Learning From Experience: Examining Implicit Bias in Immigration and Health Care

By Ann Datunashvili, MD, CMD, and Margo B. Kunze, RN, CDP

Robert Accetta is the president/owner of Rivercare Consulting, LLC, a care strategy and consulting business for the long-term care, assisted living, and community care organizations. A Board-Certified Geriatric Pharmacist, he serves as a consultant and educator in a variety of roles. Rob currently serves on the Board of Directors of the American Society of Consultant Pharmacists (ASCP). He is a graduate of St. John’s University College of Pharmacy and Health Sciences in New York.

One of us — Ann Datunashvili — is an international medical graduate, or IMG, and thus entered her career in health care as an immigrant worker. Yet despite this status, I had somehow become blind to the larger issues even as I was acutely aware of the struggles an average IMG goes through to start a career in the United States.

During this process you must find a position that will support your work visa and make sure you are qualified to get it; next comes the interminable wait to be called for an interview, followed by more waiting to hear from the immigration authorities about whether you will be allowed to come to the United States. The process is long — 12 to 18 months for nurses, for example — and costly (multiple thousands of dollars). At the end of the process, you will be bound to your sponsor organization for a significant period before you can legally change employers.

As I talked about these issues with my co-author, Margo Kunze, we both reflected on our personal experiences of being the “other.” She had grown up living with her family in multiple countries as an American expat. We spoke of the challenges we both faced: prejudice, misunderstanding, and suspicion. I also shared my overwhelming sense of gratitude for what I had been able to do: I graduated from medical school at the top of my class, I went through a junior clerkship at the Emory University Medical School, I achieved good U.S. Medical Licensing Examination (USMLE) scores, I was fluent in English, and my husband was already a medical resident. Still, it was impossible for me to secure an interview to be considered for training programs in the tri-state area of Connecticut, New York, and New Jersey.

Each program I called said they were not taking “IMGs” — foreign medical graduates. This included the programs that clearly had large numbers of international graduates. Finally, one of these programs had an urgent need for a hospitalist to fill a vacant position, and they thought of me. When the call came, I had no second thoughts or sense of feeling slighted — I was delighted! It was an excellent training program, and it was within driving distance. I worked without pay for nearly 5 months just for a chance to be considered for a match. I matched the following year.

Each time I meet fellow international professionals working in U.S. health care — physicians, nurses, certified nurse assistants (CNAs), advanced practice clinicians (APCs), and personal aides — I can’t help but notice that many of them also share this immense gratitude for being given a chance to prove themselves, to have a chance to succeed. In our discussions, Margo Kunze and I have wondered if this gratitude blunts other issues. For instance, are immigrant health care workers being treated fairly, equitably, with the respect they deserve? Are they aware of the microaggressions they experience, or do they choose to ignore them because it’s “not worth rocking the boat”? Are they concerned that speaking up could cost them their job or make them seem ungrateful?

We have also seen and heard of reverse biases: professionals with international backgrounds who are not able to leave their own baggage behind — including prejudices and biases (186:60) and a paternalistic approach to patients and families, and mistreatment of team members who are “below” them in the hierarchy.

Of course, bigotry of any kind is unacceptable, especially when rebuilding the health care force necessary to care for our residents. Medical professionals who can’t step out of their stereotypical perceptions of what professional, racial, and gender roles “should be” make it very hard for those who are flexible and able to adapt to the realities of living and working in a new society.

It’s vital that medical professionals work well with others, and that everyone learns to see the field-level care force as partners in care rather than as lesser persons to be marginalized. Without the direct care staff, health care does not get provided to our residents. If we want the care done, we must care about those providing it, regardless of their race, religion, gender identification, sexual orientation, or country of origin.

For these reasons, it’s vital that care force leaders and their organizations work to identify, confront, and mitigate eradicate both explicit and implicit bias — unconscious favoritism toward or prejudice against people of a particular ethnicity, gender, or social group. We will never completely eradicate such biases, but we need to try.

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Pandemic Problems


According to the Migration Policy Institute (MPI), in 2018 there are 2.6 million immigrant health care workers, making up 17.9% of the health care workforce. Immigrants constitute 28% of all physicians and surgeons (296,000), 15.5% of registered nurses (512,000), 37.9% of home health aides (286,400), and 22% of personal care assistants (322,000). (For more of these numbers, see J. Batalova, “Immigrant Health-Care Workers in the United States,” MPI, May 14, 2020, https://bit.ly/3SYOxH0.)

However, we feel that it is important to ensure that the system does not use the immigrant care force to delay wage gap adjustments and improvements in the work environment. During the pandemic, we saw even more clearly that nurses, CNAs, and other allied professionals are the true backbone of post-acute and long-term care. These workers are the ones who carry the burden of direct care for residents and educate incoming care force workers. The CNA/direct care staff must be seen as assets to our communities and facilities. Regardless of where they come from or what their level is in the hierarchy, all workers need to be seen as vital members of the care team.

Owners and managers should become aware of the ways that they consciously or unconsciously take advantage of the gratitude immigrant workers feel for just getting a chance to live in this country.

They must be welcomed, accepted, and provided with the same respect that we extend to our own countryfolk. These immigrants may well provide the solution to our health care force and staffing crisis.

Resources

There are entire organizations dedicated to integrating immigrants into the health care force in the United States. AMDA – The Society for Post-Acute and Long-Term Care Medicine is actively supporting immigration reform and passed two resolutions on immigration in April. One is H22L, “Undocumented Noncitizens for PALTC” (April 27, 2022, https://bit.ly/3b6IVYX), and the other is G22L, “HPSA and MUA Designation for PALTC” (April 27, 2022, https://bit.ly/3KmwiVY). Further resources include:

• PHI — Quality Care Through Quality Jobs: https://www.phina.org/


• “U.S. Long-Term Care Communities Ready to Support Ukrainian, Other Refugees: AHCA/NCAL Partnering with Local and National Organizations to Offer Refugees Meaningful Jobs and Assistance,” AHCA/NCAL, March 17, 2020, https://bit.ly/3CIvEYf

Readers interested in AHCA/NCAL efficacy in the contact AHCA’s Dani Ritchie (drichtie@ahca.org) for more information.

Dr. Datunashvili is an assistant clinical professor at Yale School of Medicine’s Department of Internal Medicine, the clinical director of NEMG YNH Geriatric Services Primary Care and Home Based Primary Care, and medical director at the Whitney Center Health Center, Hamden, CT. She is a member of the Society’s Diversity, Equity, and Inclusion Workgroup.

Ms. Kunze is president of AL Consulting, providing consulting services to assisted living and long-term care communities. She serves as a testifying expert for attorneys pursuing cases involving assisted living and skilled nursing facilities. She is also the secretary/treasurer of the American Assisted Living Nurses Association and a member of the Society’s Diversity, Equity, and Inclusion Workgroup’s Implied Bias Subcommittee.