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Justice and unintentional discrimination in health care: A qualitative content analysis

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Abstract:

BACKGROUND: Discrimination in health care is a common phenomenon whose complete understanding has always been a major concern of health-care systems to control and reduce it. This study aimed to explore the experiences of unintentional discrimination and related factors in health-care providers.

MATERIALS AND METHODS: This qualitative study was conducted with a content analysis approach in 2019. Data were collected through semi-structured interviews with 13 health-care providers including two physicians, three nursing supervisors, two head nurses, four staff nurses, and two nurse aides in two general hospitals in Tehran, Iran. Participants were selected through purposeful sampling. The obtained data were analyzed by Graneheim and Lundman method.

RESULTS: Three main categories and eight subcategories were obtained from the data analysis: (1) forced discrimination (superiors' pressures and executive orders, occupational concerns, and fear of the superiors); (2) guided discrimination (professional challenges, managers' policymaking, and lack of medical ethics knowledge); and (3) lack of resources (workforce shortage and lack of medical equipment).

CONCLUSION: The results of this study suggest that health-care providers such as doctors and nurses are unintentionally forced to provide discriminatory care on some occasions. Knowing and managing these unwanted factors can partly counteract unintentional discrimination. Thus, preventing the factors that lead to superiors' pressures and occupational forces and improving the medical ethics knowledge should be considered by health-care managers.

Keywords:

Content analysis, discrimination, ethics, health care, justice, qualitative research

Introduction

The ethical principle of justice concerns closely intertwined concepts such as "justice in health," "discrimination," and "equity." The European Institute of Bioethics defines the concepts of justice and equity in health as follows: "justice in health means the lack of systematic and potentially resolvable differences in one or more aspects of health in a population and economic, social and geographical subgroup." Accordingly,

discrimination is the opposite of justice in health-care provision.^[1] Discrimination in health care means a lack of provision, incomplete provision, or different provision of health care to an individual or group of individuals because of their individual and social characteristics.^[2,3] Discrimination in health care is experienced by many in the community, but reported only by some,^[2] most of whom are minorities in terms of race, ethnicity, or certain diseases or conditions, such as physical and mental disability.^[4] Discrimination in health care manifests itself in various forms such as

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discrimination based on sex,^[5] race,^[6] age,^[7] type of illness, religion,^[8] language,^[9] economic status, and social status,^[10] in all of which individual's access to health services is reduced or is of poor quality.

Piette *et al.* explained the situation in their study as one-third of adults in the US experience discrimination in health care in their daily lives, and that 7% of them experience it several times.^[11] In a study titled "Experienced discrimination amongst European old citizens," van den Heuvel states that on an average 26% of respondents aged 62 years sometimes and 11% of them always experience age discrimination.^[12] In a study titled "Discrimination Experience and Health Status in Spanish Immigrants," Rodríguez-Álvarez (2017) reports that at least one per ten immigrants experienced discrimination in receiving health care. They also stated that these discriminations were not due to the age, sex, and educational level of the immigrants, but merely due to their being an immigrant and ethnic differences.^[13] In another study in the UK in 2010, 1301 people over the age of 50 were surveyed, of whom 23% reported that they had experienced age discrimination in the past year.^[14] In addition, studies conducted in 28 European countries have introduced age as the most significant reason for discrimination so that one-fourth of older adults (aged over 62) have sometimes or often experienced age discrimination.^[15]

Discrimination in health-care provision has significant consequences. In several studies, Wheeler (2014), Rodríguez-Álvarez, and Wofford (2019) examined negative consequences and effects of health-care discrimination in its various forms. In a study titled "The vicarious effects of discrimination: How partner experiences of discrimination affect individual health" Wofford (2019) states that the experience of discrimination in care leads to a decrease in the confidence of patients and clients, as well as complications such as being exposed to and experiencing multiple stressors and its specific effects, anxiety, depression, hypertension, and even developing specific health problems and risk factors such as obesity, breast cancer, and substance abuse.^[12,13,15,16]

Various organizations, particularly the WHO, have designed and implemented various strategies to combat discrimination in health care such as continuous education of ethical principles for health-care providers, continuous review of health-care policies, supporting community members, and emphasizing their reporting in case of experiencing discrimination in clinical settings,^[9,17] but discrimination continues to occur in health-care provision.^[18-21] Perhaps, low effectiveness of these policies and strategies can express the fact that they were not based on the full recognition of discrimination

dimensions in health care. It is noteworthy that most studies on discrimination are quantitative research on the extent of occurrence and negative consequences, while few have addressed reasons for the emergence and subjective aspect of discriminative behaviors in health-care providers' on the other hand, perceived discrimination is influenced by culture and social factors and is perceived differently by individuals in various societies.^[22-25]

Hence, a complete understanding of discrimination in providing health care and related factors is essential to adopt effective strategies for controlling and eliminating discrimination in health care. Therefore, this study aimed to explore the process of unintentional discrimination in health-care provision in Iran.

Materials and Methods

This qualitative study aimed to explore the unintentional discrimination process among health-care providers from June to December 2019. Conventional content analysis approach was used according to the objective of this study. This approach is useful for evaluating the perceived experiences of people about a routine phenomenon.^[26]

The research setting consisted of two hospitals in Tehran, Iran, one of which was a public teaching hospital and the other was a private nonacademic one. Both hospitals provide specialty and subspecialty medical services.

Participants

Up-to-date saturation participants were 13 health-care providers who were employed in two general hospitals in Tehran, selected using purposive sampling with the highest diversity in terms of demographic characteristics (age, sex, work experience, etc.). Table 1 shows the demographic characteristics of the participants.

Data collection

Data were collected through semi-structured interviews. First, interviews started with general questions such as "Have you ever discriminated patients during health-care providing? Please explain your experience" followed by subsequent questions based on the interviewee's answers. The time and place of interviews were planned in coordination with the participants at the hospital private room. The interviews took 20–41 min based on the conditions and willingness of the participants.

Data analysis

All interviews were conducted, recorded, transcribed, reviewed, coded, and immediately analyzed by the researcher. The Graneheim and Lundman's^[27]

Table 1: The demographic characteristics of the participants

Number	Age (year)	Sex	Marital status	Education	Position	Work experience (year)	Duration of interview (minute)
1	38	Male	Married	Masters in nursing	Clinical supervisor	16	35
2	32	Female	Single	Bachelor in nursing	Nurse in gynecology ward	8	20
3	40	Male	Single	M.D	Emergency physician	16	24
4	53	Female	Married	Bachelor in nursing	Clinical supervisor	28	27
5	52	Female	Married	Bachelor in nursing	Clinical supervisor	25	30
6	33	Male	Married	Bachelor in nursing	ICU nurse	8	33
7	32	Male	Single	Bachelor in nursing	ICU nurse	10	28
8	35	Female	Married	Diploma	Nurse aid	12	25
9	38	Female	Married	Bachelor in nursing	Head nurse of surgical ward	15	23
10	48	Male	Married	MD	Anesthesiologist	22	28
11	36	Male	Married	Diploma	Nurse aid	10	35
12	48	Female	Married	Masters in nursing	Head nurse of medical surgical ward	25	41
13	42	Female	Single	Bachelor in nursing	Nurse of clinic ward	16	30

ICU=Intensive care unit

conventional content analysis approach was used for analysis. Based on the content analysis process, initially, each interview was carefully read several times to gain a basic understanding and then important statements were highlighted (to determine the initial codes or semantic units contained in the transcripts of the interview about participants' experience of unintentional discrimination). In the next step, similar semantic units were extracted for semantic clarity and labeled as categories and subcategories. In fact, data were analyzed consistently and concurrently with data collection. The data were added throughout the data collection process until data saturation.

Data rigor

The Strauss and Corbin's (2015) method was used to validate the data, which combines the criteria presented by different researchers. Accordingly, the researcher tried to gain their trust and understand their experiences with long-term engagement, contact, and communication with the participants. Data validation methods were used to eliminate any ambiguity in coding through reviewing transcripts by the participants (member check). To this end, the researcher provided parts of the interviews and codes to the participants to reach the same understanding as the participants. Confirm ability was also checked to confirm the systematic and unbiased collection of data; members' agreement on interviews, codes, and classification of similar codes; and categories and comparison of what the researcher understood and what the participants meant. Data reliability was exercised with immediate transcription, peer check, and review of the whole data.

Ethical considerations

This study was approved by the Research Ethics Committee of Tehran University of Social Welfare and Rehabilitation Sciences (Ethics code: IR. USWR. REC.1398.023). In addition, the participants studied and

signed the informed consent form for participating in this study. They were assured of the confidentiality of the information, and that the participants could withdraw from the study anytime.

Results

Participants were 13 health-care providers including two physicians, three supervisors, two head nurses, four nurses, and two nurse aids. The age of the participants ranged from 32 to 53 years. Table 1 shows the characteristics of the participants. The findings of this study helped the researcher identify the following three main categories: (1) forced discrimination, (2) guided discrimination, and (3) discrimination related to lack of resources [Table 2].

Category 1 Forced discrimination

Forced discrimination category indicates that health-care providers are forced to discriminate in health-care provision to maintain their jobs or to comply with orders. This category was formed based on the subcategories of (1) superiors' pressures and executive orders, (2) occupational concerns, and (3) fear of the superiors, based on the analysis of initial codes.

Superiors' pressures and executive orders

In the subcategory of superiors' pressures and executive orders, the participants expressed that sometimes they had to discriminate in health-care provision to patients due to the pressure that higher authorities such as the president, manager, or nursing office applied on them. For example, participant = P (12) said:

"It's an order, or the patient is a relative of a colleague and I'm asked to keep the bed beside them vacant, but I'm not doing this for other people. However, these are orders and I have to follow them" (head nurse of

Table 2: “Unintentional discrimination” with subcategories and open codes

Category	Subcategory	Open code
Unintentional discrimination	Forced discrimination	Superiors' pressures and executive orders
		Occupational concerns
		Fear of the superiors
	Guided discrimination	Professional challenges
		Managers' policymaking
		Lack of medical ethics knowledge
	Lack of resources	Workforce shortage
		Lack of medical equipment

the internal surgery ward, 48 years old, 25 years of experience).

P (9) also said: “When the nursing office calls me and recommends a patient and says that I, as the head nurse, should watch over them, what else can I say? I say OK” (head nurse of the surgery ward, 38 years old, 15 years of experience).

P (10) also said:

“Because of frequent calls made by the president for a number of patients admitted to the ICU, I act differently, I spend more time and precision on the patient” (anesthesiologist, 48 years old, 22 years of experience).

Occupational concerns

Another initial subcategory was occupational concerns where participants expressed the reason for discrimination in health-care provision as occupational concerns, such as fear of losing their job and their current position. For example, P (2) said:

“I and the rest of the nurses pay more respect to special and recommended patients; this is ordered by the organization to maintain our job and position. We do this as we have no other choice since it might be hard to find a job somewhere else” (nurse of the gynecology ward, 33 years old, 8 years of experience).

Fear of the superiors

Fear of the superiors was another initial subcategory emerging from the code analysis. The participants noted that sometimes the only reason for which they must provide different care or other forms of communication with the patient is a fear of superiors such as a supervisor or a head nurse. For example, P (8) said:

“I sometimes pay more attention to some patients, I don't know why it is so, it has always been like that, and head nurses always say this to me and other nurse aids. It has been due to our fear of the head nurse or even behavior

of some physicians” (nurse aid, 35 years old, 12 years of experience).

Category 2 Guided discrimination

This category refers to the fact that lack of professionalism in medical science majors in Iran, which can be attributed to failure to explain ethical codes as well as the lack of knowledge and training on the principles of medical ethics for physicians, nurses, and other health-care providers, which made health-care providers to have discriminatory behaviors. This category has three subcategories of professional challenges, managers' policymaking, and lack of medical ethics knowledge.

Professional challenges

This subcategory refers to the occupational nature of health-care professions and being involved in their problems. For instance, high workload and fatigue are factors that make service providers exhibit discriminatory behaviors unintentionally as P (11) said:

“If I'm very tired or working at night shifts for several days, I actually do not care much for the patient and neglect many things, or if I'm to do something, I'll do it for some special patients that I have to” (nurse aid, 36 years old, 10 years of experience).

P (7) also said:

“I've seen that doctors or nurses generally attend to patients less at nights and they somewhat discriminate among patients. They don't check the operation site, or they do less suctioning; generally medical and nursing care reduces and maybe it is due to personnel fatigue” (ICU nurse, 33 years old, 10 years of experience).

Managers' policymaking

This subcategory refers to some of the internal policies of health managers that may cause unintentional discrimination among staff by setting certain policies or less supervision. The participants also pointed out that one of the main causes of fighting discrimination is the very managers' will. For example, P (12) said:

“The one at the top of this system must want it to happen; a simple example is visiting patients; some of my colleagues here work in another hospital, too. I went to visit a patient, but they didn't allow me, even though they knew me, they didn't let me visit outside the specified time. The two hospitals are located next to each other and both affiliated to one university, but there is so much difference. It all goes back to the top of the pyramid and management. How much the manager wants to fix the system matters?” (head nurse of the internal surgery ward, 48 years old, 25 years of experience).

Lack of medical ethics knowledge

Lack of knowledge of ethics codes, lack of medical ethics knowledge, and lack of understanding of these principles at university make health-care providers pay less attention to these principles and unintentionally discriminate in the provision of health care. For example, P (3) said:

“Training on ethics was absolutely insufficient. There must be training during medical and nursing courses, but unfortunately it is not so; not even in medical ethics courses, such a problem has become so common among us and all have accepted it. So first and foremost is the teaching and learning of ethical principles at university” (emergency physician, 40 years old, 16 years of experience).

Category 3 Lack of resources

This category refers to the resources needed to provide health services, but when these resources are defective or scarce, the health-care provider is unintentionally forced to discriminate. Two subcategories of discrimination due to workforce shortage and lack of medical equipment emerged from the data analysis.

Workforce shortage

The shortage of physicians, nurses, and other health-care providers unintentionally forces health-care providers to discriminate as it leads to failure in providing the necessary care and even reducing the quality of services. P (9) said:

“As a head nurse, manpower is very important to me; when manpower is low, the quality of work reduces and now if we have some special and recommended patients in the ward, a significant portion of the manpower is dedicated to them and the quality work for other patients decreases and other patients get less attention because we are not enough” (head nurse of the surgery ward, 38 years old, 15 years of experience).

P (6) also said:

“How can I, as a nurse of the internal ward with 10 patients and one of them intubated, handle them all, I have to discriminate, and those who have better conditions will receive more care; I have no choice; we are not enough” (ICU nurse, 33 years old, 8 years of experience).

Lack of medical equipment

Lack of medical equipment also makes physicians and nurses unintentionally discriminate between patients due to access restrictions. For example, P (6) said:

“Healthcare provision is better in ICUs, but lower and poorer in regular wards because a nurse like me has

8–10 patients there and one is intubated, and I don't have time or even monitors to permanently check on them. There, I have to differentiate among patients, and care for a patient only for 2 h in a whole 12-h shift because I don't have the time or the equipment to do it” (ICU nurse, 33 years old, 8 years of experience).

Discussion

All participants expressed that they had to discriminate in health-care provision in different circumstances. In fact, the participants stated that they are forced to make ethically incorrect decisions and disobey ethical principles unintentionally when providing health care due to reasons such as fear of superiors. In this regard, Kligyte *et al.* pointed out that fear, worry, and anger can inhibit ethical decision-making. Health-care providers cannot consider justice in their nursing and care plane; finally, patients experience different types of discrimination in health care. In fact, they have no choice and they had to have discriminatory behaviors with patients.^[28]

Furthermore, our findings showed that forced discrimination affects the working environment of physicians, nurses, and other health-care providers, which creates conditions in which they cannot observe the four principles of bioethics, the principle of justice. The participants stated that they discriminate in the provision of health care to patients due to pressure from managers and officials. In fact, it can be argued that the environment in which health-care providers perform their duties can have a positive or negative approach and result in implementing the principles of bioethics. Professional ethics refers to the use of logical and consistent communication, knowledge, clinical skills, emotions, and values in practice. In this regard, Dehghani *et al.* point out that factors influencing compliance to professional ethics are divided into the following three dimensions: (1) individual dimension (personal characteristics, religious values, and family conditions); (2) organizational dimension (leadership, management, communication with colleagues, rewards and punishment system, organizational culture, etc.); and (3) environmental dimension (economic, social, and cultural). The organizational dimension is more important because it can control and make more changes. Personal ethical decision-making is related to organizational ethical atmosphere, so the viewpoint of manager in health care can change the ethical behaviors of health-care providers.^[29]

Managers' pressure on medical personnel to do things that contradict medical and nursing ethics reflects the ethics that govern an organization such as a hospital. In

fact, the ethical behavior of managers in the health-care system is a predictor of observing professional ethics. Kaabomeir *et al.* quote Douglas emphasizing that if managers and senior executives apply ethics in the workplace, an ethical climate dominates the organization, which can influence other people. According to a survey by the Institute of Business Ethics, managers' adherence to ethics can reduce employees' unethical behavior by up to 50%. Furthermore, ethical decision-making by medical personnel is affected by factors such as fear and anger.^[30]

In addition, our findings showed that some factors such as lack of medical ethics knowledge and lack of professionalism lead health-care providers to discrimination. In fact, these factors occur in the context of medical and nursing care, which reduces the focus on the structure needed to implement ethics. As mentioned in the results, the participants stated that lack of professionalism makes them pay less attention to observing the principle of justice in health-care provision. It is important that professionalism requires the development of and compliance with codes of ethics, as it can be seen in developing countries such as Iran, where medical professions are not completely professionalized, which eventually manifests itself in the form of noncompliance with the principles of medical ethics.^[31] In this regard, Mahajan *et al.* point out that ethics is an integral part of becoming a medical professional. Furthermore, they emphasized that if the professionalism process is not accomplished properly, graduates would not understand ethical principles and cannot comply with ethical principles such as justice in health care.^[32]

Lack of knowledge about the principles of medical ethics was also mentioned by the participants. In fact, health-care providers such as physicians and nurses that have the highest levels of communication with the patient and need to consider health-care ethics, ultimately provide health-care services that are practically not ethical because they lack the required knowledge. In fact, the lack of training on the principles of bioethics, health justice, leads health-care providers to discriminate in health care. Accordingly, Imran *et al.* suggest that medical students at general and specialty levels that have not received education on these principles are not capable of making necessary decisions and observing ethical principles such as independence and justice, which affects their professional qualifications, too.^[33] Dehghani *et al.* pointed out that teaching and learning professional ethics principles at university are among important and effective factors in the formation of nurses' ethical behaviors.^[29]

The importance of learning the principles of bioethics while studying medical sciences and its incorporation is

another aspect of this process. As shown by the results, the participants mentioned a lack of education and learning of bioethics principles in universities as a cause of discrimination in providing health care. In this regard, Bostani pointed out that systematic incorporation of bioethics principles in nursing education programs, while familiarizing them with ethical principles, will improve the quality of nursing care, ethical decision-making, and compliance with these principles to provide health care to patients.^[34] Acharya and Shakya (2016) also emphasized that the four principles of bioethics should be emphasized in medical students' curricula in order to respect and maintain patient autonomy, promote justice, and avoid discriminatory behaviors in health.^[35]

Lack of resources, including workforce and medical equipment, was another aspect of unintentional discrimination in health care. As shown by the results, the participants stated that they are forced to unintentionally differentiate between patients and have discriminatory behaviors in health-care delivery when they face challenges such as shortage of doctors and nurses at work.^[36-38] The global challenge of shortage of nurses in recent decades is a major concern for health-care organizations, which leads to physical and psychological harm, job dissatisfaction, burnout, and so forth. What is noticeable here is the effect of lack of resources on bioethical principles governing health-care provision such that this challenge has led to a phenomenon known as moral distress among nurses, which in turn has extensive negative consequences and causes a vicious cycle.^[39] In fact, health-care providers tend to adhere to the ethics of health care based on their professional duty, but the question is how can they provide quality care based on ethics when professionals such as physicians and nurses are not sufficient? In fact, they have no choice but to abandon some of these ethical principles when providing health care because under the present conditions, physical care is prioritized and ethical principles such as justice in care are less attended to.

Different articles have been conducted on health-care discrimination, but they are quantitative, and we cannot survey the main problems about discrimination in health care. This study was a qualitative article, so we could detect the main category of unintentional discrimination in health care. According to these findings, we can design an effective model for controlling discrimination in health care.

Every article has some limitations, so the authors reiterate that this study was based on Iranian culture and health-care system, so the results cannot be generalized to other countries, and it is recommended that similar studies be conducted in other countries.

Conclusion

The findings of this study showed three categories of unintentional discrimination including forced discrimination, guided discrimination, and lack of resources. In this study, the participants emphasized that they unintentionally discriminate health-care provision to patients due to various factors, including managers' pressure and lack of resources, as well as professional challenges such as lack of medical ethics knowledge. This study could clarify the concept of discrimination in health care, and it is recommended that health-care managers use the results of this study to plan and implement measures to control and reduce discrimination in health care.

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Conflicts of interest

There are no conflicts of interest.

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