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Invited Commentary | **Equity, Diversity, and Inclusion**

Policing of Black Children and Their Families by Health Care Professionals Through Behavioral Flags

Monica E. Peek, MD, MPH, MS; Austin Wesevich, MD, MPH, MS; Ruth Shim, MD, MPH

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Author affiliations and article information are listed at the end of this article.

Structural racism and discrimination have been documented in multiple US institutions, including the education, criminal legal, housing, employment, and health care systems, with negative impacts on the health and well-being of racially minoritized and other socially marginalized populations. In adult inpatient and emergency department settings, behavioral flags have been disproportionately applied to the electronic health records (EHRs) of Black patients. Edwell et al[1] investigated whether there were disparities in the application of behavioral flags to inpatient pediatric patients' EHRs based on race, ethnicity, payer status, and primary language. Behavioral flags were placed for inappropriate behavior, security calls, violent behavior, witnessed substance use, or child protective services holds. In that study of 55 865 inpatient encounters of pediatric patients younger than 18 years in a multihospital medical center, Black or African American compared with White patients and patients with government vs private insurance were more likely to have behavioral flags in their EHR (incidence rate ratios of 2.07 [95% CI, 1.32-3.25] and 2.60 [95% CI, 1.85-3.65], respectively). The most common reason for receiving a behavioral flag was having security called (44.5%), while witnessed substance use was a rare event (0.8%). The age group with the largest number of flags was younger than 1 year, indicating that it was the familial network and not the child whose behavior was being flagged.

Why might socially marginalized patients and their families be more likely to have behavioral flags placed in their EHR? It is important to note that differences in behavioral flags do not inherently provide information about what is happening in the health care system. That is, noted differences do not tell us (1) whether the behaviors of marginalized patients warrant more flags, (2) whether such patients are inappropriately being flagged, or (3) whether marginalized patients are disproportionately being documented for behaviors for which other patients do not receive flags. It is possible that all are occurring simultaneously. Herein, we examine each potential scenario.

First, is it possible that the behavior of socially marginalized patients and their families may objectively warrant flags disproportionately? Yes. Socially marginalized groups are more likely to experience trauma, such as racism, poverty, and adverse childhood events. Trauma can present behaviorally in many ways, including anger and defensiveness.[2] Without the use of trauma-informed practices, health care staff may trigger feelings of being unsafe among patients and families, which then inadvertently escalate interpersonal encounters. In an extreme example, placing an adolescent in physical restraints when having psychotic symptoms may trigger posttraumatic stress disorder and retraumatization if they have experienced police violence.

Second, is it possible that socially marginalized patients and their families are being flagged inappropriately? Yes. Clinicians and health care staff may be more likely to see hostility where it does not exist when interacting with racially minoritized patients. In a qualitative study of patient perspectives on the use of behavioral flags, participants were concerned that cultural differences may contribute to disparities in flag use.[3] One study participant noted,

> In my culture, when we're speaking [Creole], some of the pronunciations and the drama that comes, especially with storytelling, if you don't speak Creole you would actually think these two people are fighting. So that's where, it's like, some of these misunderstanding[s], what if there's

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> a language barrier and someone is trying to express that they're in pain, but their voice is elevated, it may seem like they're being violent or posing a threat or being intimidating.

Hugenberg and Bodenhausen[4] found that implicit racial prejudice was associated with a tendency to categorize racially ambiguous faces as African American if their expressions were hostile (but not happy), indicating an implicit association between hostility and African American people. In addition, studies have documented that stigmatizing language (eg, *aggressive*) is used more often to describe racially minoritized and socially marginalized patients compared with White patients and nonmarginalized comparison groups.[5] Behavioral flags, like stigmatizing language in clinician notes, are ways that the patient EHR can document and propagate clinician bias. There is evidence that clinician bias in the US health care system leads to subsequent racial and socioeconomic disparities in how patients are treated and the quality of the health care they receive.[6]

Third, is it possible that socially marginalized patients and their families are being overly monitored and documented for behavioral flags? Yes. Edwell et al[1] noted that Black infants and mothers in the intensive care nursery of the same health system as in their study had been disproportionately screened for illicit substances, which led to disparate calls for child protective services. Disproportionate racial surveillance and penalties for behavioral misconduct have been documented in US educational and criminal legal systems (eg, "stop and frisk" policing), with negative consequences on the health and well-being of affected individuals. This extends into emergency departments, with increased use of physical restraints or police transport for Black patients compared with White patients.[7]

Regardless of the circumstances that led to inequities in flag use in the study by Edwell et al,[1] behavioral flags are an example of structural racism operating in health care settings in that they limit the access of patients to goods and services (ie, high-quality medical care) and increase their exposure to harm (ie, interactions with security and police). One study of 683 patients seen in 3 emergency departments found that Black patients with behavioral flags had longer waiting times to be roomed and subsequently seen by clinicians and lower rates of diagnostic testing (ie, laboratory tests, imaging) compared with White patients with behavioral flags.[8] This study adds to the growing literature about the disproportionate exposure of socially marginalized populations to security and police while being cared for by health professionals and the ensuing harms that can occur.

A recent National Academies of Sciences, Engineering, and Medicine report, *Ending Unequal Treatment: Strategies to Achieve Equitable Health Care and Optimal Health for All*, identified structural racism as a primary driver of health inequities and calls on health care systems to take proactive steps to advance health equity.[6] Evaluating the upstream reasons for the inequitable application of behavioral flags and their negative consequences for socially marginalized populations are important steps to promoting equity in our health care system.

Behavioral flags, like stigmatizing language in clinician notes, are a mechanism by which EHRs may introduce bias and cause harm to patients and their families. Behavioral flags, particularly when including the use of security and police, may even cause trauma, whereas the American Academy of Pediatrics and World Health Organization recommend practices that reduce trauma, such as trauma-informed care.[9,10] Evidence-based antibias programs for health care staff and training in trauma-informed care may be better long-term strategies for health care systems to build trust, create collaborative relationships, and reduce unwanted behaviors than the current system of monitoring and flagging patients and their families.

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Corresponding Author: Monica E. Peek, MD, MPH, MS, Section of General Internal Medicine, The University of Chicago Medicine, 5841 S. Maryland Ave, MC 2007, Chicago, IL 60637 (mpeek@bsd.uchicago.edu).

Author Affiliations: Section of General Internal Medicine, The University of Chicago Medicine, Chicago, Illinois (Peek); Section of Hematology/Oncology, The University of Chicago, Chicago, Illinois (Wesevich); Department of Psychiatry and Behavioral Sciences, University of California, Davis, Sacramento (Shim).

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