Use of Patient Identifiers at the University of Washington School of Medicine: Building Institutional Consensus to Reduce Bias and Stigma

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BACKGROUND AND OBJECTIVES: Patient identifiers are used in the opening lines of case presentations and written documentation in health care and medical education settings. These identifiers can reflect physicians' implicit biases, which are known to impact patient care. Yet, no clear recommendations for the use of patient identifiers to reduce bias and stigma in patient care and medical education learning environments currently exist. We describe a process and outcomes for articulating such recommendations.

METHODS: The University of Washington School of Medicine convened a group of diverse stakeholders to create patient identifier recommendations for use in the undergraduate medical education program. After a literature review, 22 recommendations for the use of patient identifiers were articulated. These underwent public comment periods reaching 11,150 potential respondents across our 5-state institution. Feedback from 437 respondents informed modifications to the recommendations. We used consensus methodology with three rounds of surveys and an expert group of 27 stakeholders to adopt recommendations with an a priori threshold of 90% agreeing the recommendation should be used.

RESULTS: We adopted 12 recommendations for patient identifiers for age, gender/sex, race/ethnicity, sexual orientation, ability, size, and stigma; nine in round one, three in round two, and none in the third round.

DISCUSSION: Our institution vetted these patient identifier recommendations via public comment and consensus methodology. Next steps include implementation across the undergraduate medical education program, including classroom and clinical settings. Other institutions could consider similar processes as key steps to reduce bias and stigma in their medical education programs.

Physicians use patient identifiers in the opening lines of case presentations and written documentation to efficiently communicate information about the patient's identity that may be salient to their care. Identifiers allow recipients of patient information to rapidly engage in clinical reasoning about potential diagnoses and treatment plans. Patient identifiers can reinforce or dismantle implicit and explicit biases. Medical students learn professional skills through memorization and modeling of clinical preceptors, including case presentation formats; the importance of this educational process should not be underestimated. [1-15]

The process that allows physicians to quickly diagnose patients can activate implicit bias, especially if identifiers used for patients are not thoughtfully selected. This can result in disparities in care along a variety of axes of identity. Differences in health-seeking behavior between heterosexual and sexual minority individuals result from fear of discrimination in the health care system. [16-17] Implicit bias about race among pediatricians is associated with differences in treatment for asthma, pain, and attention-deficit/hyperactivity disorder. [18-20]

At the University of Washington School of Medicine (UWSOM), students and faculty noted inconsistency in identifier use within the preclinical curriculum that might promote bias and raised this concern to the UWSOM governance committee. This committee charged a faculty-led workgroup to create recommendations for the use of patient identifiers across the undergraduate medical education program, in both

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classroom and clinical settings, with a goal of decreasing bias.

Methods

The Identifier Workgroup (IW) recruited 22 members from across Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) sites, all 4 years of medical students, and different faculty and staff roles with an emphasis on diversity in lived and clinical experience. Subgroups performed a literature review with the aid of a health sciences librarian and drafted 17 identifier recommendations for the following areas: age, gender, race/ethnicity, sexual orientation, and disability status. The literature search included patient perspectives to ensure the recommendations were patient centered.

The IW gathered feedback on the recommendations through a public comment process open to all members of the institution based on a similar approach used by the US Preventive Services Task Force. To obtain public comment, the IW emailed an online survey and the draft recommendations to a listserv for students, and faculty and staff affiliated with UW Medicine. The survey was open for this group (total potential respondents=2,555) between July 10, 2018 and July 31, 2018. At the recommendation of the governance committee the IW expanded the population asked to provide public comment through

distribution of the recommendations and survey to a listserv of all adjunct, affiliated, emeritus, and acting faculty, including fellows. The survey was open for this group (8,595 total potential respondents) between August 13, 2018 and August 20, 2018. Initial public comment indicated the need for recommendations about patient size and stigma and a set of five recommendations was created for these areas which underwent comment in the second round. We qualitatively organized feedback from the comments into themes that the IW used to modify the identifier recommendations. The final revised set comprised 22 unique identifier recommendations across seven areas of age,[10,25,29] gender,[3,4,16,17,22,24,34-36] race/ethnicity,[2,6,8,26,32] sexual orientation,[3,4,11,22,36] disability status,[37] size,[38] and stigma.[39]
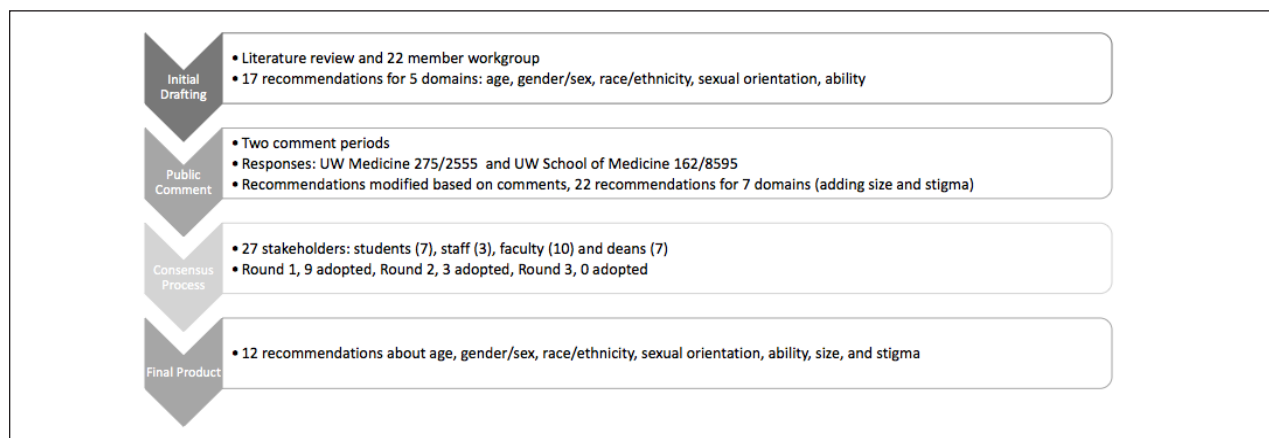
To ensure the recommendations reflected the needs of the entire medial education program, the IW used a consensus approach with a group of key stakeholders (KS) made up students (7), staff (3), faculty (10), and deans (7), that reflected diversity in lived experience, clinical experience, and role in the medical education program across WWAMI.[40] The KS were approved by the governance committee chairs and invited to participate in the consensus process. The consensus process involved three rounds of online surveys regarding inclusion,

exclusion, and potential improvements for each of the 22 identifier recommendations. In each survey round, stakeholders received a document with all the identifier recommendations and explanatory text. KS were instructed to: "Indicate if you think each should be excluded or included. If you exclude or feel neutral about an identifier recommendation, please comment in the space provided." Each recommendation was rated on a 5-point Likert scale from definitely include, possibly include, neutral, possible exclude, definitely exclude. The IW set an a priori adoption threshold at 90% of respondents rating an identifier either definitely or possibly include. After survey rounds one and two, stakeholders were given a list of recommendations they had adopted and the edited document with modified recommendations based on their feedback. Figure 1 outlines the process for patient identifier recommendation drafting and review. Figure 2 describes the different groups involved in this work. The UW Human Subjects Division deemed this study exempt from review.
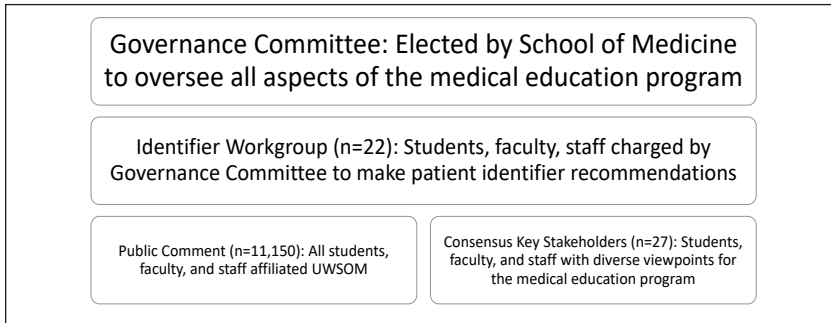
Results

The public comment resulted in 437 responses(275 from period one and 162 from period two), and respondents took an average of 31-39 minutes to complete feedback.

Figure 1: Drafting and Review Process for Patient Identifier Recommendations at the University of Washington School of Medicine, 2017-2019

Initial Drafting
- Literature review and 22 member workgroup
- 17 recommendations for 5 domains: age, gender/sex, race/ethnicity, sexual orientation, ability

Public Comment
- Two comment periods
- Responses: UW Medicine 275/2555 and UW School of Medicine 162/8595
- Recommendations modified based on comments, 22 recommendations for 7 domains (adding size and stigma)

Consensus Process
- 27 stakeholders: students (7), staff (3), faculty (10) and deans (7)
- Round 1, 9 adopted, Round 2, 3 adopted, Round 3, 0 adopted

Final Product
- 12 recommendations about age, gender/sex, race/ethnicity, sexual orientation, ability, size, and stigma

Figure 2: Groups Involved in the Process of Creating and Vetting the Identifier Recommendations

Governance Committee: Elected by School of Medicine to oversee all aspects of the medical education program

Identifier Workgroup (n=22): Students, faculty, staff charged by Governance Committee to make patient identifier recommendations

Public Comment (n=11,150): All students, faculty, and staff affiliated UWSOM

Consensus Key Stakeholders (n=27): Students, faculty, and staff with diverse viewpoints for the medical education program

Nine identifier recommendations were adopted after round one of the consensus process (Table 1). After round two, three identifier recommendations were adopted (Table 1), one of which was a composite recommendation generated by combining two initial recommendations based on feedback in round one. No identifier recommendations were adopted in round three. Table 2 shows the recommendations for identifiers that should always be included,

Table 1: Identifier Recommendations Adopted and Not Adopted During the Consensus Process at the University of Washington School of Medicine, 2019

Adopted Round 1
Age should be included in every case presentation (unless it is not known or you are talking about a group rather than an individual).
Refer to the patient in the ID/CC using their preferred (personally-articulated) gender identity term.
Information on sexual behaviors should be included in the ID/CC if it is relevant to the presenting concern. If unrelated to presenting concern, sexual behaviors and history should be listed in the sexual history.
Ask for and use the patient's (personally-articulated) term for their sexual orientation identity.
Patient-first or person-first language should be used when a medical diagnosis or disability needs to be included in the ID/CC.
Information about ability or disability status should be included when it pertains to medical decision-making for the presenting concern. Otherwise the information should be captured in the problem list or past medical history.
Understanding a patient's possibly conflicting goals, priorities and resources can assist the team in collaboratively creating a treatment plan. This information may be recorded in the HPI, PMH, problem list, or social history as appropriate.
Patient-centered, nonjudgmental, strengths-based and collaborative language can help engage patients, improve outcomes and avoid stigma. Avoid nonpreferred terms such as compliance, adherence and refusal. Instead describe facts, strengths, goals, barriers.
References to body size should not be made in the opening lines of written and oral case presentations unless pertinent (presenting concern is weight, size is pertinent to the patient care, deviation from expected weight trajectories).
Adopted Round 2
Include additional information regarding gender identity/sex assigned at birth in the social history, and information re: history of or plans for gender affirming care in the PMH or social history, as appropriate.
Information on a patient's personally-articulated sexual orientation identity should be listed in the social or sexual history.
Racial and ethnic identifiers should not be included in the opening lines of written and oral case presentations, unless there is a clear, compelling, evidence-based reason for doing so (Composite recommendation from round 1).
Not Adopted
Opening line identifiers need to be used with caution. Those described below should be used throughout the medical school curriculum including as it relates to assessment and evaluation.
Acknowledgement should be made that despite the use of these identifiers from the UWSOM curriculum there will continue to be the use identifiers that are not congruent with these recommendations within the medical institution and society as a whole.
When discussing patient populations, less specific identifiers about age may be included with caution but should not be a substitute for age.
Promote gender identity/natal sex information to the ID/CC only if relevant to the chief concern.

Race/ethnicity should be self-identified by the patient and placed in the social history that focuses more on the patient's individual socioeconomic, cultural, behavioral, and occupational characteristics.
Diagnoses associated with known genetic or chromosomal disorders consistent with the patient's presenting signs and symptoms should be the focus instead of race or ethnicity.
Stigma and marginalization are risk factors for disease and can influence interaction with and experience of the health care field and can be recorded in the social history.
Limit description of body size in the physical exam to situations when clinically relevant. When describing body size in the physical exam, use objective measures of body size (such as BMI, weight/height/length, percentile).
Use of size-based diagnoses should be clearly connected to their impact on the health or the care of the patient.

Notes: ID/CC (identification/chief concern): The one sentence opening line that includes information that identifies the patient and their reason for seeking health care. HPI (history of present illness): The narrative that describes the details of the current health concern.

PMH (past medical history): A list of diagnoses, events, or procedures the patient has experienced. Social history: The narrative that describes the details of the patient's social context. Problem list: The list of current health issues and diagnoses. For recommendations related to presenting concerns, examples of this include pelvic or abdominal pain in a patient who is transgender, or infectious disease concerns for patients with spinal cord injuries. If the clinical reasoning for presenting concern will not be modified with the inclusion of the identifier, it does not need to be part of the of the ID/CC.

Table 2: Consolidated Recommendations for Inclusion in the Chief Concern by Identifier Area at the University of Washington School of Medicine, 2019

Always Include
• Age
• The patient's personally-articulated gender identity term
Include if Pertinent to Presenting Concern
• Information on sexual behaviors
• Information about ability or disability status
• Body size
Do Not Include Unless Clear Compelling Reason
• Racial and ethnic identifiers
Preferred Locations and Terms for Other Patient Identifier Information
• Sexual behaviors and history should be listed in the sexual history.
• Personally-articulated sexual orientation identity should be listed in the social or sexual history.
• Ability/disability should be listed in the problem list or past medical history.
• Gender identity/sex assigned at birth should be listed in the social history, and information regarding history of or plans for gender affirming care in the PMH or social history.
• Understanding a patient's possibly conflicting goals, priorities and resources can assist the team in collaboratively creating a treatment plan. This information may be recorded in the HPI, PMH, problem list, or social history as appropriate.
• Patient-centered, nonjudgmental, strengths-based and collaborative language can help engage patients, improve outcomes and avoid stigma. Avoid nonpreferred terms such as compliance, adherence, and refusal. Instead describe facts, strengths, goals, barriers.

Abbreviations: PMH, past medical history; HPI, history of present illness.

be included if pertinent, and not included unless there is a compelling reason. It also outlines preferred locations and terms for identity-based information in the medical database if this information is not included in the chief concern.

Discussion

This is the first set of patient identifier recommendations that combined the approaches of literature review, institutional public comment period, and consensus methodology. As this set reflects our school, it may not be broadly applicable to other settings. However, our institution spans five states offering broad ideological and geographic representation. Next steps include implementation guidance for preclinical and clinical settings including faculty development. A document outlining approaches for preclerkship implementation was drafted and widely distributed via list-serves to faculty responsible for

this part of the medical education program. A similar document is being drafted for the faculty responsible for the clinical elements (such as required and elective clerkships).

Strengths of this study include grounding the initial identifier recommendations in a literature review, the large number of individuals invited for public comment, and the use of consensus methods with key stakeholders. Weaknesses include a single institution and the low public

comment response rate. This process did not address all possible patient identifiers. This study focused on patient identifiers, and although the work generated preferred locations for information that conveys important social and cultural information about the patient, this requires more study and elucidation. Respectful use of patient identifiers is evolving with the national conversation on issues related to these domains and use of these identifiers will require intentional revisiting and evolution over time.

Health inequities along the lines of identity persist. Identifiers used in medical education can perpetuate bias of health care providers that negatively impacts health outcomes. Informing students of practices to reduce bias and stigma can promote conscious habits to use when addressing patients.[18,21,32] Physicians have an obligation to ensure the language used to describe patients is thoughtful and works to minimize instead of replicate bias. Elucidation of patient identifier recommendations for medical education is an important step for any institution, and this study provides an approach that can be replicated to build consensus.

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