COVID-19 pandemic perceive that they experienced implicit bias?

SQ1. What are your most chronic medical conditions, please only list 2? (This Question is OPTIONAL as all these questions on this surveys)

SQ2. To what extent have you experienced what you perceive as medical bias due to your comorbidities or underlining medical conditions during the COVID-19 pandemic, what happened? (Please explain)

SQ3. To what extent during the COVID-19 pandemic have you experienced what you may perceive as racial discrimination by a healthcare provider, what exactly happened? (Please explain)

RQ2: To what extent do patients perceive that their underlying medical conditions affected the quality of care received and how they were perceived by the medical professional because of these conditions during their healthcare visits?

SQ4. Please explain whether you believe a medical professional dismissed your health-related concerns during the COVID-19 pandemic by explaining your experience.

SQ5. During the COVID-19 pandemic, do you believe your underlying medical conditions have something to do with the quality of care you have received and how the medical professional perceived you can you explain what happened?

RQ3: Given the impact of COVID-19, how do patients perceive healthcare-related implicit bias encounters, and how did these encounters impact their quality of life?

SQ6. To what extent do you believe your quality of life was compromised due to what you may have perceived as implicit bias or bias from a healthcare provider during the COVID-19 pandemic? (Explain your experience please)

SQ7. Have you formally complained to healthcare leadership about your negative healthcare experience during COVID-19? (Please explain the experience)

RQ4: How do patients describe challenges with communicating with healthcare workers, and to what extent does healthcare policy affect health equity?

SQ8. To what extent are you familiar with the policies of the healthcare facility or facilities you have had negative experiences with during the COVID-19 pandemic and what is your experience with these policies?

SQ9. Can you share a specific communicative challenge you experienced with a healthcare provider during the COVID-19 pandemic?

SQ10. Describe how you believe any perceived communication challenge caused additional pain and suffering, if any, during the COVID-19 pandemic? (Please explain what happened)

SQ11. If you had the opportunity to change, add to or modify the U.S. healthcare delivery system's policies and guidelines, what are two of the most important things you would include based on your experiences?

SQ12. Would you like to add any additional information about your experiences with the U.S. healthcare delivery system during the COVID-19 pandemic?

Appendix C: Copy of Online Research Survey

Assessing Perceptions of Implicit Bias in Healthcare During the COVID-19 Pandemic: A Population-Based New York City Qualitative Study

CONSENT FORM

You are invited to volunteer in a research study about your experiences of perceived implicit bias while interacting with a healthcare worker during the COVID-19 pandemic. The name of the study is Assessing Perceptions of Implicit Bias in Healthcare During the COVID-19 Pandemic: A Population-Based New York City Qualitative Study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part. A contact email address will be required for communication purposes during this study. You will automatically be emailed a copy of this form and survey when you click "submit" at the end of the survey.

This study seeks 8 to 20 volunteers who:

- are 30 years of age or older
- are African American
- were New York City residents during the COVID-19 pandemic
- experienced perceived implicit bias during an encounter with a healthcare professional during the COVID-19 pandemic in New York City
- have underlying medical conditions, for example, high blood pressure, diabetes, or asthma

This study is being conducted by a researcher named Kiesha Jackson, who is a doctoral student at Walden University.

Study Purpose:

The purpose of this study is to examine and understand healthcare-related implicit bias encounters during the COVID-19 pandemic through the lived experiences of African American New York City residents aged 30 and over. This study is being conducted because research shows that African Americans are underrepresented and understudied when it involves healthcare policy and because of the disproportionate number of deaths during the COVID-19 pandemic. This study aims to inform, understand, encourage positive social change, and influence positive changes in healthcare policy if needed.

Procedures:

This study will involve you completing the following steps:

<https://docs.google.com/forms/d/1A4lyhEigUzZ6EVRj9Y33-jRnkXdLFT4wgS0QRllwX5I/edit>

- All communication and document exchanges will be conducted via email.
- After submitting this survey, you will automatically receive a copy of the consent form and survey you completed. You may delete this copy from your email and then dump your deleted emails permanently or save it for your records.
- Next, you will be sent a friendly debriefing email.
- Shortly after you receive the debriefing email, your answers to the survey questions will be analyzed and edited for clarity if needed; however, your responses will be verbatim as far as the content is concerned. Harsh profanity, repeated words, extreme grammatical errors, typos, and personal identifiers of people and places not involved in this study will be removed. For example, that that (the repeated word will be deleted), thw will be changed to the. However, some understandable and reasonable slang words will remain; the goal is not to compromise the integrity of your lived experience.
- Next, during a process called memberchecking (this is a validation technique), you will receive a copy of your responses by email to change, modify, or delete anything you would like (this should take approximately 20 min.). You will have 48 hours to look over your data and send it back to me with your changes, if any.
- By day 3, from the time you received your emailed responses for review, I will include my edited version of your responses in the study if you do not respond to my memberchecking email. I will make use of ellipsis and brackets to highlight the words that I have changed without your review.

If you have any questions or comments, please send me an email, and I will respond as soon as I can.

Here are some sample questions:

- SQ4. Please explain whether you believe a medical professional dismissed your health-related concerns during the COVID-19 pandemic by explaining your experience.
- SQ9. Can you share a specific communicative challenge you experienced with a healthcare provider during the COVID-19 pandemic?

Voluntary Nature of the Study:

Research should only be done with those who freely volunteer so, everyone involved will respect your decision to join or not. If you decide to join the study now, you can still change your mind later and you may stop at any time.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of the minor discomforts that can be encountered in daily life such as sharing sensitive information. With the protections in place, this study would pose minimal risk to your wellbeing. There is no obligation to answer any of the open-ended questions on the survey; these questions can be skipped, you can quit the survey, start the survey over, or quit this study.

If you feel or become distressed at any time before, during, or after completing this survey, here are some following resources that may help you:

- Emergency Medical Services—911, the National Suicide Prevention Lifeline 1-800-273-TALK (8255)
- SAMHSA Treatment Referral Helpline, 1-877-SAMHSA7 (1-877-726-4727)
- or visit the MentalHealth.gov website at: <https://www.mentalhealth.gov/get-help/immediate-help>

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by encouraging positive changes within healthcare policy. Once the analysis is complete, the researcher will share the overall results by emailing you a summary of the study results.

Payment:

There will be no compensation for participation nor gifts, favors, or reimbursements. This study is entirely voluntary, and you have no obligation to participate.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept confidential, within the limits of the law. The researcher is only authorized to share or disclose your personal contact information with Walden University supervisors, who are also required to safeguard your privacy and, in very rare cases, with the authorities if/when court-ordered. The researcher will not use your personal information for any purposes outside of this research project.

The researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of obtaining informed consent. Data will be kept secure by being stored and analyzed in a password-protected application called NVivo for thematic coding until the study is complete. Your survey will be assigned a code in place of your email after your survey is submitted for confidentiality purposes.

In maintaining your privacy when published, no identifiable information will be included in the study. The survey data included in the results will identify all participants as participant 1 and participant 2 and numerically so forth. After the study is complete and you receive a summary of the results, anything that can identify you will be deleted.

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Assessing Perceptions of Implicit Bias in Healthcare During the COVID-19 Pandemic: A Population-Based New York City Qualitati...

Your data collected from the surveys will be stored on a secured password-protected personal laptop computer in the researcher's home office. A hard copy of your data will be printed out; and downloaded on an external drive; both copies will be stored in a locked file cabinet no one else has access to, located in the researcher's home office. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You can ask questions of the researcher by emailing the researcher at

Omitted for Publishing. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at Omitted for Publishing. Walden University's approval number for this study is 08-19-21-0166402. It expires on August 18, 2022.

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent:

If you feel you understand the study and wish to volunteer, please indicate your consent by providing a contact email address below:

* Required

1. Email *

Inclusion Questions

This section consist of qualifying criteria questions to take the Survey.

2. Were you a New York City resident during the COVID-19 pandemic? *

Mark only one oval.

Yes

No

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Assessing Perceptions of Implicit Bias in Healthcare During the COVID-19 Pandemic: A Population-Based New York City Qualitati...

3. Are you aged 30 or over? *

Mark only one oval.

Yes

No

4. Do you identify as Black or African American? *

Mark only one oval.

Yes

No

5. Do you have comorbidities or any underlying medical health conditions? *

Mark only one oval.

Yes

No

6. If you Consented on the Consent Form in section 1, consenting to participate in this study, you agree to have your responses published. Your name, email address, or other personal information that identifies you will not be included in the study as you are guaranteed confidentiality. If you answered "YES" to all the inclusion questions, please indicate that you would like to continue with the survey by selecting "YES" or "NO" if you do not wish to continue. If you do not wish to continue, none of your information will be saved, and this document will be deleted. Do you wish to continue with the survey? *

Mark only one oval.

Yes

No

- 7. Have you encountered a negative experience, what you perceive as implicit bias when interacting with a healthcare provider during the COVID-19 pandemic? *

Mark only one oval.

- Yes
- No

Assessing Perceptions of Implicit Bias in Healthcare During the COVID-19 Pandemic: A Population-Based New York Qualitative Study

Please answer all of the survey questions below, to the best of your ability, and then click Submit. Remember, you can skip the questions you do not want to answer, or you can quit the survey anytime. If you are submitting via cell phone or computer, there may be a microphone that you can speak into that will autotype your answers.

- 8. SQ1. What are your most chronic medical conditions, please only list 2? (This Question is OPTIONAL as all the questions on this survey are)

- 9. SQ2. To what extent have you experienced what you perceive as medical bias due to your comorbidities or underlying medical conditions during the COVID-19 pandemic, what happened? (Please explain)

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Assessing Perceptions of Implicit Bias in Healthcare During the COVID-19 Pandemic: A Population-Based New York City Qualitati...

10. SQ3. To what extent during the COVID-19 pandemic have you experienced what you may perceive as racial discrimination by a healthcare provider, what exactly happened? (Please explain)

11. SQ4. Please explain whether you believe a medical professional dismissed your health-related concerns during the COVID-19 pandemic by explaining your experience.

12. SQ5. During the COVID-19 pandemic, do you believe your underlying medical conditions have something to do with the quality of care you have received and how the medical professional perceived you can you explain what happened?

- 13. SQ6. To what extent do you believe your quality of life was compromised due to what you may have perceived as implicit bias or bias from a healthcare provider during the COVID-19 pandemic? (Explain your experience please)

- 14. SQ7. Have you formally complained to healthcare leadership about your negative healthcare experience during COVID-19? (Please explain the experience)

- 15. SQ8. To what extent are you familiar with the policies of the healthcare facility or facilities you have had negative experiences with during the COVID-19 pandemic and what is your experience with these policies?

16. SQ9. Can you share a specific communicative challenge you experienced with a healthcare provider during the COVID-19 pandemic?

17. SQ10. Describe how you believe any perceived communication challenge caused additional pain and suffering, if any, during the COVID-19 pandemic? (Please explain what happened)

18. SQ11. If you had the opportunity to change, add to or modify the U.S. healthcare delivery system's policies and guidelines, what are two of the most important things you would include based on your experiences?

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Assessing Perceptions of Implicit Bias in Healthcare During the COVID-19 Pandemic: A Population-Based New York City Qualitati...

19. SQ12. Would you like to add any additional information about your experiences with the healthcare delivery system during the COVID-19 pandemic?

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Google Forms

Appendix D: Raw Survey Data Word Count

Word	Length	Count	Weighted Percentage (%)
yes	3	20	1.13
pain	4	17	0.96
care	4	16	0.90
like	4	16	0.90
doctor	6	15	0.85
get	3	15	0.85
feel	4	14	0.79
medical	7	14	0.79
told	4	14	0.79
appointment	11	13	0.73
covid	5	13	0.73
due	3	12	0.68
emergency	9	11	0.62
given	5	11	0.62
hospital	8	11	0.62
treatment	9	11	0.62
healthcare	10	10	0.56
help	4	10	0.56
nurse	5	10	0.56
people	6	10	0.56
take	4	10	0.56
doctors	7	9	0.51
medication	10	9	0.51
well	4	9	0.51
anxiety	7	8	0.45
believe	7	8	0.45
health	6	8	0.45
oxygen	6	8	0.45
patient	7	8	0.45
phone	5	8	0.45
room	4	8	0.45
seen	4	8	0.45

treated	7	8	0.45
white	5	8	0.45
better	6	7	0.40
diabetes	8	7	0.40
felt	4	7	0.40
friend	6	7	0.40
made	4	7	0.40
pressure	8	7	0.40
receive	7	7	0.40
still	5	7	0.40
symptoms	8	7	0.40
able	4	6	0.34
caused	6	6	0.34
didnt	5	6	0.34
getting	7	6	0.34
high	4	6	0.34
home	4	6	0.34
just	4	6	0.34
know	4	6	0.34
one	3	6	0.34
patients	8	6	0.34
policies	8	6	0.34
see	3	6	0.34
sent	4	6	0.34
seriously	9	6	0.34
think	5	6	0.34
went	4	6	0.34
american	8	5	0.28
back	4	5	0.28
black	5	5	0.28
blood	5	5	0.28
come	4	5	0.28
condition	9	5	0.28
department	10	5	0.28
even	4	5	0.28

facility	8	5	0.28
front	5	5	0.28
heart	5	5	0.28
less	4	5	0.28
matter	6	5	0.28
need	4	5	0.28
needs	5	5	0.28
never	5	5	0.28
pneumonia	9	5	0.28
priority	8	5	0.28
seem	4	5	0.28
seemed	6	5	0.28
staff	5	5	0.28
african	7	4	0.23
also	4	4	0.23
another	7	4	0.23
asked	5	4	0.23
asthma	6	4	0.23
brain	5	4	0.23
called	6	4	0.23
concern	7	4	0.23
concerns	8	4	0.23
denied	6	4	0.23
desk	4	4	0.23
everyone	8	4	0.23
familiar	8	4	0.23
family	6	4	0.23
got	3	4	0.23
higher	6	4	0.23
ignored	7	4	0.23
insurance	9	4	0.23
issues	6	4	0.23
lady	4	4	0.23
looked	6	4	0.23
lot	3	4	0.23

meds	4	4	0.23
months	6	4	0.23
nurses	6	4	0.23
regular	7	4	0.23
rushed	6	4	0.23
severe	6	4	0.23
someone	7	4	0.23
speaking	8	4	0.23
sure	4	4	0.23
system	6	4	0.23
taking	6	4	0.23
tell	4	4	0.23
things	6	4	0.23
took	4	4	0.23
wait	4	4	0.23
weak	4	4	0.23
workers	7	4	0.23
2020	4	3	0.17
afraid	6	3	0.17
anoxic	6	3	0.17
away	4	3	0.17
breath	6	3	0.17
calls	5	3	0.17
canâ	4	3	0.17
cell	4	3	0.17
cold	4	3	0.17
depression	10	3	0.17
diabetic	8	3	0.17
diet	4	3	0.17
else	4	3	0.17
extent	6	3	0.17
give	4	3	0.17
glasses	7	3	0.17
hallway	7	3	0.17
hour	4	3	0.17

information	11	3	0.17
injury	6	3	0.17
last	4	3	0.17
later	5	3	0.17
level	5	3	0.17
life	4	3	0.17
listen	6	3	0.17
lobby	5	3	0.17
make	4	3	0.17
many	4	3	0.17
may	3	3	0.17
needed	6	3	0.17
new	3	3	0.17
non	3	3	0.17
order	5	3	0.17
others	6	3	0.17
pandemic	8	3	0.17
pay	3	3	0.17
person	6	3	0.17
pills	5	3	0.17
placed	6	3	0.17
primary	7	3	0.17
put	3	3	0.17
saturation	10	3	0.17
screen	6	3	0.17
send	4	3	0.17
service	7	3	0.17
sick	4	3	0.17
sickle	6	3	0.17
taken	5	3	0.17
time	4	3	0.17
trust	5	3	0.17
vertigo	7	3	0.17
waiting	7	3	0.17
walk	4	3	0.17

want	4	3	0.17
wanted	6	3	0.17
weight	6	3	0.17
without	7	3	0.17
work	4	3	0.17
absolutely	10	2	0.11
actual	6	2	0.11
actually	8	2	0.11
administrators	14	2	0.11
airway	6	2	0.11
allergic	8	2	0.11
anger	5	2	0.11
appointments	12	2	0.11
arrived	7	2	0.11
ask	3	2	0.11
attacks	7	2	0.11
available	9	2	0.11
bad	3	2	0.11
best	4	2	0.11
breathing	9	2	0.11
bring	5	2	0.11
call	4	2	0.11
came	4	2	0.11
certain	7	2	0.11
change	6	2	0.11
check	5	2	0.11
color	5	2	0.11
comes	5	2	0.11
complain	8	2	0.11
complained	10	2	0.11
compromised	11	2	0.11
computer	8	2	0.11
constantly	10	2	0.11
corner	6	2	0.11
customers	9	2	0.11

cut	3	2	0.11
day	3	2	0.11
decided	7	2	0.11
dehydrated	10	2	0.11
delay	5	2	0.11
delivery	8	2	0.11
describing	10	2	0.11
detail	6	2	0.11
diagnosis	10	2	0.11
difference	10	2	0.11
different	9	2	0.11
difficult	9	2	0.11
discomfort	10	2	0.11
discriminated	13	2	0.11
disease	7	2	0.11
dismissed	9	2	0.11
donâ	4	2	0.11
door	4	2	0.11
drug	4	2	0.11
dying	5	2	0.11
enter	5	2	0.11
equally	7	2	0.11
express	7	2	0.11
extreme	7	2	0.11
fact	4	2	0.11
found	5	2	0.11
friends	7	2	0.11
frustration	11	2	0.11
going	5	2	0.11
good	4	2	0.11
grandchild	10	2	0.11
hours	5	2	0.11
inappropriate	13	2	0.11
instead	7	2	0.11
instructions	12	2	0.11

isolation	9	2	0.11
issue	5	2	0.11
itâ	3	2	0.11
ketamine	8	2	0.11
kidney	6	2	0.11
lack	4	2	0.11
law	3	2	0.11
leave	5	2	0.11
liver	5	2	0.11
long	4	2	0.11
longer	6	2	0.11
lost	4	2	0.11
mental	6	2	0.11
middle	6	2	0.11
minutes	7	2	0.11
much	4	2	0.11
normal	6	2	0.11
nothing	7	2	0.11
now	3	2	0.11
office	6	2	0.11
overlook	8	2	0.11
packed	6	2	0.11
pass	4	2	0.11
passed	6	2	0.11
past	4	2	0.11
perceived	9	2	0.11
prescribed	10	2	0.11
probably	8	2	0.11
problems	8	2	0.11
professionals	13	2	0.11
proper	6	2	0.11
provider	8	2	0.11
questions	9	2	0.11
reaction	8	2	0.11
really	6	2	0.11

reasons	7	2	0.11
regardless	10	2	0.11
remove	6	2	0.11
replacement	11	2	0.11
seek	4	2	0.11
set	3	2	0.11
simply	6	2	0.11
spanish	7	2	0.11
stomach	7	2	0.11
test	4	2	0.11
therapist	9	2	0.11
therapy	7	2	0.11
though	6	2	0.11
times	5	2	0.11
transferred	11	2	0.11
treat	5	2	0.11
try	3	2	0.11
video	5	2	0.11
virus	5	2	0.11
vision	6	2	0.11
visit	5	2	0.11
way	3	2	0.11
weeks	5	2	0.11
working	7	2	0.11
worse	5	2	0.11
worst	5	2	0.11
wrong	5	2	0.11
youre	5	2	0.11
110	3	1	0.06
125	3	1	0.06
157	3	1	0.06
1st	3	1	0.06
abandoned	9	1	0.06
ability	7	1	0.06
accesible	9	1	0.06

accomodate	10	1	0.06
accuracy	8	1	0.06
achieved	8	1	0.06
acqua	5	1	0.06
across	6	1	0.06
acute	5	1	0.06
addict	6	1	0.06
ademint	7	1	0.06
admission	9	1	0.06
admissions	10	1	0.06
afro	4	1	0.06
agreed	7	1	0.06
allow	5	1	0.06
almost	6	1	0.06
alot	4	1	0.06
always	6	1	0.06
amount	6	1	0.06
anemia	6	1	0.06
answered	8	1	0.06
anyones	7	1	0.06
anything	8	1	0.06
apologized	10	1	0.06
appeared	8	1	0.06
approach	8	1	0.06
approve	7	1	0.06
appt	4	1	0.06
around	6	1	0.06
arrangemy	9	1	0.06
aspects	7	1	0.06
assist	6	1	0.06
assistant	9	1	0.06
assumed	7	1	0.06
asthmatic	9	1	0.06
atake	5	1	0.06
attend	6	1	0.06

attending	9	1	0.06
attention	9	1	0.06
avoid	5	1	0.06
aware	5	1	0.06
backgrounds	11	1	0.06
badly	5	1	0.06
based	5	1	0.06
beat	4	1	0.06
become	6	1	0.06
bedroom	7	1	0.06
beginning	9	1	0.06
beyond	6	1	0.06
bias	4	1	0.06
bill	4	1	0.06
body	4	1	0.06
bones	5	1	0.06
borderline	10	1	0.06
bother	6	1	0.06
bothersome	10	1	0.06
breathe	7	1	0.06
business	8	1	0.06
cant	4	1	0.06
cared	5	1	0.06
catching	8	1	0.06
cause	5	1	0.06
challenge	9	1	0.06
chances	7	1	0.06
changed	7	1	0.06
cholesterol	11	1	0.06
chose	5	1	0.06
chronic	7	1	0.06
closed	6	1	0.06
cognizant	9	1	0.06
comfortable	11	1	0.06
coming	6	1	0.06

common	6	1	0.06
communication	13	1	0.06
community	9	1	0.06
compare	7	1	0.06
complaining	11	1	0.06
complains	9	1	0.06
complaints	10	1	0.06
concerned	9	1	0.06
conference	10	1	0.06
considered	10	1	0.06
consultations	13	1	0.06
control	7	1	0.06
convenient	10	1	0.06
cookie	6	1	0.06
coordination	12	1	0.06
copd	4	1	0.06
couldnt	7	1	0.06
counterparts	12	1	0.06
covid19	7	1	0.06
created	7	1	0.06
crisis	6	1	0.06
cup	3	1	0.06
customer	8	1	0.06
cutter	6	1	0.06
date	4	1	0.06
deepen	6	1	0.06
demographics	12	1	0.06
deny	4	1	0.06
depending	9	1	0.06
depressio	9	1	0.06
describe	8	1	0.06
destroyed	9	1	0.06
diagnosed	10	1	0.06
diagnosed	9	1	0.06
diagnoses	9	1	0.06

diagnosis	9	1	0.06
died	4	1	0.06
dieting	7	1	0.06
differed	8	1	0.06
difficulty	10	1	0.06
directives	10	1	0.06
discriminating	14	1	0.06
discrimination	14	1	0.06
disputting	10	1	0.06
disrespect	10	1	0.06
distress	8	1	0.06
disturbed	9	1	0.06
doc	3	1	0.06
doesnâ	6	1	0.06
donr	4	1	0.06
dont	4	1	0.06
double	6	1	0.06
downplayed	10	1	0.06
drawn	5	1	0.06
drs	3	1	0.06
dyspnea	7	1	0.06
earlier	7	1	0.06
easy	4	1	0.06
emergent	8	1	0.06
emergently	10	1	0.06
emotional	9	1	0.06
english	7	1	0.06
enormous	8	1	0.06
enough	6	1	0.06
entry	5	1	0.06
episodes	8	1	0.06
equal	5	1	0.06
etc	3	1	0.06
ethnic	6	1	0.06
ethnicity	9	1	0.06

evaluation	10	1	0.06
ever	4	1	0.06
every	5	1	0.06
exacerbation	12	1	0.06
exactly	7	1	0.06
exemption	9	1	0.06
exercise	8	1	0.06
existence	9	1	0.06
experience	10	1	0.06
experienced	11	1	0.06
experiencing	12	1	0.06
explain	7	1	0.06
expressed	9	1	0.06
extended	8	1	0.06
facilities	10	1	0.06
facilities	11	1	0.06
fainting	8	1	0.06
fairly	6	1	0.06
fatty	5	1	0.06
familiar	9	1	0.06
fear	4	1	0.06
feedback	8	1	0.06
feeling	7	1	0.06
fending	7	1	0.06
fevers	6	1	0.06
find	4	1	0.06
finishing	9	1	0.06
first	5	1	0.06
floor	5	1	0.06
fluids	6	1	0.06
focusing	8	1	0.06
follow	6	1	0.06
forced	6	1	0.06
form	4	1	0.06
formally	8	1	0.06

forward	7	1	0.06
frequently	10	1	0.06
frightened	10	1	0.06
frowned	7	1	0.06
frustrating	11	1	0.06
full	4	1	0.06
gather	6	1	0.06
gave	4	1	0.06
gets	4	1	0.06
goals	5	1	0.06
gonna	5	1	0.06
gotten	6	1	0.06
grandchildren	13	1	0.06
greater	7	1	0.06
greatest	8	1	0.06
gtt	3	1	0.06
gym	3	1	0.06
hand	4	1	0.06
hanging	7	1	0.06
happening	9	1	0.06
hard	4	1	0.06
havent	6	1	0.06
head	4	1	0.06
healthwise	10	1	0.06
heard	5	1	0.06
hearing	7	1	0.06
height	6	1	0.06
helps	5	1	0.06
hippa	5	1	0.06
history	7	1	0.06
honestly	8	1	0.06
hook	4	1	0.06
hope	4	1	0.06
hourly	6	1	0.06
however	7	1	0.06

huge	4	1	0.06
huh	3	1	0.06
human	5	1	0.06
humiliating	11	1	0.06
hung	4	1	0.06
ignoring	8	1	0.06
illness	7	1	0.06
illnesses	9	1	0.06
immediate	9	1	0.06
impacted	8	1	0.06
important	9	1	0.06
impossible	10	1	0.06
include	7	1	0.06
increase	8	1	0.06
individual	10	1	0.06
initial	7	1	0.06
input	5	1	0.06
inside	6	1	0.06
insitant	8	1	0.06
interact	8	1	0.06
interaction	11	1	0.06
interested	10	1	0.06
interviews	10	1	0.06
intubated	9	1	0.06
isnâ	4	1	0.06
isolated	8	1	0.06
items	5	1	0.06
jeopardy	8	1	0.06
joints	6	1	0.06
joked	5	1	0.06
keep	4	1	0.06
kept	4	1	0.06
kidneys	7	1	0.06
knowing	7	1	0.06
labled	6	1	0.06

lacked	6	1	0.06
laser	5	1	0.06
latests	7	1	0.06
left	4	1	0.06
literally	9	1	0.06
literature	10	1	0.06
little	6	1	0.06
live	4	1	0.06
lives	5	1	0.06
look	4	1	0.06
looking	7	1	0.06
lose	4	1	0.06
losing	6	1	0.06
loud	4	1	0.06
low	3	1	0.06
lowest	6	1	0.06
lunch	5	1	0.06
makes	5	1	0.06
making	6	1	0.06
man	3	1	0.06
managers	8	1	0.06
mask	4	1	0.06
mean	4	1	0.06
meaning	7	1	0.06
medications	11	1	0.06
meeting	7	1	0.06
member	6	1	0.06
mentioned	9	1	0.06
mess	4	1	0.06
metformin	9	1	0.06
might	5	1	0.06
migrate	7	1	0.06
mildly	6	1	0.06
mind	4	1	0.06
misinterpreted	14	1	0.06

mistreated	10	1	0.06
month	5	1	0.06
must	4	1	0.06
nationality	11	1	0.06
nausea	6	1	0.06
negative	8	1	0.06
neglected	9	1	0.06
norm	4	1	0.06
nourishment	11	1	0.06
nurseâ	6	1	0.06
nursing	7	1	0.06
obviously	9	1	0.06
occur	5	1	0.06
opposed	7	1	0.06
optometrist	11	1	0.06
overhaul	8	1	0.06
overhauled	10	1	0.06
overlooked	10	1	0.06
overweight	10	1	0.06
painful	7	1	0.06
paperwork	9	1	0.06
parked	6	1	0.06
parking	7	1	0.06
passing	7	1	0.06
payment	7	1	0.06
period	6	1	0.06
persons	7	1	0.06
pharmacy	8	1	0.06
phoned	6	1	0.06
physical	8	1	0.06
physicians	10	1	0.06
pick	4	1	0.06
picked	6	1	0.06
pill	4	1	0.06
point	5	1	0.06

pointless	9	1	0.06
polic	5	1	0.06
pool	4	1	0.06
positive	8	1	0.06
possible	8	1	0.06
practitioner	12	1	0.06
practitioners	13	1	0.06
pre	3	1	0.06
precautions	11	1	0.06
present	7	1	0.06
pretty	6	1	0.06
prior	5	1	0.06
problem	7	1	0.06
proceed	7	1	0.06
proceeded	9	1	0.06
process	7	1	0.06
professional	12	1	0.06
providers	9	1	0.06
psychoanalyst	13	1	0.06
quality	7	1	0.06
quite	5	1	0.06
race	4	1	0.06
races	5	1	0.06
racial	6	1	0.06
rate	4	1	0.06
reactive	8	1	0.06
received	8	1	0.06
recommend	9	1	0.06
referrals	9	1	0.06
refuse	6	1	0.06
regards	7	1	0.06
regimen	7	1	0.06
rehab	5	1	0.06
rehabilitation	14	1	0.06
relearn	7	1	0.06

remained	8	1	0.06
report	6	1	0.06
reported	8	1	0.06
requirements	12	1	0.06
rescheduled	11	1	0.06
response	8	1	0.06
responsibility	14	1	0.06
restrictions	12	1	0.06
results	7	1	0.06
return	6	1	0.06
royalty	7	1	0.06
rude	4	1	0.06
rudeness	8	1	0.06
rulled	6	1	0.06
rush	4	1	0.06
saved	5	1	0.06
saw	3	1	0.06
saying	6	1	0.06
scale	5	1	0.06
scared	6	1	0.06
scheduling	10	1	0.06
screamed	8	1	0.06
seeking	7	1	0.06
self	4	1	0.06
selves	6	1	0.06
sense	5	1	0.06
serious	7	1	0.06
services	8	1	0.06
shift	5	1	0.06
show	4	1	0.06
sicker	6	1	0.06
similar	7	1	0.06
similiar	8	1	0.06
since	5	1	0.06
sitting	7	1	0.06

slighted	8	1	0.06
slow	4	1	0.06
sob	3	1	0.06
solution	8	1	0.06
somethimes	10	1	0.06
something	9	1	0.06
son	3	1	0.06
speak	5	1	0.06
state	5	1	0.06
stated	6	1	0.06
states	6	1	0.06
stating	7	1	0.06
status	6	1	0.06
stones	6	1	0.06
stood	5	1	0.06
stop	4	1	0.06
storke	6	1	0.06
stress	6	1	0.06
suffered	8	1	0.06
suffering	9	1	0.06
suggested	9	1	0.06
suppose	7	1	0.06
survery	7	1	0.06
talk	4	1	0.06
talking	7	1	0.06
taste	5	1	0.06
team	4	1	0.06
tears	5	1	0.06
technology	10	1	0.06
telling	7	1	0.06
thats	5	1	0.06
theres	6	1	0.06
thyroid	7	1	0.06
tone	4	1	0.06
tossed	6	1	0.06

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tough	5	1	0.06
trained	7	1	0.06
translation	11	1	0.06
translator	10	1	0.06
trauma	6	1	0.06
treatments	10	1	0.06
treats	6	1	0.06
triggered	9	1	0.06
trying	6	1	0.06
types	5	1	0.06
unavailable	11	1	0.06
underlying	10	1	0.06
understand	10	1	0.06
unfamiliar	10	1	0.06
unimportant	11	1	0.06
upset	5	1	0.06
urgency	7	1	0.06
use	3	1	0.06
using	5	1	0.06
usual	5	1	0.06
vaccine	7	1	0.06
vague	5	1	0.06
variety	7	1	0.06
view	4	1	0.06
violated	8	1	0.06
visits	6	1	0.06
vitals	6	1	0.06
volume	6	1	0.06
waited	6	1	0.06
wanting	7	1	0.06
water	5	1	0.06
weaker	6	1	0.06
wheezing	8	1	0.06
whether	7	1	0.06

whites	6	1	0.06
wish	4	1	0.06
witnessed	9	1	0.06
wont	4	1	0.06
wonâ	4	1	0.06
worer	5	1	0.06
worthy	6	1	0.06
yeah	4	1	0.06
year	4	1	0.06
yelled	6	1	0.06
zoom	4	1	0.06