Cultivating an

EQUITY MINDSET

in Clinical Practice

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UW Medicine
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Opening Reflection

It’s the last day of the conference - How are you feeling?

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How to change the design

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The Slido app must be installed on every computer you’re presenting from

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Overview

Broader Context

Power Management Strategies

Scenario Discussion

Practice and Takeaways

Learning Objectives

ONE	TWO
Describe how one's own identity (including lived experience and societal/social power) can influence patient -provider interactions.	Develop a personal practice of using an equity mind -set in managing patient -provider power dynamics

HEALTH EQUITY

Everyone has a fair and just opportunity to be as healthy as possible.

Power is the mechanism through which inequities are reproduced, from policy design to the bedside.

Power within systems

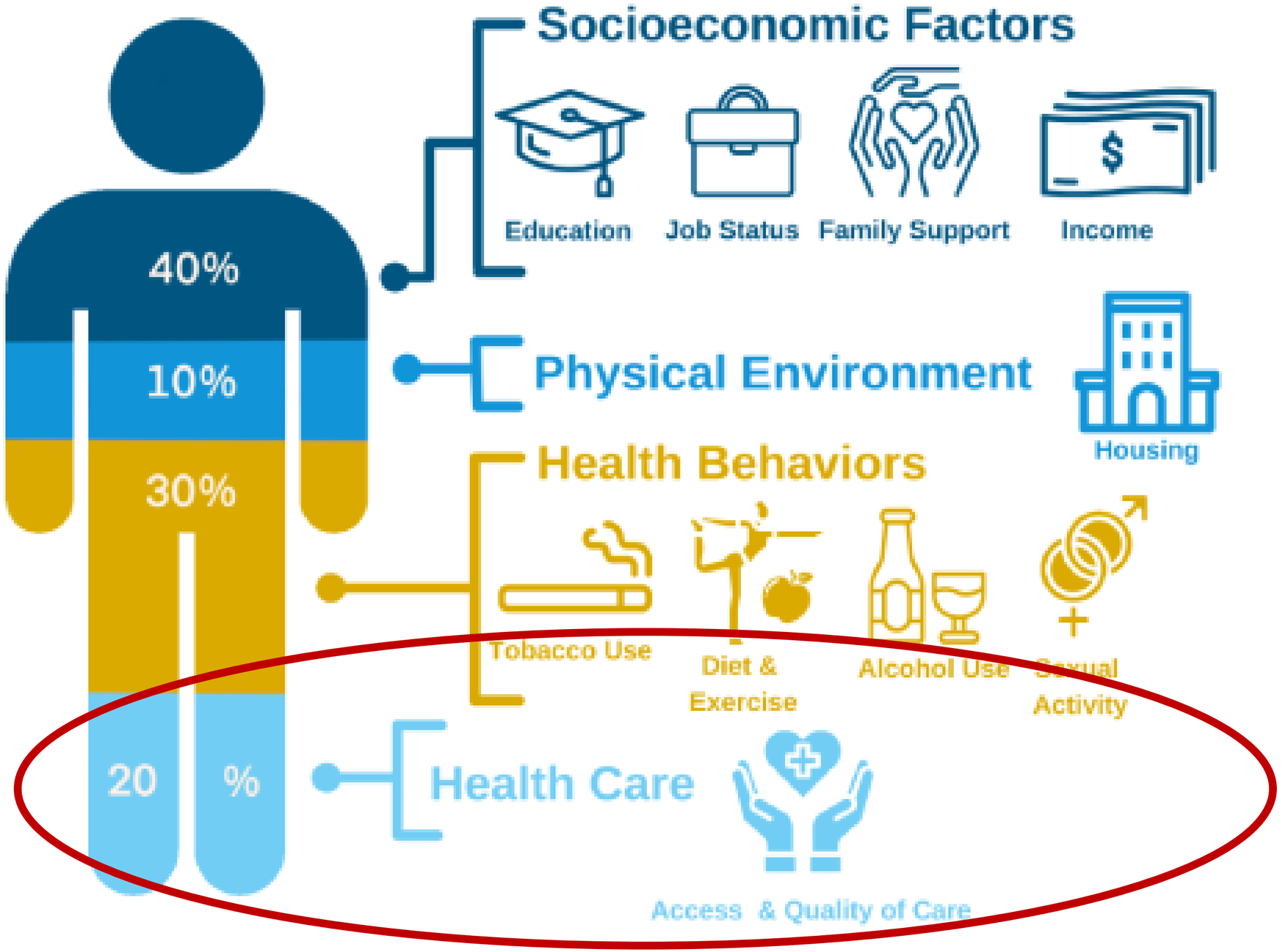
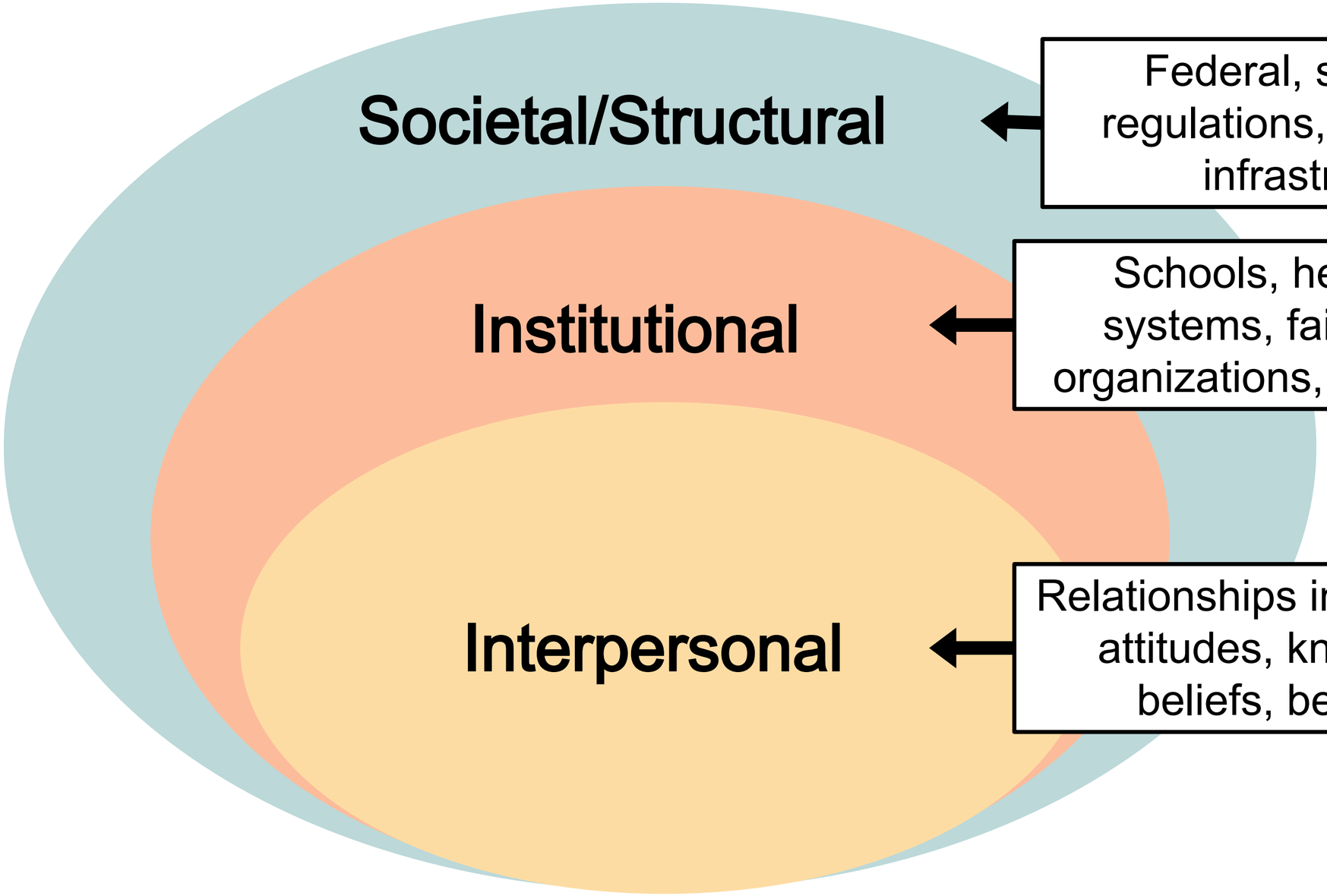


Image source: UCLA Health

Context

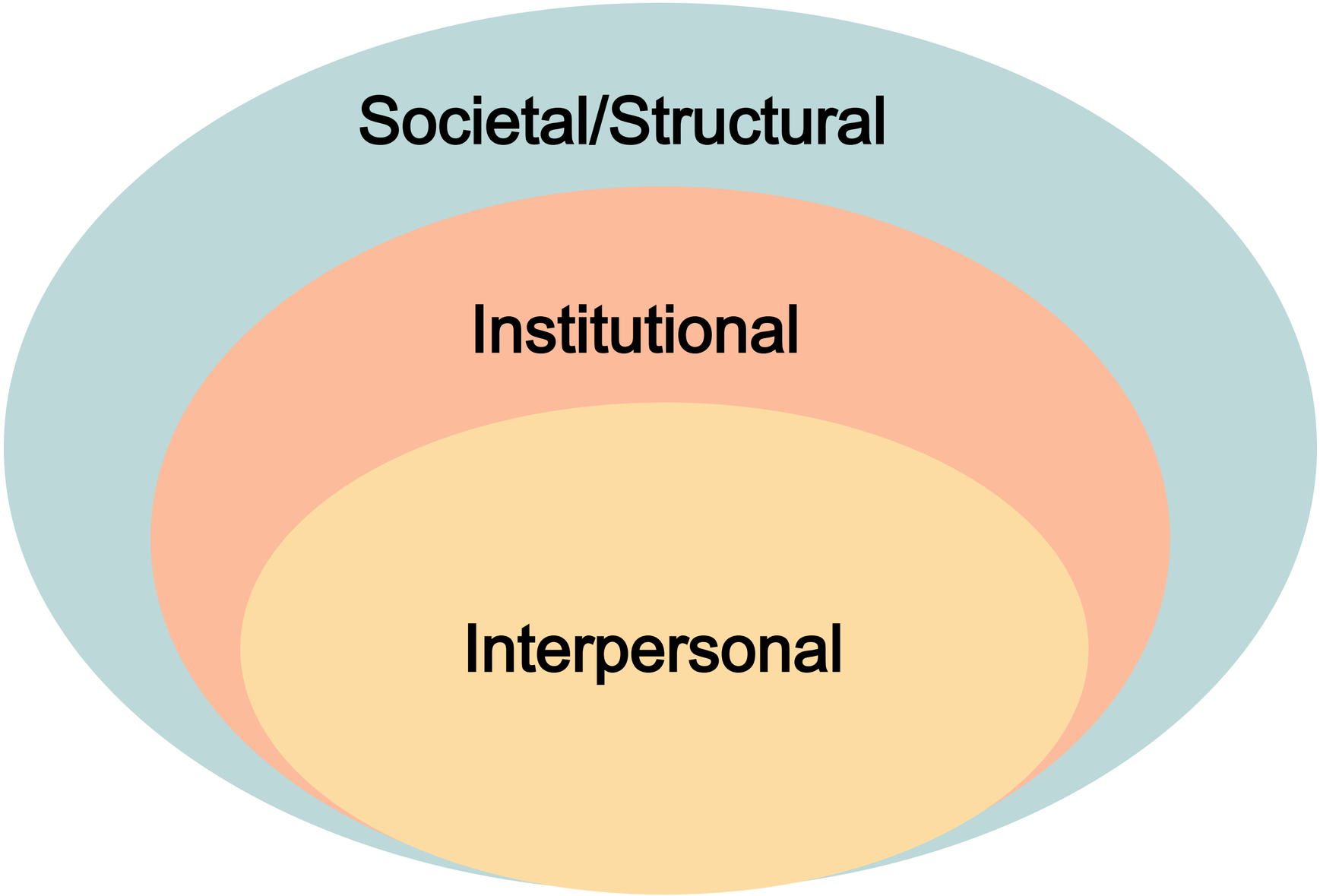


Federal, state, local regulations, laws, public infrastructure

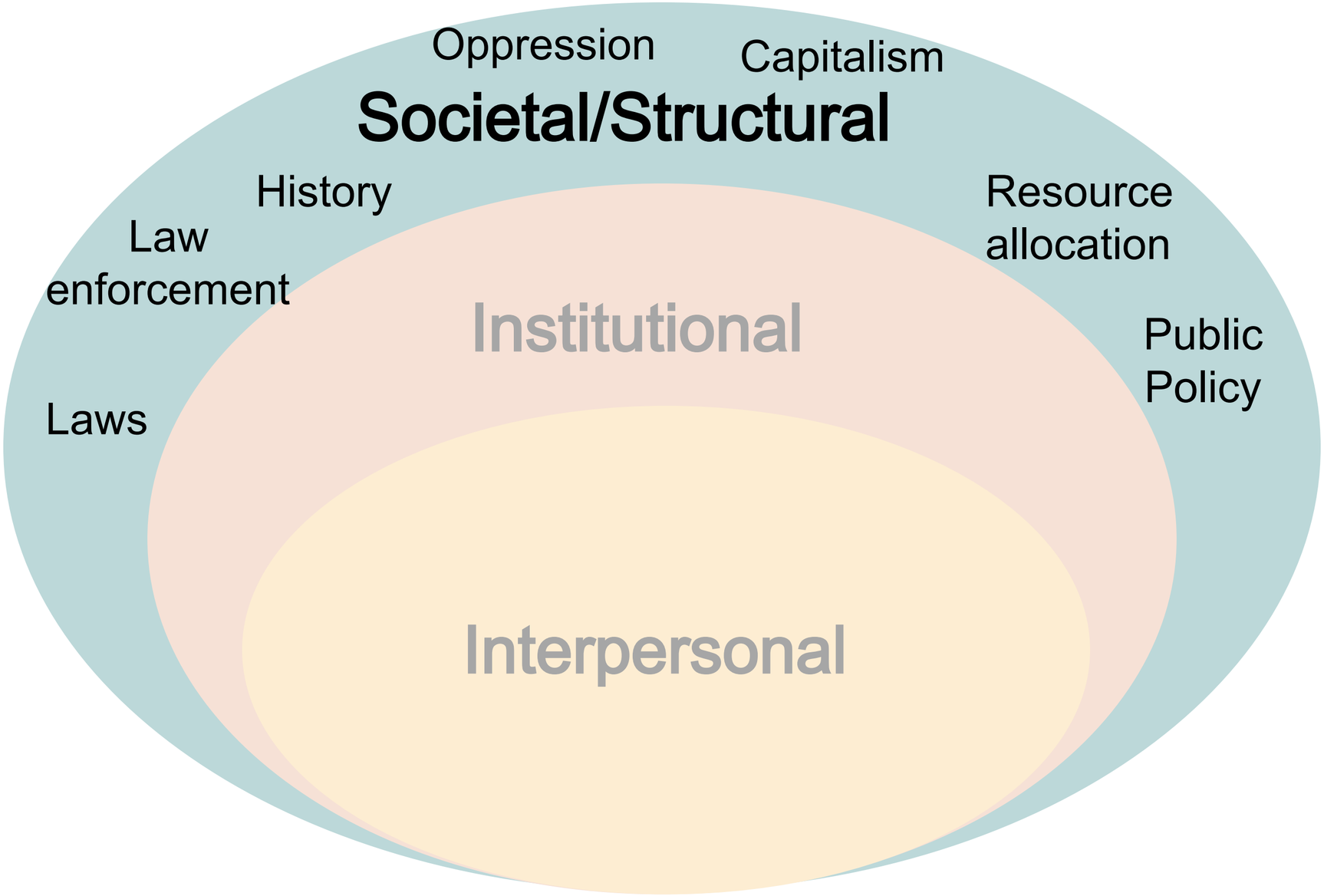
Schools, healthcare systems, faith -based organizations, businesses

Relationships influenced by attitudes, knowledge, beliefs, behaviors

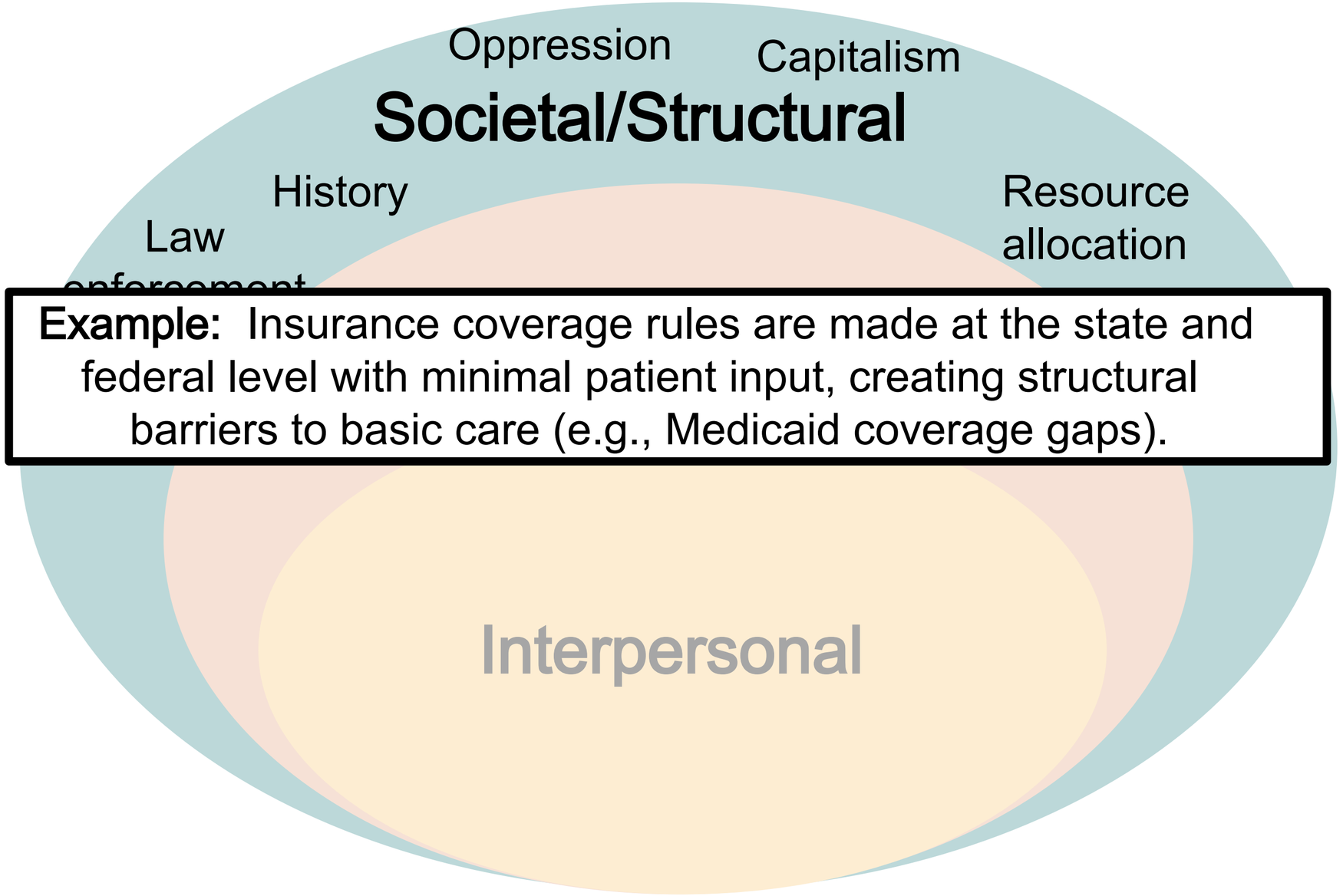
Context



Context

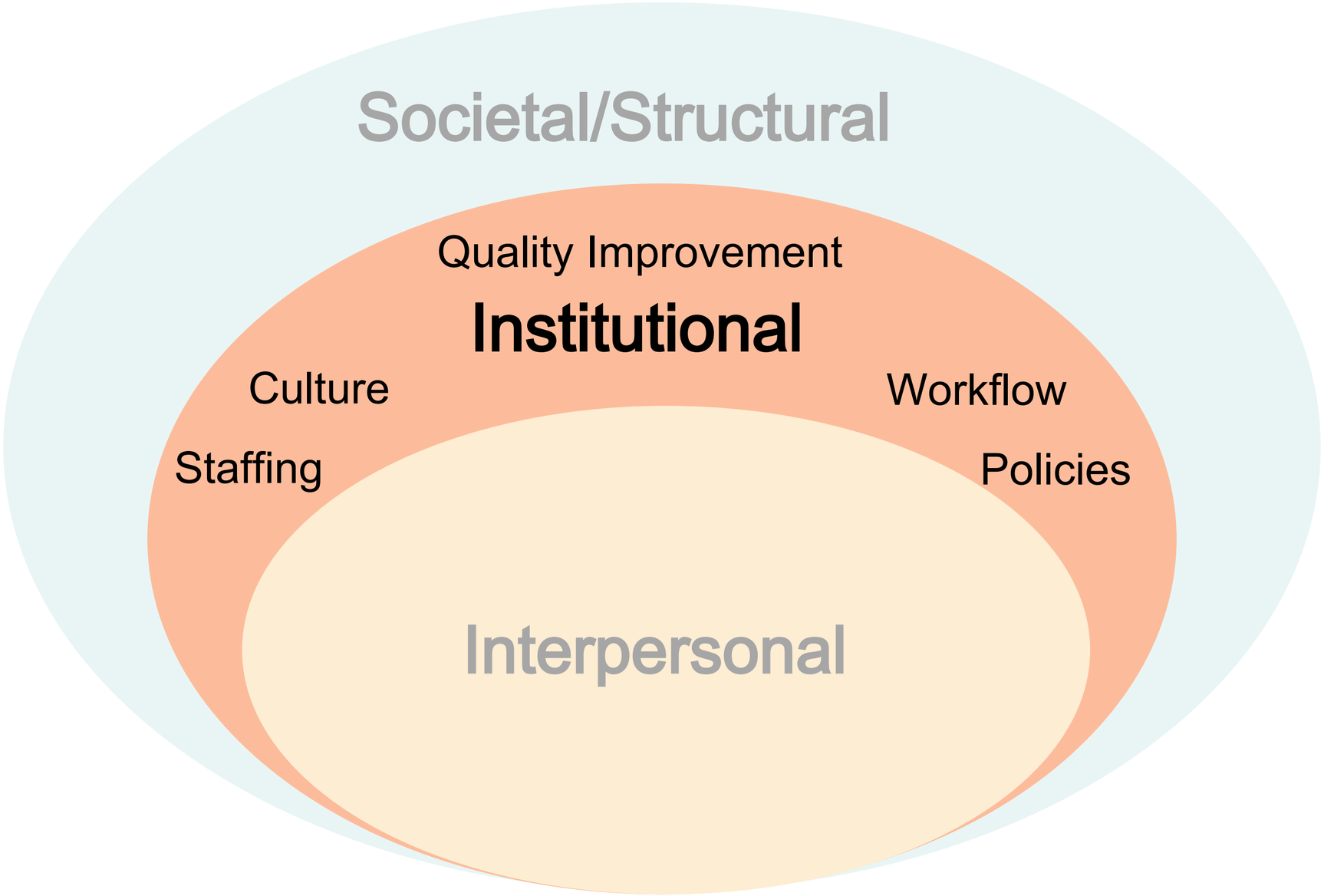

Oppression
Capitalism
Societal/Structural
History
Law enforcement
Laws
Resource allocation
Public Policy
Institutional
Interpersonal

Context

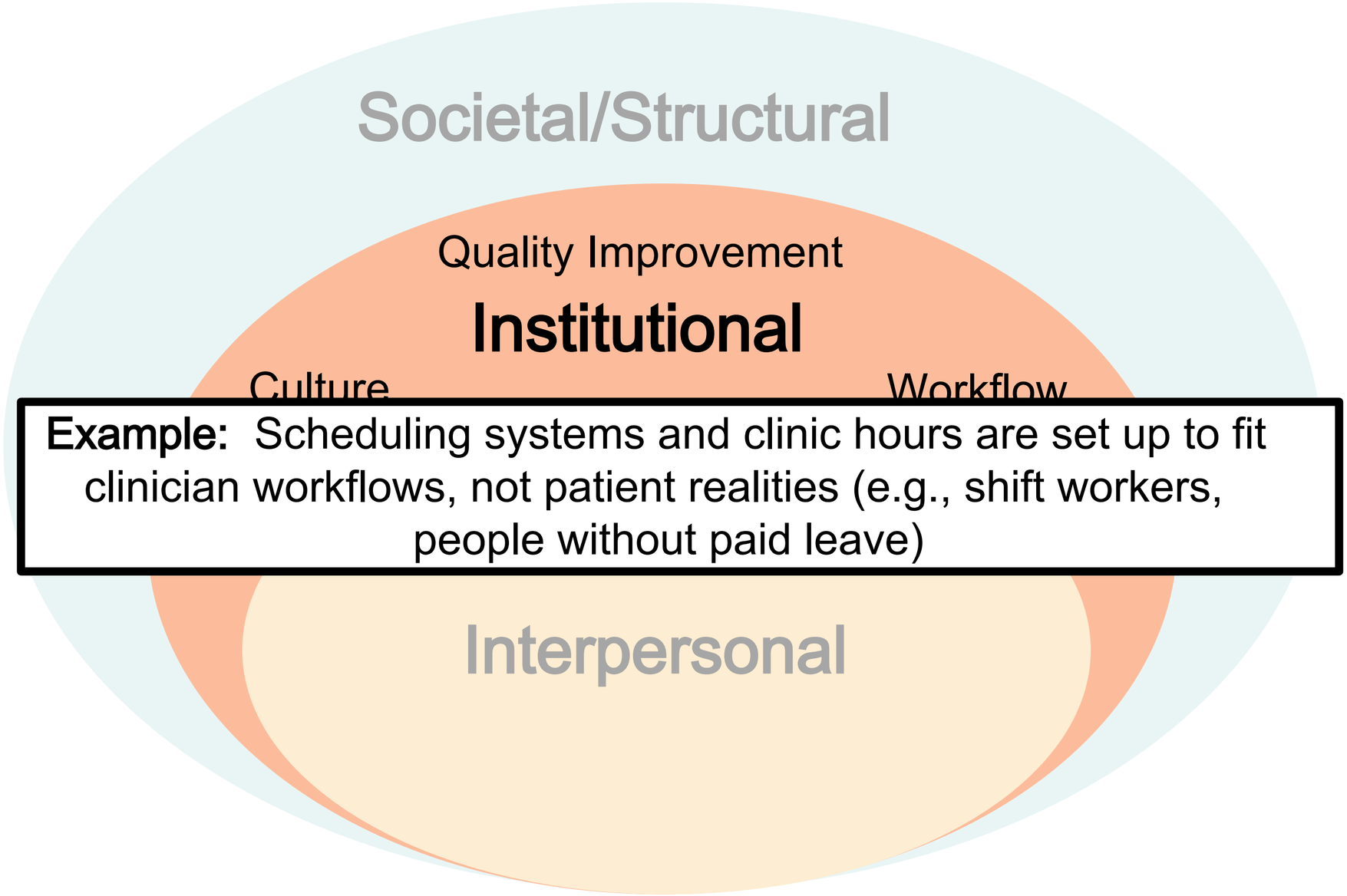


Example: Insurance coverage rules are made at the state and federal level with minimal patient input, creating structural barriers to basic care (e.g., Medicaid coverage gaps).

Context

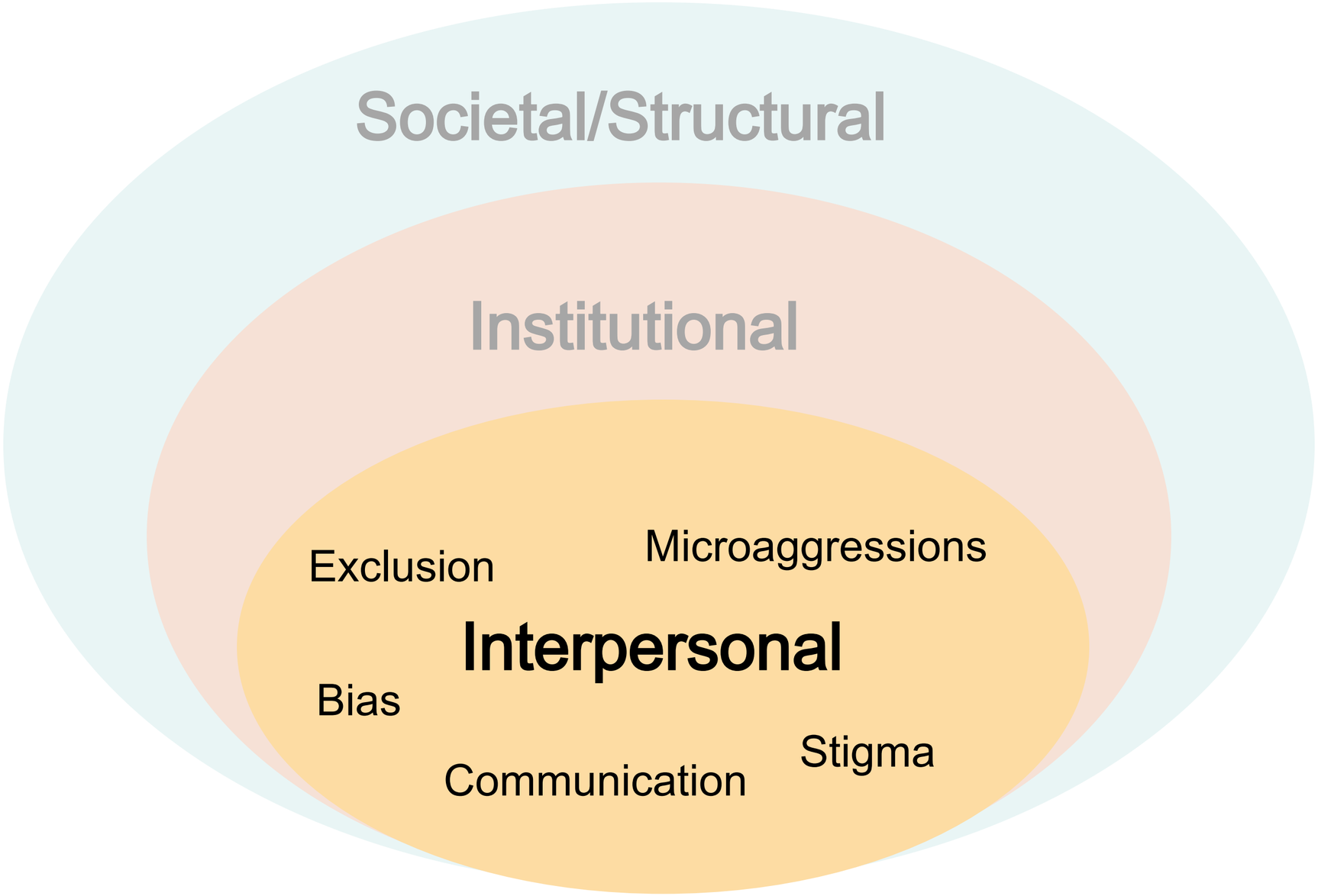

Societal/Structural
Quality Improvement
Institutional
Culture
Workflow
Staffing
Policies
Interpersonal

Context

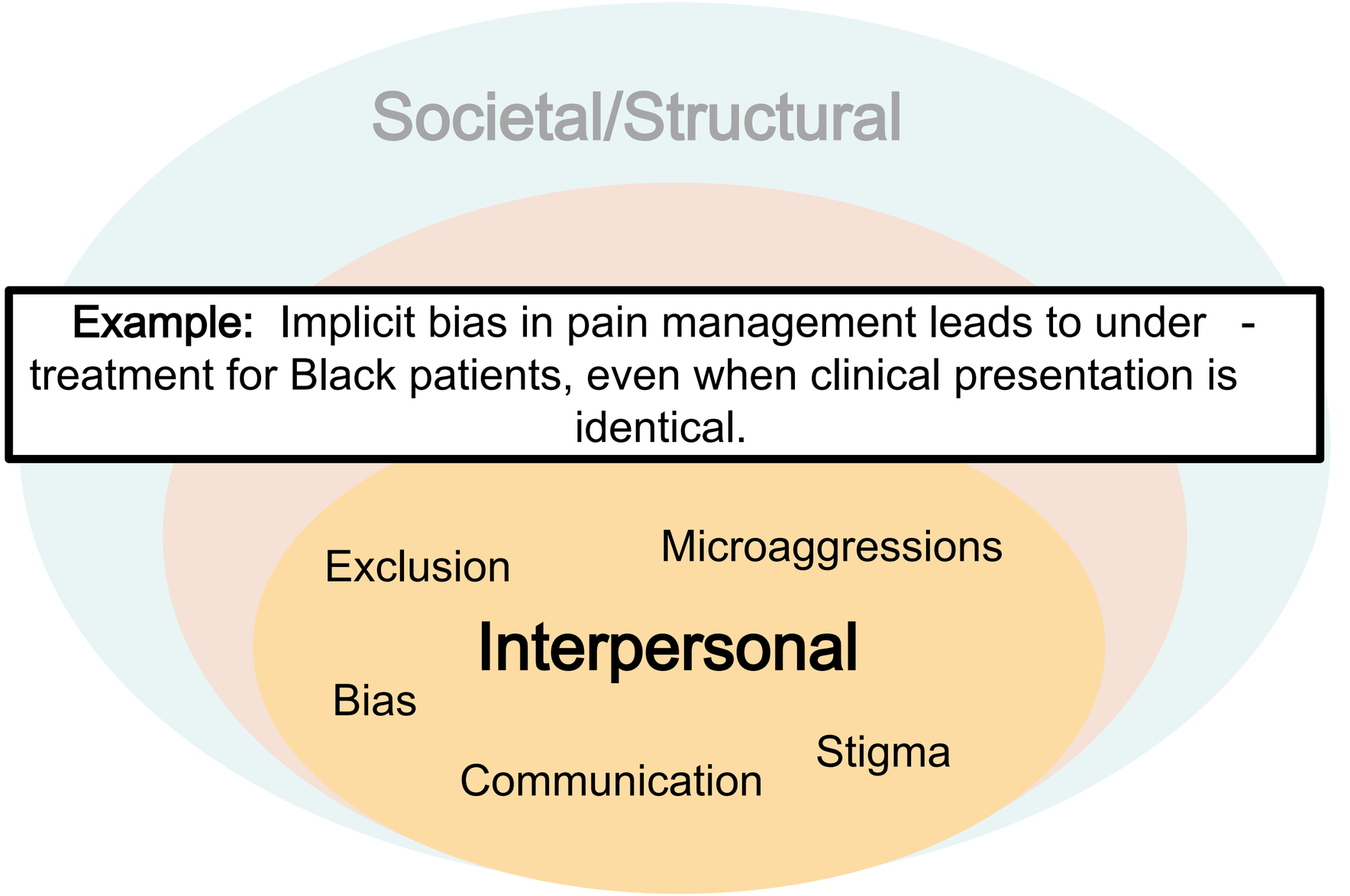


Example: Scheduling systems and clinic hours are set up to fit clinician workflows, not patient realities (e.g., shift workers, people without paid leave)

Context


Societal/Structural
Institutional
Exclusion
Microaggressions
Interpersonal
Bias
Stigma
Communication

Context



Example: Implicit bias in pain management leads to under - treatment for Black patients, even when clinical presentation is identical.

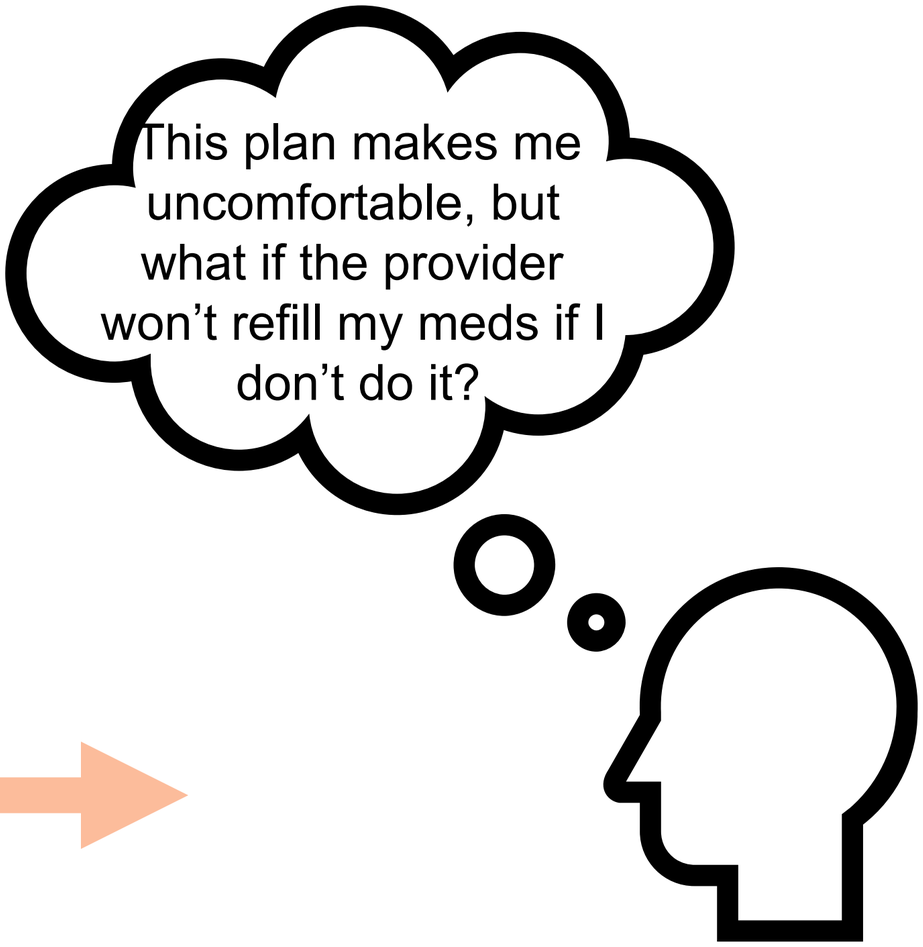
Defining Power

The ability to act

Power is constructed between two or more people

Why care?

Why care?


This plan makes me uncomfortable, but what if the provider won’t refill my meds if I don’t do it?

Reflect & Share

What power do you have as a provider?

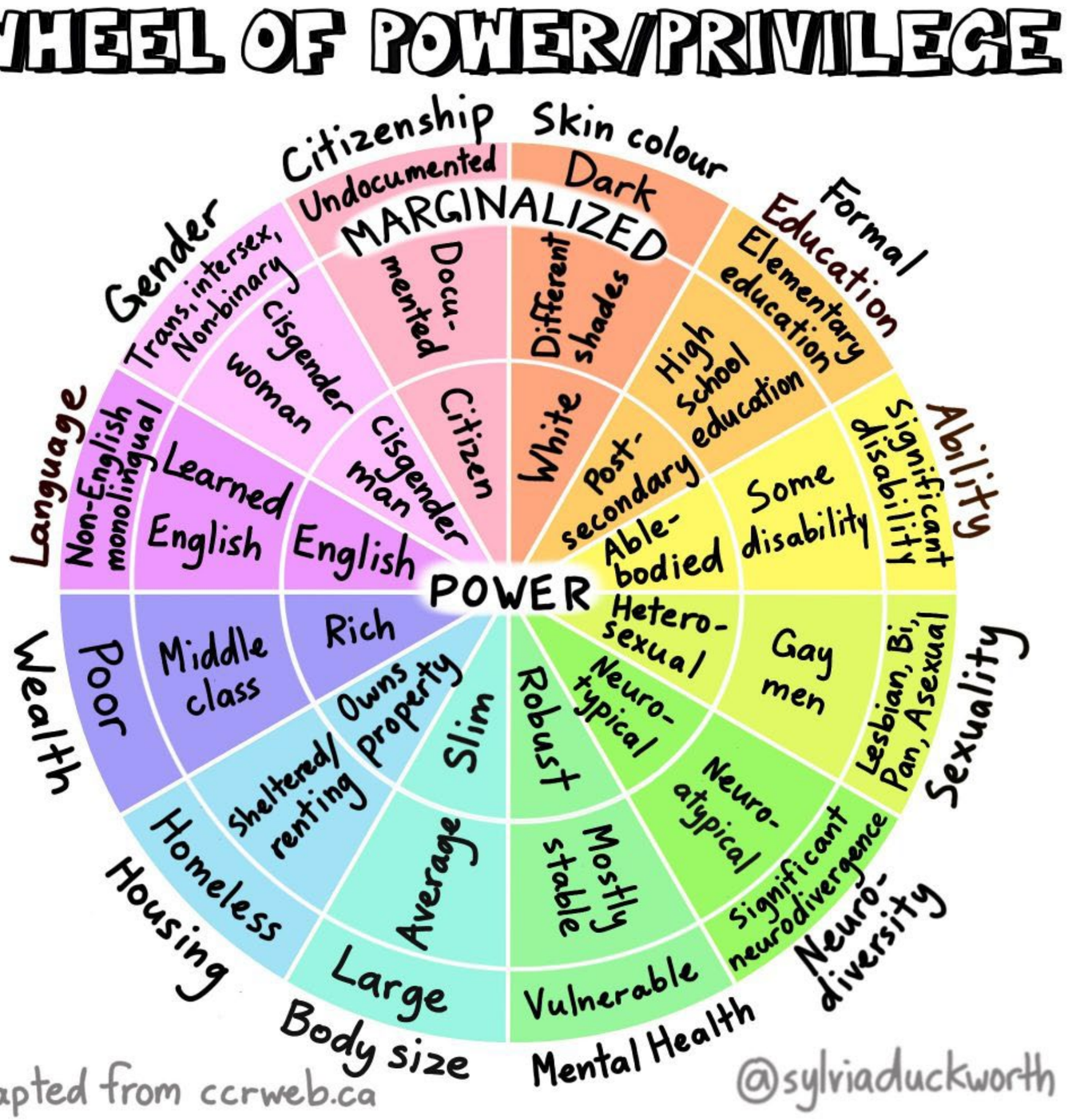
What power might a patient *perceive* you to have?

Power Distribution

Provider	Patient
• Access specialized information • Influence patient decisions • Order testing • Order medications • Represent patient to other members of team • Direct visit agenda • Direct evaluation • Visible identities	• Access publicly available information • Influence provider decisions • Choose how/whether to follow plan • Seek alternative opinions • Direct visit agenda • Influence evaluation • Influence provider ordering • Visible identities

How might different parts of your identity shape the patient's perception of your power in a clinical interaction?

Can you think of a time when an aspect of your identity increased your perceived power and a time when it diminished it? What made those contexts different?



Power management strategies

1. Exerting Power
2. Sharing Power
3. Moderating Power
4. Relinquishing Power

1

Exerting Power

Pulling the “I’m the provider” card

Deliberately calling attention to power differential of provider and patient.

Example

“My best medical recommendation is…”

Example

Sharing personal experience:

"My mom also had a terminal illness and it was hard for me too"

2 Moderating Power

Deliberately reducing patient's perception of provider power

Goal is to reduce power differential

3 Relinquishing Power

Explicitly reminding patient of their power and ceding own

Goal is to unilaterally increase patient's perceived power

Example

"At the end of the day, I'm your advisor and it's your decision."

Example

Shared Decision Making

4 Sharing Power

Explicitly acknowledging power that both patient and provider hold

Goal is to reduce power differential

Scenario Discussion

...

Practice

...

Pair-Share

Think of a time when a patient requested a test you believe is not indicated.

1. How did you handle this situation and what was the outcome?
2. Using this framework, what would it look like to use each of the 4 strategies? (Exert/Share/Moderate/Relinquish)?
3. If you had this encounter again, would you do anything differently?

Takeaways

Clinicians Are Active Agents

- We may not be able to fix systems in the moment, but we can change how we show up.
- Reject the narrative that “I have no power”. Clinicians always hold some power.
- Make the implicit explicit: name policies, power, and emotions/safety concerns

Power Is Co -Constructed, Not Fixed

- Perceived ≠ actual power: patients’ perceptions matter.
- Naming power can shift encounters from coercion to collaboration.
- Slow the tempo; make space for the patient’s story and goals.

Name and Challenge Normalized Harm

- Harmful policies are “the water we swim in.”
- Naming them is a power management strategy that creates safety and opens space for co-creating solutions.

Extend Power -Sharing Beyond the Room

- Prepare patients to navigate other teams (scripts, phrases).
- Advocate behind closed doors to carry their voice forward.
- Power-sharing can ripple beyond your own encounter.

Closing Reflection

What is one thing you will do differently
next week to adopt an equity mindset?

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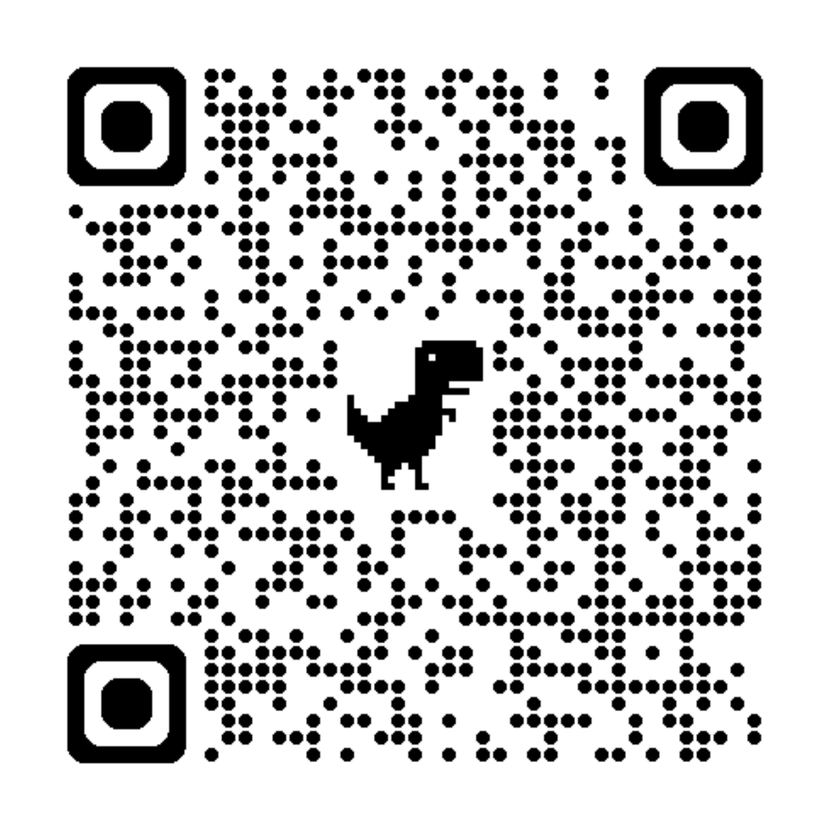
Equity Frameworks in Communication



Scan for resources

Sources

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Thank You!

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