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Public HealthEd

BIAS AND BELONGING: Cultivating Community

FEATURE:
CULTIVATING
SOCIAL
BELONGING AS
A PILLAR OF
WELLNESS

**SPECIAL
REPORT:**
BEYOND THE
CLIPBOARD:
DISMANTLING
PROVIDER BIAS
TO REBUILD
PATIENT TRUST



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LETTER

from the

EDITOR

“Dismantling bias and engineering spaces of radical belonging is not an administrative burden or an optional checkbox.”

The clinical encounter is, at its core, a vulnerability contract. A patient steps into an examination room, steps away from the comfort of their daily life, and discloses intimate physical or emotional realities. In return, they expect an objective evaluation rooted in science and delivered with empathy. Yet, beneath the clinical, sterile surface, an invisible friction often persists. When implicit bias dictates clinical assumptions, that foundational contract is broken.

This month, we invite you to explore the vital intersections of bias and belonging.

Throughout this issue, we pull back the curtain on the subtle, structural, and systemic forces that quietly dictate who gets healed and who gets left behind. Our article, *Beyond the Clipboard: Dismantling Provider Bias to Rebuild Patient Trust*, challenges the medical community to move past superficial checklists toward deep, structural accountability.

We confront the historical skepticism woven into modern medicine in our Women's Health Spotlight, *Overcoming the Gender Pain Gap and Diagnostic Bias*, and analyze how emotional wellness is shaped by our sense of belonging in our communities in *What Happened to Places Where We Simply Belong?*

But identifying systemic friction is only half of our responsibility. True health equity requires us to build a visionary, solution-oriented future. In this edition, we also shift our focus toward the material and emotional dimensions of inclusion. We look at how belonging can be intentionally designed into the very fabric of our healthcare

infrastructure—from the representation in medical media and inclusive clinical environments to models of shared community governance. Finally, we ground these structural changes in an exploration of emotional belonging and emotional wellness, recognizing them not as optional luxuries, but as foundational pillars necessary for overall health, healing, and holistic wellbeing.

Dismantling bias and engineering spaces of radical belonging is not an administrative burden or an optional checkbox. It is a core clinical competency, and the definitive first step toward a healthcare ecosystem where everyone truly belongs.



Editor-in-Chief

Vaishnavi Bharadwaj

CULTIVATING SOCIAL BELONGING AS A

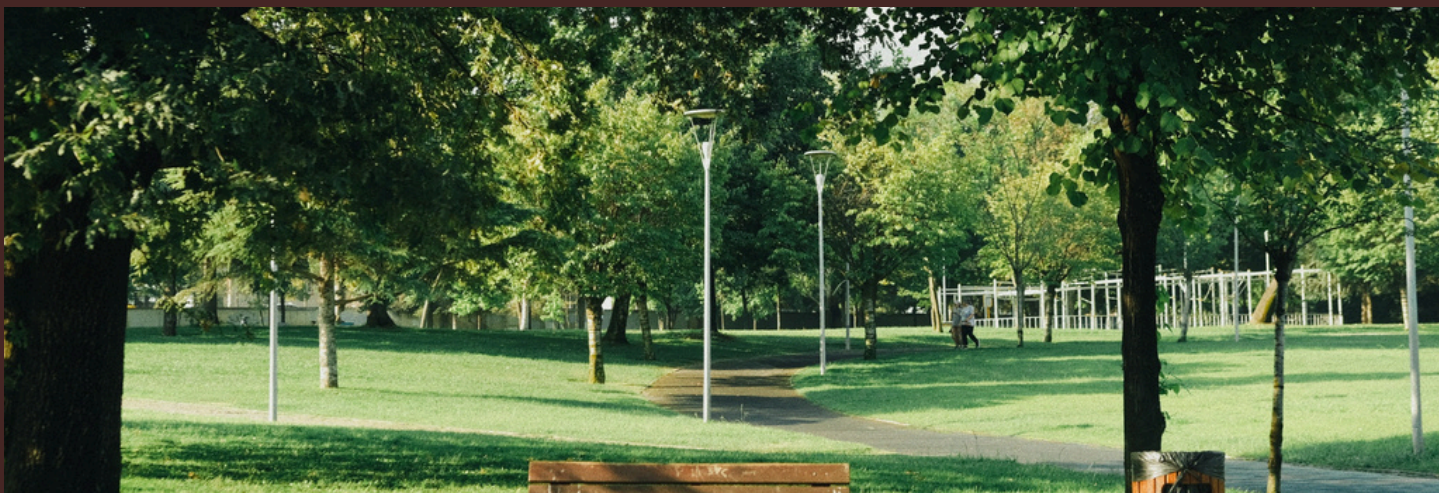


PILLAR OF WELLNESS

By
Vaishnavi Bharadwaj

There was a time when belonging happened naturally. Children played outside until the streetlights came on. Neighbours knew each other. Families gathered without scheduling it. Conversations happened without notifications. Friendships were built over time, not algorithms.

Somewhere along the way, we became more connected than ever before—and yet many of us have never felt more disconnected. Today, we have thousands of followers but very few people we can call when life becomes difficult. We have endless content but very little reflection. We have information everywhere, but wisdom seems increasingly hard to find. Work follows us home. Phones follow us everywhere. Cafés are often noisy. Malls are crowded. Homes can feel isolating. Even our moments of rest are interrupted by screens competing for our attention.



And while mental health has rightly become an important conversation, it sometimes feels as though we have only two options: either struggle silently or seek professional help when things become overwhelming. But this binary misses a vital truth about human psychology: clinical interventions cannot replace the protective power of everyday social belonging. Emotional wellness is deeply tied to the informal, unscripted spaces of community life—and to protect our collective mental health, we must intentionally rebuild them.

The Pathology of Separation

In modern public health discourse, we frequently treat mental health struggles as purely individualized, neurochemical events. While biological factors are undeniable, this narrow framework overlooks the profound impact of our social environment.

Human beings are evolutionarily wired for interdependence; our nervous systems are designed to co-regulate with others.

When structural isolation and digital saturation disrupt this baseline, the psychological consequences are measurable:

- **The Hypervigilant Mind:** Deep, chronic loneliness triggers a survival mechanism in the brain. Without a reliable "tribe" to provide safety, the nervous system shifts into a state of hypervigilance, elevating cortisol levels and keeping the mind in a low-grade, persistent state of anxiety.
- **The Loss of the "Third Place":** Spaces like local parks, community halls, and neighborhood plazas provide an anchor for regular, low-stakes human contact. As these spaces disappear or become commercialized, we lose the casual encounters that ground us in a shared reality.

- **The Perfectionism Loop:** When our primary avenue for connection is mediated by curated digital platforms, our relationships become transactional and performance-based. We swap authentic vulnerability for performative updates, further alienating ourselves from the messy, healing reality of genuine human flaws.

Reclaiming Collective Well-Being

Addressing the loneliness epidemic requires moving beyond self-care checklists and individual coping mechanisms. True psychological resilience is built collectively. To cultivate an environment where emotional belonging supports mental wellness, we must foster intentional shifts in our daily lives:

1. Designing Pockets of Shared Silence and Presence

Reclaiming belonging means actively protecting spaces from digital intrusion. Whether it is enforcing phone-free family meals, organizing local walking groups, or creating quiet, community-centered reading spaces, we must build environments where deep reflection and unhurried conversations can breathe without the competition of screens.

2. Normalizing Low-Stakes Community Care

We need to close the gap between everyday life and crisis intervention by revitalizing informal networks of mutual aid. True belonging means knowing that if a crisis hits, an overextended healthcare provider isn't your only lifeline; your neighbors, peers, and local community members are there to catch you before you fall.

3. Cultivating Relational Humility

Belonging thrives when we drop the pressure to look perfect and embrace the vulnerability of being known. It requires us to show up for others consistently—not just when it is convenient or algorithmically rewarded—and to build friendships rooted in shared values, shared struggles, and shared humanity.



Healing Happens Together

Clinical therapy and medical support are indispensable tools for managing acute mental health crises. However, the ultimate goal of psychological healing is not merely the absence of clinical symptoms; it is the presence of a meaningful, connected life.

We cannot expect individuals to heal in isolation from the very environments that fractured their well-being. By actively dismantling the systemic isolation embedded in modern life and intentionally engineering communities of safety, presence, and mutual respect, we do more than just lower anxiety statistics. We restore the baseline contract of human society: the reassuring, quiet certainty that you are not walking through this world alone.

Beyond the Clipboard: Dismantling Provider Bias to Rebuild Patient Trust

The clinical encounter is, at its core, a vulnerability contract. A patient steps into an examination room, steps away from the comfort of their daily life, and discloses intimate physical or emotional realities. In return, they expect an objective evaluation rooted in science and delivered with empathy.



Yet, beneath the clinical surface, an invisible friction often persists. When a practitioner looks at a patient, they do not just see a clinical case; they see a person through a lens shaped by their own upbringing, social stratification, and structured medical training. When implicit bias dictates clinical assumptions, that foundational contract of vulnerability is broken. To build a healthcare ecosystem where every community member truly feels safe, we must look past the paperwork and address the deep-rooted biases that quietly erode patient trust across diverse populations.

The Anatomy of the Trust Gap in Diverse Communities

Implicit biases—the subconscious associations and stereotypes we hold without conscious awareness—are not moral failings; they are cognitive shortcuts. However, in medicine, these shortcuts have measurable, sometimes life-altering, consequences.

Across communities, public health data and lived experiences reveal that marginalized groups consistently face distinct barriers to equitable care.



Whether it is the dismissive treatment of individuals from lower socio-economic or rural backgrounds, language-based discrimination, the minimization of women's health concerns, or the immediate pathologizing of higher-weight patients before a true diagnostic workup begins, the trends are deeply entrenched.

When patients repeatedly encounter a healthcare system that minimizes their symptoms, misinterprets their lifestyles, or treats their background as a hurdle, they experience a profound form of clinical alienation. The result is a systemic trust gap. Families stop seeking preventive care, delay presenting to clinics until conditions are advanced, and withhold critical symptom histories out of fear of judgment or being misunderstood. The clipboard, meant to be a tool for gathering diagnostic data, transforms into a shield that insulates the provider from the patient's actual reality.

Moving From "Checking Boxes" to Cultural Humility

For years, institutional responses to these disparities have focused on rigid diversity checklists. While well-intentioned, this approach carries a fundamental flaw: it suggests that community dynamics and diverse cultural realities are static textbook chapters that a provider can simply memorize, test out of, and master.

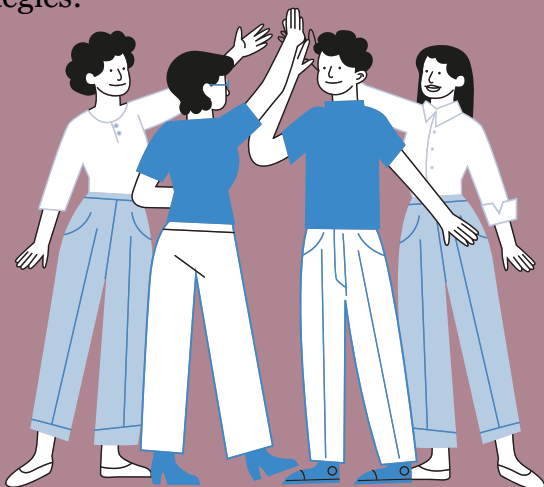
True equity requires a shift from superficial competence to cultural humility.

Cultural Humility is a lifelong commitment to self-evaluation and critique. It requires a provider to relinquish the role of the ultimate expert on the patient's life, acknowledging that the person sitting in the clinic is the true expert on their own body, environment, and daily lived experience.

Where a rigid checklist says, "I know your background," humility says, "I want to understand your unique reality, and I recognize that my own perspective has limits."

Structural Frameworks for Clinical Change

Dismantling bias cannot rely solely on individual goodwill; it requires structural, protocol-driven changes within everyday clinical workflows. To move the needle, healthcare organizations and practitioners can implement three core strategies:



1. **Standardizing Clinical Intake Protocols:** Objective, standardized intake procedures reduce the room for subjective, biased assumptions. By ensuring that every patient receives the same comprehensive diagnostic pathways, regardless of baseline demographics, literacy levels, or physical appearance, clinics can minimize the risk of premature diagnostic closure—the tendency to stop looking for answers once a convenient stereotype fits.
2. **Mitigating Cognitive Overload in High-Volume Settings:** Implicit bias thrives under pressure. When providers are overworked, managing massive daily patient volumes, and sleep-deprived, their brains default to cognitive shortcuts. Restructuring clinical schedules where possible and utilizing community health workers to bridge the gap helps protect the diagnostic process from rushed, biased decisions.
3. **Practicing Active Micro-Affirmations:** Just as subtle biases alienate, intentional micro-affirmations build trust. Simple shifts—such as practicing inclusive, respectful body language, speaking in the patient's preferred language or securing clear translation, utilizing collaborative decision-making models, and validating self-reported symptoms—signal to the patient that they are a respected partner in their own care.

Rebuilding the Contract

Rebuilding patient trust does not require providers to be flawless; it requires them to be accountable. It demands that the medical community acknowledges the historical and ongoing biases embedded within its own social structures and training institutions, and actively works to unlearn them.

When a provider steps out from behind the clipboard, looks a patient in the eye, and listens with an open, analytical mind free of preconceptions, the clinical encounter changes. It transforms from a rigid administrative transaction into a space of genuine healing, mutual respect, and shared humanity.

WHAT HAPPENED TO PLACES WERE WE SIMPLY BELONG?



By Dr. Srivats Bharadwaj

But what about everything in between? What about the ordinary human need for connection, conversation, learning, music, reflection, community, and simply being around other people without pressure or expectation?

What about places where people can slow down before they burn out? What about places where a student can study quietly, a parent can unwind, a professional can work in peace, a retiree can share stories, a musician can inspire, and strangers can leave as friends?

Perhaps what many of us are seeking is not another app, another course, or another social media platform. Perhaps we are seeking what previous generations often had without realising its value - a place to gather, to learn, to listen, to share, and to feel part of something larger than ourselves.

Not a hospital. Not a counselling centre. Not a workplace. Not a shopping destination. Just a warm, welcoming human space. A place where books, music, ideas, stories, conversations, creativity, silence, and community can coexist. A place where nobody is expected to perform. A place where people can simply be.

In a world that often feels rushed, fragmented, and transactional, perhaps the greatest luxury is not technology, wealth, or convenience. Perhaps the greatest luxury is belonging. And perhaps it is time we started creating spaces that make that possible again.

There was a time when belonging happened naturally. Children played outside until the streetlights came on. Neighbours knew each other. Families gathered without scheduling it. Conversations happened without notifications. Friendships were built over time, not algorithms.

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Today, we have thousands of followers but very few people we can call when life becomes difficult. We have endless content but very little reflection. We have information everywhere, but wisdom seems increasingly hard to find.

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THE GENDER PAIN GAP

and

DIAGNOSTIC BIAS

For centuries, a quiet crisis has played out in emergency departments, primary care clinics, and specialized medical centers around the world: the systematic minimization of women's physical pain. When a female patient articulates severe, debilitating symptoms, her clinical reality is frequently filtered through a historical lens of skepticism. Where a male counterpart's report of pain is often met with immediate diagnostic investigation, a woman's pain is disproportionately attributed to emotional, psychological, or psychosomatic origins.

This systemic trend is known as the gender pain gap—the measurable disparity in how pain is perceived, diagnosed, and treated based on a patient's gender. Rooted in deep-seated diagnostic biases, this gap doesn't just alienate patients; it leads to delayed diagnoses, prolonged suffering, and preventable clinical complications. To bridge this divide, the medical community must dismantle historical biases and shift toward a framework that treats lived patient experiences as objective clinical data.

The History of the "Hysterical" Patient

The dismissal of women's health concerns is not a modern anomaly; it is an institutional inheritance. For millennia, Western medical literature relied on the diagnosis of "hysteria"—derived from the Greek word for uterus (*hystera*)—as a catch-all explanation for virtually any unexplained physical symptom a woman experienced, from chronic pain to seizures. While hysteria was officially struck from psychiatric manuals in the late 20th century, its underlying cognitive shortcut remains firmly embedded in modern clinical culture. Today, this manifest as **diagnostic overshadowing**, where physical pathology is prematurely dismissed as anxiety, stress, or lifestyle factors.

- **Surgical and Diagnostic Delays:** Public health data consistently shows that women face significantly longer wait times for diagnoses across a spectrum of conditions. For instance, the average diagnostic delay for endometriosis ranges from seven to ten years globally, during which patients are routinely told their debilitating pelvic pain is merely a "normal period."

- **The Cardiovascular Paradox:** Cardiovascular disease is a leading cause of mortality among women, yet women presenting to emergency departments with acute coronary syndrome are significantly less likely to be assigned a high triage priority compared to men. Because women frequently present with "atypical" symptoms—such as jaw pain, nausea, and shortness of breath rather than classic crushing chest pain—their cardiac events are frequently misdiagnosed as panic attacks.
- **The Under-Medication Phenomenon:** Studies in emergency medicine reveal that women are less likely to be prescribed appropriate doses of opioid analgesics for acute abdominal pain and face longer wait times to receive pain medication altogether, reflecting a subconscious clinical assumption that women exaggerate their physical distress.

The Root Causes: Exclusion and Overload

The gender pain gap is sustained by two primary structural failures within medicine: historical research exclusion and high-pressure clinical environments.



1. The Medical Research Gap

For decades, biomedical research and clinical trials standardly excluded female subjects—both human and animal—under the assumption that fluctuating hormonal cycles introduced too many variables into data collection. Consequently, standard diagnostic criteria, pharmaceutical dosages, and anatomical benchmarks were constructed using a male baseline. Medicine, by design, has long treated the male body as the human default, leaving a profound deficit in our understanding of conditions that uniquely or disproportionately manifest in women.

2. Cognitive Shortcuts Under Pressure

Implicit bias does not require conscious malice; it thrives on cognitive overload. In fast-paced clinical environments characterized by high patient volumes and administrative burdens, a provider's brain naturally seeks cognitive shortcuts to reach rapid decisions. When faced with complex, multi-system chronic conditions—such as autoimmune diseases, which disproportionately impact women and lack a single, straightforward diagnostic biomarker—overburdened clinicians are highly susceptible to premature diagnostic closure, defaulting to the path of least resistance: "It must be stress."

From Skepticism to Validation: Redesigning Care

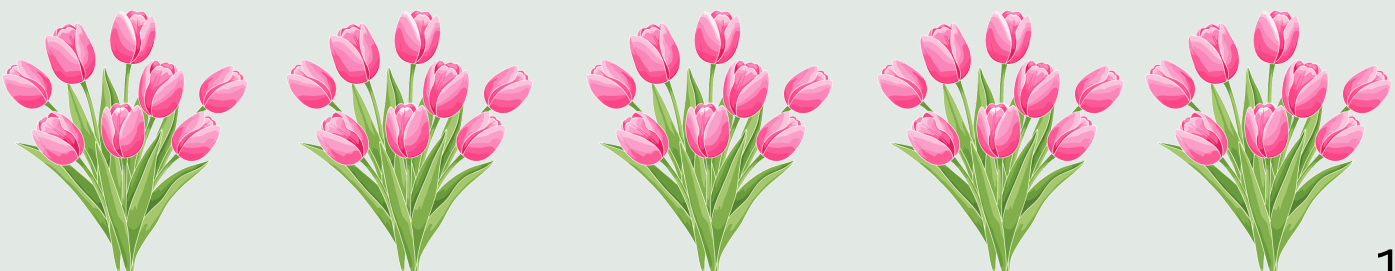
Closing the gender pain gap requires a structural shift from a culture of reflexive skepticism to one of objective validation. To achieve this, clinical workflows must be intentionally restructured to protect patients from diagnostic bias:

- **Standardizing Symptoms-First Intake Protocols:** Standardized diagnostic pathways that force clinicians to systematically rule out physical pathology based on clinical metrics—rather than subjective initial impressions—can minimize the influence of gendered assumptions.
- **Integrating Lived Experience into Objective Data:** A patient's self-report of pain and functional impairment must be treated as critical diagnostic data points, not merely subjective anecdotes. If a patient notes that their pain disrupts daily baseline functioning, that metric carries the same weight as a lab value.
- **Medical Education Reform:** Medical curricula must actively integrate sex- and gender-specific medicine, educating future practitioners on the distinct physiological presentations of disease in women and explicitly training students to recognize and interrupt implicit gender biases during clinical rotations.

Believing Women is a Clinical Competency

Overcoming the gender pain gap is not an ideological luxury; it is a fundamental requirement for clinical safety and systemic health equity. A healthcare system cannot claim to be evidence-based if it routinely minimizes the evidence provided by half of the population it serves.

When a clinician steps out from behind gendered assumptions, listens to a patient with an analytical and open mind, and validates her physical reality, the dynamic of care shifts. Trust is restored, diagnoses are accelerated, and the clinical space finally becomes what it was always intended to be: a landscape of true safety and belonging.



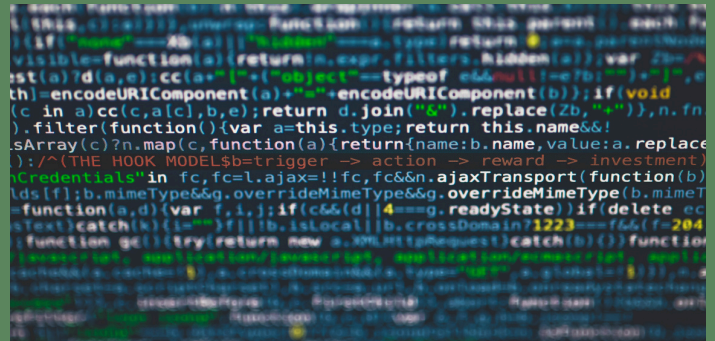
MYTH OR FACT? THE TRUTH ABOUT "OBJECTIVE" DATA



Myth: Algorithms are always unbiased because computers don't have opinions.

01

Fact: Algorithms learn from human-created data, which may contain historical biases and inequities.



Myth: More data automatically means fairer healthcare decisions.

02

Fact: Large datasets can still reflect unequal access to care, leading to biased outcomes.



Myth: If a healthcare tool works for most people, it works equally well for everyone.

03

Fact: Some medical technologies and algorithms may perform differently across populations if diversity was not considered during development.



Myth: Bias in healthcare only comes from individual providers.

04

Fact: Bias can also be embedded in systems, policies, technologies, and clinical algorithms.



Myth: Algorithmic bias is a technology problem, not a healthcare problem.

05

Fact: Biased algorithms can affect diagnoses, treatment recommendations, resource allocation, and patient outcomes.



The Anatomy of an Inclusive Encounter: Micro-Affirmations in Clinical Care

Small words. Big impact. Better care for everyone.

1 GREET WITH RESPECT

Start with a warm, respectful greeting that affirms every patient's humanity.

"Welcome! What name and pronouns would you like me to use?"

"How can I best support you today?"



Micro-affirmations are small, intentional actions and words that recognize and respect each patient's identity, experience, and dignity. They build trust, reduce bias, and improve health outcomes.

2 LISTEN DEEPLY AND WITHOUT ASSUMPTIONS

Let patients be the experts of their own lives and experiences.

"Thank you for sharing that with me. I'm here to listen."



3 ACKNOWLEDGE IDENTITY AND EXPERIENCE

Recognize the many identities and lived experiences that shape health.

"I see you. Your experiences matter in your care."



4 USE INCLUSIVE LANGUAGE

Words matter. Use language that affirms, respects, and includes.

"Let me know if there's a different word you'd like me to use."



Inclusive care isn't just what we do—it's how we show up, every time.

5 PARTNER IN DECISIONS

6 RESPECT BOUNDARIES AND PREFERENCES

7 ADDRESS BIAS AND BARRIERS

Share information clearly and invite patients into decisions about their care.

"What matters most to you as we make this decision together?"



Honor cultural, spiritual, and personal preferences that support comfort and trust.

"Are there any cultural or personal preferences I should know about to support your care?"



Name bias when you see it. Advocate for equity in care.

"I'm sorry that happened. You deserve to be heard and respected."



8

CLOSE WITH CARE AND CONTINUITY

Affirm ongoing support and follow through—because trust is built over time.

"Thank you for trusting me with your care."

"Is there anything else you need before we finish today?"

"I look forward to continuing to support your health."



WHY IT MATTERS



Builds trust and stronger relationships



Improves patient experience and engagement



Leads to better health outcomes for all



Creates a culture of belonging in healthcare



REMEMBER:

You don't need the perfect words—just the willingness to see, respect, and care. Every micro-affirmation makes a difference.

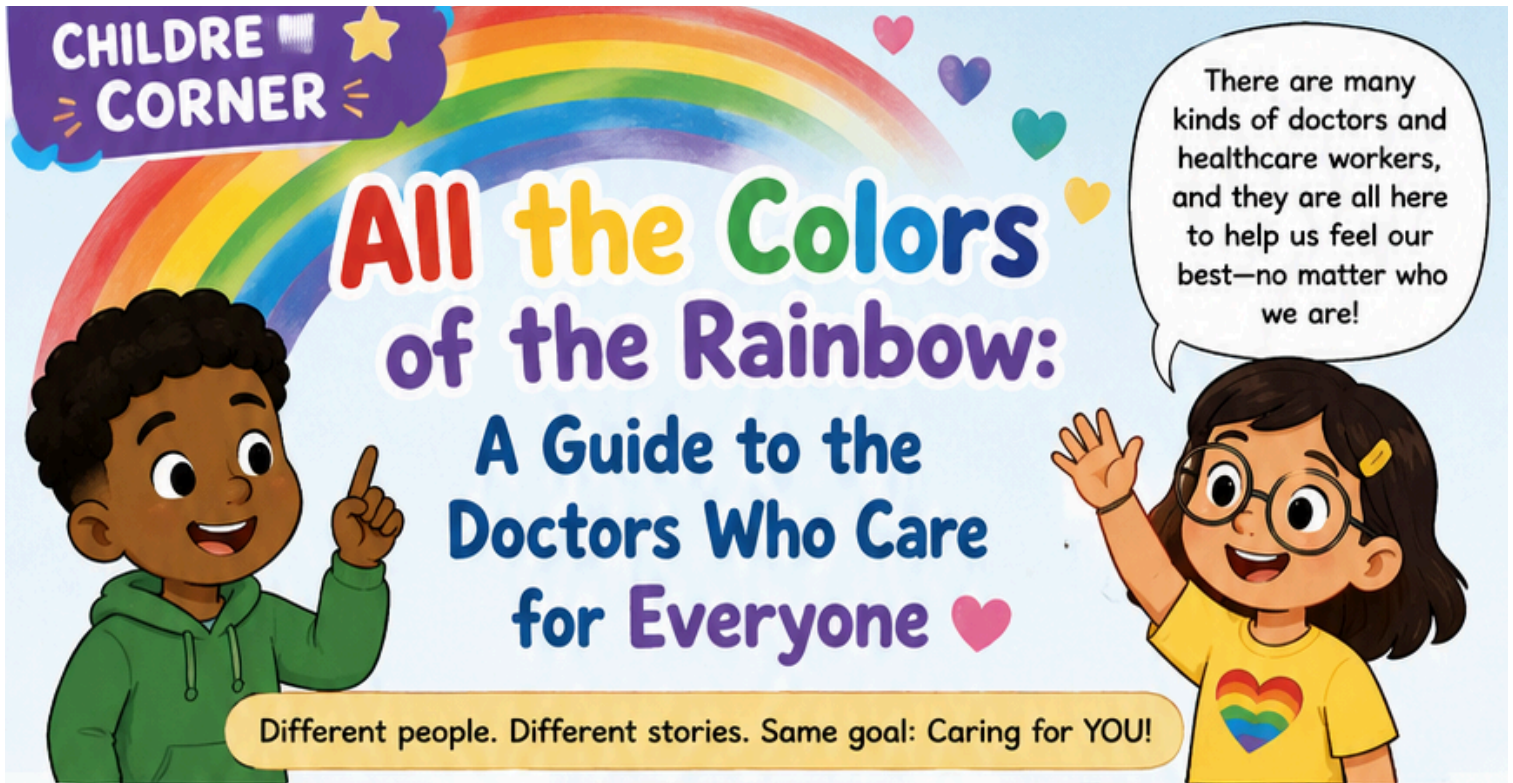


🌸 Inclusive care is quality care. Every patient. Every time. 💜

CHILDREN'S CORNER

By Vaishnavi Bharadwaj

A Guide to the
Doctors Who Care for
Everyone



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A Guide to the
Doctors Who Care for
Everyone

The Mental Health Professional
Listens, supports, and helps
with big feelings.

It's okay to talk
about how you
feel. I'm here
for you.



The Interpreter
Helps everyone
understand and
be understood.

I help share
what's important
in everyone's
language.



And Many More!

Pharmacists, Physical
Therapists, Optometrists,
Social Workers, and more!



We all belong in healthcare.

Everyone deserves kindness, respect, and fair care.
When we include everyone, we help **everyone!**



**Different colors. Different strengths.
Together, we make a healthier world!**



Next time you visit a clinic or hospital, look around and remember:
There's a whole team of caring people who see you, hear you, and care about you.



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