The Role of Implicit Bias in Emergency Department (ED) Triage

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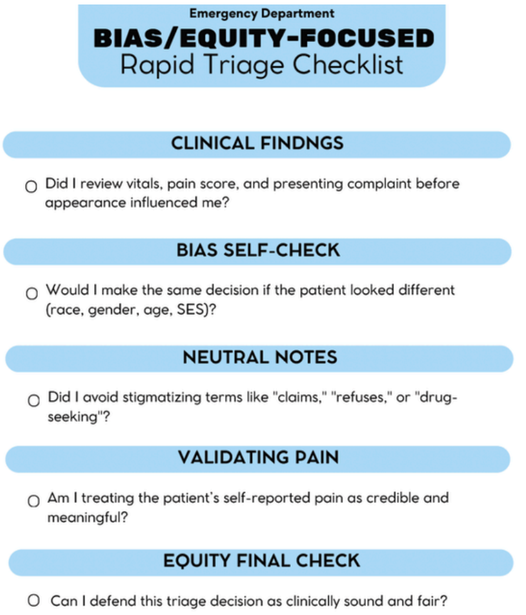
Introduction

Triage in the emergency department (ED) helps nurses and physicians prioritize patients based on the severity of their condition. However, unconscious (implicit) biases can influence how healthcare providers interpret symptoms and assign triage levels. This may result in inequitable care. This proposal examines recent research on the impact of bias in triage and explores the development of a tool to support more equitable and consistent decision-making.

Self Reflection

From my experience as an emergency department (ED) nurse, I have seen how triage decisions can sometimes be influenced by assumptions rather than only the patient's symptoms and level of urgency.

- For example, patients may be given a lower priority if they do not look visibly unwell, even when their symptoms suggest a serious condition. This can happen when healthcare workers rely too much on first impressions or "typical" symptom patterns.
- Patients with a history of substance use, chronic pain, or frequent ED visits may also face delayed assessment because past health information can influence current care decisions.
- Older adults or people living in group settings may have symptoms linked too quickly to common illnesses or outbreaks, which can reduce consideration of other possible diagnoses.
- In some cases, patients reporting severe pain or distress may not be assessed with the same urgency when early tests appear normal, which can delay further investigation or treatment.



Proposed Methods

Based on these findings and clinical experience, a bias-aware triage checklist (as shown to the left) was developed to support nurses and clinicians in pausing, reflecting, and applying consistent decision-making across patient groups. The goal is not to add burden, but to offer a simple, structured prompt that promotes equity, context awareness, and critical thinking during triage. Its effectiveness can be evaluated by actively monitoring and documenting ED wait times across different patient demographics.

Literature Review

- A 2024 study examined stigmatizing language in ED triage notes using over 51,000 records from an urban hospital (2017–2021).[1] Results showed that 5.2% of notes contained at least one stigmatizing term, with higher use in Black patients, men, and in abdominal, chest, and headache presentations compared to back or injury-related pain.[1] The findings highlight the presence of documentation bias and support the use of AI tools, training, and checklists to reduce stigma in emergency care.[1]
- **Precipitating factors: stigmatizing language.**
- A 2025 study found that ED nurses become more lenient in triage decisions as their shifts progress, leading to potential variation in acuity assignment for patients with similar symptoms, particularly around shift changes.[2] This pattern is attributed to decision fatigue from sustained, rapid decision-making.[2] The authors suggest mitigation strategies including overlapping shifts, improved feedback systems, and AI support to promote more consistent and equitable triage decisions.[2]
- **Precipitating Factors: decison fatigue, long shift, high cognitive load.**
- Two 2024 studies examined equity in ED triage decision-making. One found that patients were assigned different urgency levels based on appearance alone, with males and White patients more likely to receive higher priority than females and Black patients despite identical clinical information.[3] A second large study of ~187,000 ED visits across three hospitals showed similar disparities, with white males more likely to be triaged as urgent, while women and racial/ethnic minorities were less likely to receive high-acuity ratings despite comparable conditions.[4] Together, these findings highlight persistent gender and racial differences in triage decisions and support the need for improved training and structured tools to promote equitable care.[3,4]
- **Precipitating Factors: gender bias, racial bias.**

Implications

Triage is often seen as a fast and objective way to prioritize care, but both research and clinical experience show it can be influenced by unconscious bias. The studies reviewed highlight that these inequities are real, yet modifiable. One practical strategy is a bias-aware triage checklist that prompts nurses to reflect on their decisions and consider potential bias. This could be incorporated into ED huddles or used as a portable ID badge reference. Additional approaches, such as training on triage decision-making, implicit bias awareness, and reducing stigmatizing language in documentation, may further promote equitable care. While a single checklist cannot address all systemic issues, it is a feasible step toward improving consistency and fairness in emergency triage.

References

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