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"LET UP"

A Systematic Approach to Responding to Cultural Bias in Health Care

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Abstract
Everyone is impacted by cultural bias due to life experiences, trauma, societal values, and exposure to prejudice and racism. Consequently, even the most well intentioned and culturally humble health care provider working in primary care pediatrics must learn to identify and reduce cultural bias. Experiencing cultural biases is often unexpected and triggers emotional, behavioral, cognitive, and physical reactions in providers. In this article, the authors describe the mnemonic, LET UP (Listen, Empathize, Tell your story, Understand, and Psychoeducate) as a method to address cultural biases in the health care setting.

Regardless of the level of cultural competency of a health care provider, it is a challenge to provide medical care that is free of cultural bias. The reality is that in American society, certain groups are privileged and protected, whereas others have been oppressed, discriminated against, and the victims of great injustices, simply because of some aspect of their culture (e.g., gender, race, ethnicity, religion, nationality, sexuality). Furthermore, many individuals experience intersectionalities of privileges and disadvantages. For example, having the identities of female, Jewish, lesbian, and physician all present unique questions of privilege and disenfranchisement depending on the clinical setting.

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Multicultural experts provide recommendations and interventions aimed at helping providers increase their awareness of implicit cultural biases and increase cultural humility, with the goal of engaging in culturally effective care (Fisher-Borne, Cain, & Martin, 2015). The American Academy of Pediatrics (AAP, 2019) defined culturally effective care as "the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of cultural distinctions leading to optimal health outcomes." This definition may leave readers with a clear mission, yet a vague method of implementation, and many providers are searching for concrete skills to use in fast-paced medical settings as they pursue the lifelong journey toward cultural competency.

Experiencing cultural biases is often unexpected and can trigger emotional, behavioral, cognitive, and physical reactions (Crawford, 2012). These reactions, left unresolved, add another layer of difficulty and stress for providers trying to offer optimal health care to patients. Being triggered is both

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internally and interpersonally stressful, leaving the provider to evaluate the clinical situation, professional situation, or both, as harmful, threatening, or taxing on coping resources (Fauth & Hayes, 2006). Having awareness is a critical component of cultural competency, yet insufficient in reducing the visceral reaction triggered when navigating the landscape of cultural bias. More specifically, providers may feel sad, angry, overwhelmed, frustrated, and incompetent in addition to a physical stress response. It is therefore not surprising that they may consciously or unconsciously avoid addressing the trigger, engage inauthentically, or become judgmental. Finally, providers are left asking: (1) "Once I notice my biases, what do I do right now?" (2) "When I suspect a cultural issue is a barrier to best practice, what do I say?" and (3) "How do I respond when I experience biases from colleagues?"

The LET UP Model

In this article, a team comprised of a psychologist and three pediatricians provide concrete recommendations for moving from awareness to concrete action. Dana E. Crawford, the psychologist, has created the framework for this discussion. Dr. Crawford offers a novel mnemonic, LET UP (**L**isten, **E**mpathize, **T**ell your story, **U**nderstand, and **P**sychoeducate; see Table 1), to guide the process. LET UP is an internal processing

Table 1. LET-UP Internal Processing and Theoretical Approach

Steps	Internal Processing	Theoretical Approach/Concrete Action
Listen	Acknowledge and explore your experience, affective, behavioral, cognitive, and physical reactions **Reflection Questions** How are your brain and body communicating you are triggered? What about this triggers you? How are you focused on your own values, rather than the patient/family/colleague?	Make sure you are hearing the person, not your triggers. **Sample questions to ask** What about this medical approach makes you uncomfortable? Are there members of your family or community who are opposed to this approach? Do you have a different theory of what is happening? What am I not understanding that would be important for me to know?
Empathize	Avoid judging your reactions; instead, honor your own history, trauma, and reactions related to the trigger.	Avoid judging their position; instead, engage with their history, trauma, and concerns. **Sample statement** "You are saying you feel angry and afraid when you are around X." "I am hearing how upsetting this has been for you."
Tell your story	On the basis of insight gained from listening and empathizing, determine what information about your cultural factors are relevant for culturally effective care. Engage in *strategic* self-disclosure.	Acknowledge the role of cultural factors in health care. Communicate authentic valuing of understanding the role cultural factors play in the patient and family's health care experiences. Invite a conversation of collaboration and transparent communication. **Sample statements** "Because I am also Black, you might assume I understand, and I think I do, but can you tell me more about your experience" "As a straight person, I have not had those worries, but this is not about me, it's about your worries for your babies. Please tell me your concerns about your babies."
Understand	Reflect on your role in the larger system of bias, prejudice, and racism.	Understand the person's individual experiences related to the bias, prejudice, and racism. Reflect on the person's experiences of fear, trauma, lack of exposure, and anger.
Psychoeducate	Use your expertise to correct unhelpful/unhealthy thinking patterns.	Focus on research related to social determinants of health, health equity, and culturally and clinically relevant statistics. Make it clear that you do not collude with bias, prejudice, and racism. **Sample Statements** "A lot of same sex couples have expressed your concerns, and we want to support you with these resources that focus on some of your unique experiences of parenting." "This is a place where everyone needs to feel safe and respected." "Research has shown everyone has some form of bias, which is normal and does not make you a bad person." "Women in particular are more prone to this health issue, which is why I am spending extra time on this."

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model and a concrete approach to engaging in culturally effective care in a fast-paced medical setting.

Listen

Imagine your patient or colleague has made a statement about a particular group that you have deep emotional connections with, and you completely disagree with their perspective. In addition, you feel offended, unsafe, or perhaps disgusted. Prior to responding, stop and internally acknowledge and explore your internal experience. Engage in a quick scan of your physiological, emotional, and intellectual experiences.

Empathize

It is critical, regardless of how you think and feel about the particular cultural trigger, that you access and express empathy and connect authentically to the patient and family, or to your colleague. You might be tempted to ignore or avoid engaging with your own thoughts and feelings for the sake of honoring the person who has been disenfranchised. However, in order to provide authentic empathy to others, you must first engage with your own history, anchored in values, morals, trauma, fear, or pride. Consequently, you may feel defensive, protective, disrespected, afraid, angry, or offended. Once you reflect on your internal process, express that while you have your own history and experiences, you can also empathize with the challenges the patient and family are experiencing.

Tell Your Story

You are in a position of power and authority simply by the nature of the provider–patient relationship. Cultural factors add additional layers of complexity to those interactions. It is highly likely that your patient is aware of at least some aspect of the power dynamics present in the exam room. You may choose to briefly acknowledge your own cultural identity through strategic self-disclosure, modeling transparency, demonstrating authenticity, and transferring the power dynamics into a collaborative process. Outside of the exam room, there are also power dynamics present such as seniority, popularity, institutional history, and supervisory structure that also contribute to the complexity of interactions. When issues related to cultural bias are also present, strategic self-disclosure can be particularly useful. Finally, depending on the affective and cognitive experiences related to the cultural triggers, telling your story may occur during the initial interpersonal interaction, at follow-up interactions, within a supervision or consultation relationship, or a combination of these.

Understand

Although every patient's experience is different, it is the provider's responsibility to be knowledgeable about the experiences of bias, prejudice, and racism that patients are forced to contend with because of their cultural identities. For example, you should be aware of the impact of poverty, health literacy, and other social determinants of health while your patient explains their unique challenges related to following up with treatment. Understanding systems allows the provider to identify the patient's experience in that system rather than viewing the patient based on their cultural identities alone. As recommended by the AAP and other professional organizations, providers must make the commitment to engage in ongoing professional development and acquiring new cultural competence knowledge and skills as necessary (AAP, 2004; American Psychological Association, 2017; National Association of Social Workers, 2015). Furthermore, knowledge of institutional history can also improve understanding of the affective, behavioral, and cognitive reactions of colleagues.

Psychoeducate

Having knowledge of how systems impact people allows providers to use research to both confront biases and educate others on common symptoms related to experiencing biases. For example, if a provider is knowledgeable about higher rates of homophobia within particular geographical, religious, and political groups, the provider will be more culturally effective when discussing social support challenges and resources for same sex parents of newborns.

LET UP on Cultural Tensions

Once you have engaged in the internal LET UP process and understand the theoretical underpinnings of each step, you are ready to implement the LET UP approach with patients, families, and professional associates. We provide three real-life vignettes to demonstrate implementation of the LET UP approach. The vignettes address ways to respond when patients express concerns regarding cultural bias and when colleagues demonstrate cultural biases in clinical and social settings.

Vignette 1: Concerns About Vaccinations

Jason is an incredibly adorable 12-month-old Black baby boy. You are not the only one who thinks that. His mom tells you he has more than 900 followers on Instagram! You have been seeing him since he was a newborn, and both his mother and father have been with him at most of the visits. You get along well with both parents and enjoy their visits. They have lots of questions as first-time parents, and you think that you have been able to answer them and reassure the mother and father that their baby is growing and developing beautifully. As you wrap up the visit, the mother asks about vaccines. She does not want Jason to get the measles, mumps, and rubella vaccine. When you ask her what her concerns are, she tells you that she heard that African-American boys have more reactions to the vaccine. You recognize that you are very triggered, so you engage in the LET UP approach (see Table 2).

Vignette 2: Pain Assessment

You are admitting a Black 3-year-old boy to the hospital after an accident on the playground where he broke his leg. Your Emergency Department colleague gives you an update on the

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Table 2. Vignette 1: Concerns About Vaccinations

Steps	Internal Processing	Approach
Listen	**What about this triggers you?** It is incredibly frustrating that parents are listening to people on social media, or antivax rhetoric, and refusing to vaccinate their kids, putting them and other children at risk. If you do not trust my judgement as a pediatrician, why are you coming to see me? I am afraid your child is going to get a vaccine-preventable illness. I want to protect him.	"It is scary to make a decision about vaccinating your child when you hear about kids having bad reactions, especially African-American boys, like Jason." **Sample questions to ask** What about this makes you uncomfortable? Where did you hear that information? Are you worried about something in specific? Is there someone in your family who is concerned about vaccines?
Empathize	**Honor your history and pain** I've studied a long time to be a pediatrician, and opinions about vaccines are based in science. My goal is to help people, not to hurt them. I am also aware that there is a long and terrible history of discrimination and racism in science. I know that many Black people mistrust medicine because of this. I wonder if that is what is happening with this family.	"Other patients have mentioned to me that they don't trust the medicine because of the history of experimentation on Black people and the Tuskegee study. Does that resonate with you?"
Tell your story	**Prepare for strategic self-disclosure** I am a pediatrician. I believe in vaccines. There are many studies that show that vaccines are safe and effective. I am a mom. I understand how scary it is to make decisions for my child that have any potential for side effects. When I saw that *20/20* special about a girl who could not walk or talk after she got the HPV vaccine, I had a fleeting moment of doubt. Even though the studies show that vaccines are safe, every medicine and vaccine has side effects. But I chose to give them to my kids anyway because if I can keep them from catching diseases or getting some types of cancer, I will.	"I deeply believe in the importance of vaccines. Part of me wants to go over all the studies that show that vaccines are safe, and my worries about vaccine preventable diseases, and the other part wants you to know how much I want to support and understand you. I also recognize that I am a white woman doctor and you are expressing concerns about your Black baby and that feels important to acknowledge, too. "Let me be open and honest, as a mom, I also worried about the things I heard. It's hard not to! And nothing is ever 100% safe. But I vaccinated my own children, because the risks of the diseases are much greater than the risks of the vaccine."
Understand	**Reflect on your role in the larger system of bias, prejudice, and racism** I am part of the medical establishment. The term *Latinx* refers to ethnicity not race. I identify as Latina but am white so don't look like what you expect (other than the fact that I speak fluent Spanish and love and always wear Mexican embroidered shirts!). I've struggled with this, am I Latino enough? In the end, I have come to terms that as a bilingual, bicultural Latino white woman, I can understand my Latino families at a deeper level than I would if I didn't have that background, and as an immigrant, having seen my parents be discriminated against, I can empathize with the feeling. But as a white, middle class, educated woman, I am privileged that I've never personally felt discrimination, and I don't worry about my kids in that way. In the exam room my Latino patients usually ask about my background. My white, Black, and Asian patients see me as white. That understanding helps me know where I stand as I navigate these complicated issues.	"You might not feel I can understand your concerns, maybe because I am a white woman, and a part of the medical establishment."
Psychoeducate	**Use your expertise to correct unhelpful/unhealthy thinking patterns** When kids are not vaccinated, it not only puts them at risk, it also affects their communities. There have been recent outbreaks of measles and pertussis all over the US. There are racial disparities in health care. Not vaccinating African American babies will only serve to increase these. Vaccines are the standard of care.	"The horrible things that happened to Black people related to medicine are real and I hear your concerns. But I worry that if this awful legacy causes African-American parents to stop vaccinating their children, that Black kids will be more vulnerable to vaccine-preventable diseases and suddenly there could be outbreaks of infections like measles, mumps, and pertussis, that could be devastating. Then this legacy will be doubly damaging. "Jason is an amazing little guy. I want to protect him and all my patients. He deserves to have the same level of care that I was able to offer to my own children, and that includes his vaccines."

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Providers may feel sad, angry, overwhelmed, frustrated, and incompetent in addition to a physical stress response.

child's status and you go to see the patient in the Emergency Department. The child is resting in his father's arms with a splint in place but appears uncomfortable. You ask when was the last time the child received any medication for his pain, and his parents, who are Somalian-American immigrants and are assisted by an interpreter, appear frustrated and reply that since being first seen and given "something" to help they haven't been asked about it. They are waiting on the nurses to return after bringing their concern about his pain up with them several times. You go back to your Emergency Department colleague to see if there was some concern or clinical reason behind this lag in treatment and your colleague's response is, "He seemed fine."

Although pain has been dubbed the "5th vital sign" (Baker, 2017), there has been a long history of pain being an area where patients' and clinicians' subjective beliefs enter into the interaction and care that is given and received. These beliefs continue to be influenced by cultural myths about Black individuals' biology. Myths such as Black people possessing "neurological stoicism" (Hoberman, 2012, p. 93) or having "thicker skin" not only linger in the general public but have been demonstrated in studies involving current medical students and resident physicians (Hoffman, Trawalter, Axt, & Oliver, 2016). These beliefs then lead to disparate outcomes in the treatment of children's pain, even in obvious incidences such as appendicitis (Goyal, Kuppermann, Cleary, Teach, & Chamberlain, 2015) or a broken leg (Todd, Deaton, D'Adamo, & Goe, 2000). So how do clinicians LET UP (see Table 3) in situations in which they suspect a colleague's bias is on display; bias they know leads to patient harm?

Vignette 3: Bias From a Colleague

You are at work at a community health center that employs a diverse staff of pediatricians, nurses, administrators, and interpreters and serves patients from various cultural and socioeconomic backgrounds. The health center is organizing a "Global Luncheon," a potluck-style meal meant for all employees to come together and celebrate their individual cultures during an afternoon of food and performances. One of your colleagues asks you why you have not signed up to bring in a dish, insisting that you must know how to cook food from India. She goes on to say that if you do not have time to cook, perhaps you can instead contribute by doing "that dance with your hands in the air." She expresses disbelief when you tell her you are not knowledgeable about either. See Table 4.

Conclusion

The LET-UP framework offers a concrete approach to the complicated and often vague world of culturally effective health care. The amount of time and comfort it takes to implement LET UP on cultural biases depends on both clinical expertise and level of cultural competency. It might feel awkward at first, but the more the model is used the more effective and efficient the implementation process. The key is going beyond the recognition that everyone has biases, to acknowledging that these biases affect the way individuals think, feel and interpret their interactions with others, and learning how to simultaneously honor personal experience and empathize while communicating with and educating patients and colleagues with bias challenges of their own.

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Nathan T. Chomilo, MD, practices as a general pediatrician and an internal medicine hospitalist with Park Nicollet Health Services/HealthPartners in Minneapolis, MN. He received a zoology degree from Miami University (Oxford, OH) and graduated from the University of Minnesota Medical School. He completed his combined residency in internal medicine and pediatrics at the University of Minnesota and was the

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pediatric chief resident at the University of Minnesota Children's Hospital. His advocacy work includes the impact early childhood intervention and health care access have on the long-term prospects of children and how physicians and health systems can address racial and health equity. He is a member of the American Academy of Pediatrics Council on Early Childhood and Section on Minority Health, Equity and Inclusion, is one of the Early Childhood Champions for the Minnesota chapter of the American Academy of Pediatrics, currently serves as the medical director of Reach Out and Read

Table 3. Vignette 2: Pain Assessment

Steps	Internal Processing	Approach
Listen	**What about this triggers you?** This is a child in pain who has not been treated when his family came here for help. I'm mad. How would my colleague be acting if it was their child or family member? Or a child and family that looked and sounded more like theirs?	"It sounds like the parents have tried to relay their concerns about their child's pain." **Sample questions to ask** "Was this brought to your attention?" "What did or did not concern you about this child's injury and pain?"
Empathize	**Honor your own history and pain** I'm a Black man with a multiracial son. I myself have received unequal treatment in many settings whether they be school, encounters with police, or service at restaurants and stores. I know this has created an awareness that others who haven't experienced this do not have. I also have many friends and family members who are all shades of black and brown. It angers, frustrates, and hurts me to think that if they ended up at the institution I work for with a similar injury or condition they could be subjected to this type of treatment.	"Pain is often relative and subjective. Getting a specific history of where pain is and how intense it is can be even more difficult when it is a toddler and can require more from us as we have less ability to get a detailed account of how they are feeling."
Tell your story	**Prepare for strategic self-disclosure** This isn't the first time I have witnessed this type of bias. It has been noticeable ever since I was a medical student. It is important to acknowledge my race and the perspective I bring yet also be aware that these are not easy conversations for everyone.	"I have had other experiences with colleagues undertreating or outright questioning patient reports of pain. I find it more common with Black and Brown patients and those who require an interpreter than with other patients. As a Black man, I wonder if this questioning is based on race. I know that any attempt to talk about how preconceived notions about race impact our clinical judgement and the care we give can be perceived as someone calling us bigoted. This isn't easy for me to say, and I do not want to offend you, I just want to make sure all our patients get the best care possible. Are you willing to explore this more with me?"
Understand	**Reflect on your role in the larger system of bias, prejudice, and racism** Although I have experienced bias and could recognize it, it is only in the last several years that I have learned about concepts such as implicit bias and race-based medicine. I also have had to unlearn much of what the "hidden curriculum" in medical school and residency teaches when it comes to implicit or explicit associations made about patients who are not white or who are poor, women, disabled, obese, etc.	"We are not taught in medical school how our own biases may impact our clinical judgement and care. And living in the US socializes us to have intentional and unintentional bias based on someone's race."
Psychoeducate	**Use your expertise to correct unhelpful/unhealthy thinking patterns** There is a lot of evidence of the impact on patient health outcomes of bias and personally mediated racism in medicine. However, it is not a common topic at conferences or educational workshops. The first step is often acknowledging we all have bias and understanding what some of your biases may be and how to identify them. We then have to think about how we can systematically decrease the impact our own bias has on our patients just like we would approach any other known and modifiable variable that is harming our patients.	"Did you see that *JAMA Pediatrics* study (Goyal, Kuppermann, Cleary, Teach, & Chamberlain, 2015) that has pointed out that cultural bias is often commonly related to Black pain? Because we are working with Black patients, this should be on our radar, to make sure we are not engaged in clinically culturally biased practices. Living in our current society, it is impossible not to have some kind of bias. When the field found out how dangerous it is to patients' health to not wash our hands we didn't just stop there, we learned to wash our hands every encounter. The same needs to be done for addressing bias."

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Minnesota, is an adjunct assistant professor of pediatrics at the University of Minnesota Medical School, has been appointed to the Minnesota Governor's Early Learning Council, and helped start the organization Minnesota Doctors for Health Equity (MDHEQ) where he serves as the vice president. His advocacy work with Reach Out and Read Minnesota and MDHEQ has been recognized by *MplsSt Paul* magazine in their 2018 Top Doctors: Rising Stars edition; by Reach Out and Read National, which awarded him the 2018 Medical Champion Achievement Award; and by the City of Minneapolis Department of Civil Rights, which recognized him as a 2019 History Maker at Home recipient.

Mariana Glusman, MD, has dedicated her career to decreasing health and educational disparities among low-income children. She is an associate professor of pediatrics at Northwestern University's Feinberg School of Medicine and an attending pediatrician at Ann and Robert H. Lurie Children's Uptown clinic where, for the past 22 years, she has cared for a diverse, multilingual, medically complex, underserved patient population. She completed her undergraduate studies at Brown University, medical school at the University of Chicago, and her pediatric residency at Children's Memorial, now Ann and Robert H. Lurie Children's Hospital of Chicago. She is the current president of the Illinois Chapter of the American Academy of Pediatrics (AAP) and is a member of the AAP Council on Early Childhood and Section on Minority Health, Equity and Inclusion. She is nationally recognized for her work with Reach Out and Read (ROR), a program that partners with pediatricians to promote early literacy development, and is currently serving as medical director of ROR Illinois, representing and supporting 130 ROR sites throughout the state, and training medical providers regionally on literacy promotion in pediatrics. Dr. Glusman is the author of *I Love You Like Sunshine: How Everyday Play and Bedtime Stories Grow Love Connections and Brainpower*, a book for newborns and their caregivers, with more than 55,000 copies in distribution in hospitals, clinics, libraries, and community programs nationwide.

Milani Patel, MD, is currently an outpatient pediatrician at Lincoln Community Health Center in Durham, NC. She completed her undergraduate studies at Tufts University and attended

Table 4. Vignette 3: Bias From a Colleague

Steps	Internal Processing	Approach
Listen	**What about this triggers you?** I don't appreciate when assumptions are made about me based on the color of my skin or my name.	"Thank you for trying to include me, especially since I have never participated in this event before." **Sample questions to ask** "Can you tell me more about the event?" "Is the event about representing a specific country or is it about bringing something that is meaningful and authentic?"
Empathize	**Honor your own history and pain** Being a first-generation immigrant (an American-born child of immigrants) has been a struggle at times, straddling two very different worlds and cultures, and it frustrates me when I am stereotyped.	"Though I myself do not feel comfortable representing my country of origin for this event, I understand you want this to be a successful event that is well-represented and inclusive."
Tell your story	**Prepare for strategic self-disclosure** A part of me feels like a failure, that I do not represent my parents' country well, that I may not pass aspects of my parents' culture, like language and food, to my children.	"I actually was born and raised in the United States and, though my parents are foreign born, I am and consider myself American. Though I grew up eating ethnic food, I actually have no idea how to cook it. This actually has been a source of conflict for me, as I struggle with how to pass my cultural heritage on to my children."
Understand	**Reflect on your role in the larger system of bias, prejudice, and racism** Understanding my own personal history as a first-generation immigrant has been a long process for me, so I should not assume others will grasp it so easily. I, myself, make assumptions about others, so it is not something for me to judge or become frustrated with when bias is directed toward me.	"I'm interested in hearing more about what your experience has been with people from an Indian background, both here at work and while you were growing up. I also recall you mentioning that you were born abroad. I would love to hear more about your migration story and your experience since moving to the US."
Psychoeducate	**Use your expertise to correct unhelpful/unhealthy thinking patterns** Recognizing one's own implicit biases is an important aspect of providing quality health care. My colleague works with many other providers as well as patients in this clinic, so I want to make her aware of her thought processes, so she can be a more effective team member.	"Though I appreciate your interest in my Indian background, I hope we can agree that a person's self-identity can be much more nuanced and complicated. This is likely true of many of our patients here at clinic. Though it is easy to make assumptions based on our own past experiences, it would be in the best interest of our patients to put aside any preconceived notions and biases and honor each patient's individual story."

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medical school and residency at the Albert Einstein College of Medicine/Children's Hospital at Montefiore in the Bronx, NY. She previously served as chief resident and faculty member of the residency program in social pediatrics, assistant professor in the Department of Pediatrics and Department of Family and Social Medicine at Montefiore, and outpatient attending at a community health center in the South Bronx.

Laura Krug, MSW, LCSW, is the director of training and technical assistance for HealthySteps, a program of ZERO TO THREE. Ms. Krug's team works to meet the expanding demands of this fast-growing nationwide program providing a 2-day onsite HealthySteps Institute to onboard new sites and creating new resources, webinars, newsletters, and both in-person and online trainings for existing sites. The team supports interested sites' efforts in bringing HealthySteps to their practices, and technical assistance with their implementation. Prior to joining ZERO TO THREE, Ms. Krug was the director of quality and a HealthySteps specialist at the Montefiore Medical Group in Bronx, NY. As the first HealthySteps hire at Montefiore, the program grew from one trial intervention site to being completely integrated into all 20 outpatient pediatric and family medicine practices in 10 years. Ms. Krug earned her bachelor of arts at Emory University and master of social work at Washington University in St. Louis, MO. Ms. Krug completed the Parent-Infant Study Center, a 2-year postgraduate training program of the Jewish Board of Family and Children's Services in New York City.

Margot Kaplan-Sanoff, EdD, retired as an associate professor of pediatrics at Boston University School of Medicine/Boston Medical Center where she served as director of the residency training in child development. She was the co-founder and national program director of HealthySteps, developing and implementing the HealthySteps model for more than 20 years. She was also responsible for training most of the original 78 HealthySteps sites nationwide before serving as a consultant to HealthySteps at ZERO TO THREE. She served as the infant specialist for Region 1 of the Head Start Quality Technical Assistance Initiative, while also directing Steps for Kids: A Family Recovery Outreach Training, OSERS/Outreach Training. Prior to her work at Boston University, she was an assistant professor and coordinator of the Teaching Young Children With Special Needs Graduate Program, Wheelock College.

References

American Academy of Pediatrics. (2004). Ensuring culturally effective pediatric care: Implications for education and health policy. *Pediatrics, 114*(6), 1677–1685. Retrieved from https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/effective-care.aspx

American Academy of Pediatrics. (2019). *Providing culturally effective care.* Retrieved from https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/effective-care.aspx

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality.* Retrieved from http://www.apa.org/about/policy/multicultural-guidelines.pdf

Baker, D. W. (2017). *The Joint Commission's pain standards: Origins and evolution.* Oakbrook Terrace. IL: The Joint Commission.

Crawford, D. E. (2012). *Therapists' awareness, identification, and management of culture-based countertransference.* (Doctoral dissertation, Miami University).

Fauth, J., & Hayes, J. (2006). Counselors' stress appraisals as predictors of countertransference behavior with male clients. *Journal of Counseling & Development, 84*(4), 430–439.

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165–181.

Goyal, M. K., Kuppermann, N., Cleary, S. D., Teach, S. J., & Chamberlain, J. M. (2015). Racial disparities in pain management of children with appendicitis in emergency departments. *JAMA Pediatrics, 169*(11), 996–1002.

Hoberman, J. (2012). *Black and blue: The origins and consequences of medical racism.* Berkeley, CA :University of California Press.

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America, 113*(16), 4296–4301.

National Association of Social Workers. (2015). *Standards and indicators for cultural competence in social work practice.* Retrieved from https://www.socialworkers.org/LinkClick.aspx?fileticket=ICxAggMy9CU%3d&portalid=0

Todd, K. H., Deaton, C., D'Adamo, A. P., & Goe, L. (2000). Ethnicity and analgesic practice. *Annals of Emergency Medicine,35*(1), 11–16.