Equitable Care in the Emergency Care Setting

The lived experience of being human varies greatly among people. The basic moral and ethical premise of the practice of nursing is respect for human dignity and the provision of unbiased and equitable care (ENA, 2022; ANA, 2021; Gurney et al., 2017). However, there continues to be a disconnect between the ethical standards and actual practice in large part due to biases, lack of cultural knowledge and humility, as well as inequities in healthcare that presents a threat to the well-being of historically marginalized populations, including people of the global majority (Baratipour et al., 2022; HHS, n.d.; National Academies of Sciences, Engineering, and Medicine (NASEM), 2021; Orr & Unger, 2020). The work of correcting health inequities must be a priority for nurses. Health equity work includes requires emergency nurses to gain an understanding how structural factors like racism and other forms of oppression impact social determinants of health (SDoH) resulting in disparate health outcomes.

The patients and communities that emergency nurses serve deserve to have clinicians who are committed to providing unbiased and equitable care. This requires that nurses practice reflexivity and the perspective that includes critically evaluating their own cultural beliefs to ensure that they provide and facilitate safe, culturally informed, and respectful care (Foronda, 2020; Kahlilanen et al., 2019). Thoughtful consideration of how biases, social determinants of health (SDoH), historical and structural inequalities, language, and cultural humility might affect the nurse-patient relationship is essential. In all aspects of nursing, in particular in the emergency care setting thoughtful consideration of how biases, social determinants of health (SDOH), historical and structural inequalities, language and cultural humility might affect the nurse-patient relationship.

ENA Position

It is the position of the Emergency Nurses Association (ENA) that:

1. Emergency nurses act with knowledge, compassion, and respect for human dignity and the uniqueness of every individual.

2. Emergency nurses deliver care in a manner that preserves and protects patient and family autonomy, dignity, rights, values, and beliefs.

3. Emergency nurses develop, integrate, and implement culturally informed nursing care.

4. Emergency nurses apply knowledge about the origins of health inequities to ensure that historically marginalized and minoritized populations receive unbiased and appropriate nursing care.

5. Emergency nurses be educationally prepared and have access to resources to promote and provide unbiased and culturally congruent healthcare.
6. Emergency nurses use appropriate language in communications with patients and their families that promotes health equity including but not limited to context, language proficiency, spoken and written words.

Background
The delivery of equitable care in the emergency care setting, particularly to populations that have been historically minoritized and marginalized, demands education/re-education on a variety of topics including but not limited to biases, social determinants of health (SDoH), causes of outcomes of health inequities, effective communication, language, cultural humility, and dignified care. Understanding basic definitions, how biases impact health outcomes, as well as nurses examining their own biases both conscious (explicit) and unconscious (implicit) will promote equitable healthcare.

Bias
Biases can be a significant barrier to providing equitable care. There are over 100 biases that directly impact health care (Joint Commission, 2016). Biases can be negative or positive and are often viewed as unfair when seen in healthcare. Health care providers, including emergency nurses, have both implicit (unconscious) or explicit (conscious) biases. Implicit biases by healthcare providers can lead to poor health outcomes and health disparities (Edgoose et al., 2019; Wolf et al. 2023). Implicit bias is developed sub-consciously early in life based on exposure to information from various sources including family beliefs, the community, schools, and media (Edgoose et al., 2019). This early life exposure causes one to associate particular traits, stereotypes and/or prejudices against persons of a particular ethnicity, gender, or social group that influences how they interact with those groups even though they may believe they are treating everyone equally. Regardless of the bias, those affected might be reluctant to seek care or feel shame if they do. Edgoose et al. (2019) and Wolf et al. (2023) believe that healthcare workers can understand, unlearn, and correct implicit bias to improve equitable health care. Edgoose et al. (2019) encourage healthcare workers to incorporate their eight “Strategies to Combat Our IMPLICIT Biases” as a way to combat biases.

Social Determinants of Health (SDoH)
Social Determinants of Health (SDoH) have a direct impact on health outcomes and include elements of the lived environment including education, employment, housing, income, health literacy, access to healthy food, and access to health care (HHS, n.d.; NASEM, 2021). SDoH affect the entire global population either positively or negatively and include a variety of social, economic, environmental, or other community conditions that impact health outcomes and can result in health inequities. According to the National Healthcare Quality and Disparities Report (NHQDR) (AHRQ, 2022) SDoH contribute more to health outcomes than the care provided while Donkin et al. (2017) compiled data showing that SDoH contribute between 45% and 60% of the variation in health status globally. SDoH are similar to building blocks in which an individual’s social needs (housing, transportation, insurance, etc.) are met which ideally supports better health outcomes with the goal of healthier communities. A lack of any one or combination of resources associated with SDoH such as access to healthy food might disproportionately affect a person’s health and/or health outcomes (AHRQ, 2022; NASEM, 2021; HHS, (n.d.).

Health Inequities & Health Disparities
Health inequities and disparities must be addressed by healthcare providers because those affected by them have little control over the conditions that make inequity and disparity pervasive globally. Health inequities and disparities are preventable. Health inequities are considered avoidable unfair differences such as distribution of resources and/or social conditions between differing populations that might prevent that group an opportunity to reach optimal health (World Health Organization, 2018).

Health disparities are preventable and measurable differences that affect an individual’s health or affect various populations that might be socially disadvantaged based on race, ethnicity, culture, gender, sexual identity or SDoH variables regardless of the patient’s age (AHRQ, 2021; AHRQ 2022). Emergency nurses must commit to providing and facilitating equitable care. Strategies for emergency nurses to improve care include knowledge of what causes health inequities, how they can directly improve health outcomes, examining one’s own biases that might impact everyday decisions as well as understanding the impact of communication and language.

Communication/Language
Communication is an integral part of the healthcare delivery system but is wrought with challenges and barriers. Some of these challenges/barriers are non-verbal (eye contact, facial expressions, or hand gestures) verbal communication, limited English proficiency (LEP), low health literacy, and mistrust of the healthcare system. Language is spoken, signed, and written communication between two or more people to convey information or express themselves. Language is an important part of any culture, constantly evolving with words and context always mattering. Stigmatizing language that may have seemed appropriate in the past are no longer appropriate especially patient labels commonly used in the emergency department (AMA/AAMC, 2021; Stubbe, 2020; Valdez, 2021). In addition to avoiding obviously derogatory labels, healthcare workers should strive to use “person first” language which places the emphasis on the patient and not the disease or disability. For example, “asthmatic” and “diabetic” should be replaced with “patient with asthma” and “patient with diabetes.” Adequate communication skills go beyond words or language. It requires all healthcare workers to improve understanding of different cultures represented in the emergency care setting population (Kaihlanon et al., 2019), to increase communication skills by improving cultural intelligence (Baratipour et al., 2022) and more importantly to stop using biased patient labels that contribute to health inequalities and disparities particularly among marginalized and minoritized populations (AMA/AAMC, 2021; Valdez, 2021). Increased awareness will enable better communication between the emergency nurse and their patients.

Culture/Cultural Competency, Humility & Intelligence
Despite the various names the importance of cultural competency has long been at the foundation of nursing education and a practice that is ever evolving (Orr & Unger, 2020). Culture includes the beliefs, behavior practices, societal norms, attitudes, rituals, languages, and customs that are incorporated into the way of life of an individual (Horvat et al., 2014; Merriam-Webster, 2023). Cultures can be related to racialized identity and ethnicity, but this is not always the case. Historically marginalized populations such as people who identify as LGBTQIA+, disabled people, and the deaf community also have unique cultures, which can be intersectional. Cultural competency involves knowing and understanding biases while cultural intelligence is the ability to adapt to various cultures seamlessly when communicating and caring for patients (Baratipour et al., 2022).
Cultural humility implies openness and respect for all cultures (Foronda, 2020). Cultural humility might appear to be new terminology but was initially defined by Tervalon and Murray-Garcia in 1998 to address cultural training of physicians to incorporate self-evaluation of biases in order to be empathetic with their physician-patient relationships (Foronda, 2020). Being a culturally humble nurse is an ongoing lifelong process in which the nurse participates in self-reflection and self-improvement to affect positive change.

Marginalized Populations
Marginalized and minoritized populations consist of any persons that experience bias based on traits, characteristics, and/or identity such as race, ethnicity, sexual or gender identity, persons with disabilities (ableism) as well as those with limited English proficiency (LEP) or low health literacy (AMA/AAMC, 2021; Schillinger, 2021). Importantly, many people actually belong to more than one group creating an overlap leading to intersecting inequities. Additionally, within various populations there is diversity meaning not all within an identified group share the same cultural experiences and beliefs. Research shows that marginalized and minoritized populations experience health inequities including decreased access to healthcare services, worse health outcomes, and a lower quality of care (Brach & Fraser, 2022; Schillinger, 2021).

Health inequities exist in many marginalized populations. One example of a marginalized population that experiences health inequities include members of the LGBTQIA+ community. Gender identity is related to a person’s internal sense of being male, female, both, or neither and often begins at a young age (ENA, 2019; Milici, 2022). Sex is determined by anatomic and physiologic features. How an individual identifies may or may not be the sex assigned to them at birth. Transgender people are those whose gender identity is not the same as the sex they were assigned at birth (ENA, 2019; Milici, 2022). Sexual orientation is different from gender identity: it refers to the way that individuals relate to or express sexual attraction to other people, which is independent of gender identity (ENA, 2019, Milici, 2022). Understanding basic definitions such as these and taking measures to promote respectful and effective communication including using the patient’s stated pronouns is one small but significant first step that emergency nurses can take to begin creating a gender-affirming practice environment (ENA, 2019).

Other marginalized populations may include but are not limited to members of racial, ethnic, or religious groups as well as persons with disabilities, LEP, or low health literacy. Each specific population has unique characteristics and healthcare needs and can be affected by SDoH and clinician biases.

Emergency nurses are on the forefront of patient care in emergency departments and must advocate for the dignity and humanity of all people and communities. A recent study published in the Journal of Emergency Nursing examined the experience of United States emergency department nurses related to witnessed and experienced bias (Wolf, et.al, 2023). The mixed methods study included 1140 nurses in the survey arm and 23 participants in the focus group (Wolf, et.al, 2023). Results revealed significant differences in “reported experiences of institutional, structural and personal microaggressions for non-white versus white participants” (Wolf, et.al, 2023, p. 175). The authors concluded safe patient care is threatened by racism and...
other forms of bias and challenged institutions and emergency nurses to engage in learning opportunities to reflect on biases, both implicit and explicit, they may hold to affect positive change (Wolf et. al, 2023).

In summary, improved educational efforts are essential for all staff to promote a culture of inclusivity, sensitivity, and respect for all humans regardless of their identity. Quality improvement efforts focusing on staff competency and communication training for diversity, equity, inclusivity, cultural humility, electronic health record modification, and assurance of privacy for discussing identity and culture are some ways emergency departments can create an inclusive equitable care environment. Other measures include assuring resources are available for interpretive services in various languages with due consideration for the patient’s literacy. It is important that emergency nurses not only advocate for the inclusion of the patient’s cultural beliefs, personal identity, and practices in all dimensions of healthcare but also practice humility with all patient populations.

Resources
Agency for Healthcare Research and Quality (AHRQ) (2020). Consider Culture, Customs, and Beliefs: Tool #10. AHRQ, Rockville, MD.


American Nurses Association (2021) National Commission to Address Racism in Nursing


Emergency Nurses Association (2023). Diversity, Equity, and Inclusion in Action...
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Milici, Justin; Bergeson, Meg; Brennan, Elizabeth; McLaughlin, Kirstin; Neira, Paula M; Wall, Matthew; Wohlt, Christi (2019). Care of the LGBTQ patients in the emergency care setting toolkit.
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