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Disparity in Healthcare: The Role of Discriminatory Communication

Introduction

Imagine this: A middle-aged woman walks into a local clinic in Yerevan, clutching her chest in silent discomfort. She has waited far too long to seek help, convincing herself that the tightness in her chest is nothing more than the stress of daily life or perhaps just anxiety. After days of worrying, she finally decides to seek medical attention. She enters the clinic feeling vulnerable, unsure if her fears are warranted, but hoping for reassurance. She steps into the sterile waiting room, the scent of antiseptic filling the air, and waits for what feels like an eternity before her name is called.

As she enters the doctor's office, she is greeted by a doctor who barely acknowledges her presence. The doctor does not look up from his notes, instead muttering a few words under his breath. "Դեմքիցդ հեշտ չի երևում, որ հիվանդ ես" (You don't look sick at all), he says dismissively, as if her appearance alone could determine the severity of her condition. Without making eye contact, he scribbles down a prescription for tests she knows she will barely be able to afford, as if the monetary cost is just another decisive detail in the equation of her health. The woman stands there, embarrassed and dismissed. She has heard this tone before, cold, indifferent, and unprofessional, yet it never stops hurting or feeling usual. She hesitates to ask any questions, fearing the same condescending attitude will follow. The only thing that matters is leaving that space as soon as possible.

Her mind races as she exits the clinic. She had been hoping for empathy, for someone to listen, to reassure her that her concerns were valid and everything she is going to be fine as she is in reliable hands. Instead, she feels humiliated, as if her discomfort is not worthy of attention.

Despite her unease, she leaves the clinic, telling herself she will try again later and come back more prepared. But deep down, She feels the system is set up against her, and just thinking about returning to a place where she feels invisible is exhausting.

Later that week, her discomfort worsens. She feels more pain in her chest, this time sharper and more persistent. This time, there is no denying it. She has rushed to the emergency room, where doctors quickly diagnose her: a heart attack. The weight of her situation hits her all at once. If only she had been taken seriously sooner, if only the healthcare system had shown her the care and respect she deserved, things might have been different.

Issue: In Armenia, and in many other countries, the tone and attitude of medical professionals can be just as damaging as their clinical inaction. A cold phrase, a judgmental glance, or a dismissive comment like *hivand* (a topic explored in more detail later in this paper) ,seemingly small things,can cause real harm. The woman's experience is a prime example of how healthcare professionals can inadvertently undermine a patient's confidence in their care. It creates a snowball effect, where the patient feels very distrustful, unheard, and alone. And this ripple effect does not stop at the doctor's office; it can ripple through entire communities, making people more reluctant to seek help and eroding trust in the system that is meant to protect them. Healthcare disparity is not just about seperate incidents or individual choices, it is woven into the larger systems that shape our lives. One of the biggest barriers people face is economic hardship. In Armenia, like in many parts of the world, people from low-income families often struggle to

get the care they need. They may delay seeing a doctor because they cannot afford it, skip important tests, or miss out on preventive care altogether. These are not just personal setbacks, they are symptoms of a broken system.

For those living in poverty, the lack of resources can mean living with untreated illnesses, dealing with more severe health problems, or even dying from conditions that could have been prevented. It is not about people making bad choices, it is about a system that fails to give everyone a fair opportunities at staying healthy.

This is not just an abstract, hypothetical problem, it is about real lives and real consequences. In most cases the problem is not even financial. Most of the times patients avoid professional intervention or refuse to see a doctor, because of unpleasant and discriminatory behavior they have experienced or felt once, coming from healthcare professionals' side. Fixing this will take time and big changes, but there are steps we can take now. One of them is making sure healthcare providers truly listen to patients and communicate clearly. Even small improvements like this can help bridge the gap and make care feel more respectful, more human, and more fair or at least reduce the cases of healthcare professionals being the main reason for patients avoiding care.

Healthcare disparities remain a serious issue worldwide, influencing patients' access to care, treatment outcomes, and overall health experiences. While much research has focused on multicultural societies with diverse ethnic groups, Armenia presents a distinct and underexplored case. As a predominantly mono-ethnic nation, Armenia's healthcare disparities are shaped

primarily by social, economic, and cultural factors that influence both the delivery of care and the language used in medical settings. One often overlooked yet critical aspect of these disparities is the role of communication, more specifically, the use of stigmatizing language in healthcare interactions. This project examines how language in Armenian healthcare settings can contribute to inequality, focusing on how healthcare providers' words and attitudes impact patients from different social, economic and sometimes even ethnic backgrounds.

How healthcare professionals communicate with patients plays a crucial role in shaping their experiences and outcomes. Some significant researches cited in literature review have shown that language affects not only how patients perceive their care but also how providers make treatment decisions. While much attention has been given to racial and ethnic biases in communication in other contexts, Armenia's case offers a different perspective, i.e., one where stigmatizing language reinforces social and economic divisions. Whether intentional or not, discriminatory language can create harmful stereotypes, leading to unequal care for patients, particularly those from lower-income communities or socially marginalized groups.

Goal: The goal of this capstone project is to shed light on how discriminatory communication in Armenian healthcare settings impacts patients and contributes to disparities within the system. By examining Armenia's unique socio-cultural context, this research highlights the importance of respectful, unbiased communication and explore strategies to mitigate the impact of stigmatizing language. Ultimately, this project aims to support a more inclusive and equitable healthcare environment in Armenia, one that acknowledges and addresses the role of language in shaping health outcomes, particularly for socially and economically disadvantaged groups.

Literature Review

In the sterile brightness of a hospital corridor, trust should be as essential as oxygen. When we enter a clinic, a maternity ward, or an emergency room, we do so with the silent expectation that our pain will be met with empathy, that our bodies will be seen as human rather than problematic, and that the labels others place on us will be checked at the door. Yet, for far too many people, this expectation goes unmet. Behind the crisp white coats and clinical procedures lies a complex and often invisible web of biases, biases that shape the words spoken, the care delivered, and ultimately, the outcomes received.

Healthcare, at its core, is supposed to be a great equalizer. But in practice, it can become a mirror of societal inequalities, magnifying them in the moments when patients are most vulnerable. Implicit bias a form of unconscious stereotyping quietly undermines the integrity of care, particularly for those who fall outside the perceived norm. Whether it is a woman experiencing labor pains, a person living with obesity, a patient struggling with addiction, or someone from a racial or ethnic minority group, the quality of their care can be subtly and profoundly shaped not just by symptoms, but by judgments.

This review begins by facing that uncomfortable truth: that health disparities are not only systemic but also deeply interpersonal. The language scratched into charts, the unspoken assumptions made in a split second, the tone of voice, the absent eye contact, each of these micro-

moments can carry the weight of bias. And these biases do not emerge in isolation. They are sustained by a healthcare culture that often prioritizes efficiency over empathy, and tradition over transformation.

Consider the experiences of pregnant women in marginalized communities, who too often find themselves ignored or mistreated during delivery. Or patients with obesity, who walk into clinics not only to seek help, but to defend their dignity. Or the countless individuals with substance use disorders, whose humanity is obscured by stigmatizing labels. In each case, the damage extends far beyond miscommunication, it breeds mistrust, discourages follow-up care, and deepens inequality.

But there is hope. As more research brings these patterns to light, there are growing efforts to acknowledge and dismantle implicit bias in medical settings. From revised clinical guidelines to training programs focused on communication and cultural sensitivity, the medical field is beginning to recognize that healing is not just about diagnoses and treatments, it is also about relationships, empathy, language, and the willingness to self-reflect.

This literature review explores the many ways implicit bias seeps into healthcare delivery and affects patients across different demographics, diagnoses, and interactions. It looks at the consequences of bias in language, the evolving understanding of weight stigma, the specific vulnerabilities of pregnant women, and the promising interventions aimed at creating a more equitable system. Grounded in global evidence and with a personal eye toward the Armenian

context, this review underscores a simple yet urgent message: care must begin with respect, and healing must begin with seeing each patient as fully human.

Implicit Bias in Unequal Healthcare Delivery: According to research, negative attitudes toward patients can significantly impact the quality of healthcare and contribute to health disparities. Patients are often treated unequally within healthcare systems, with certain groups, such as racial/ethnic minorities, older adults, and individuals with conditions like low health literacy, obesity, and substance use disorders, receiving poorer care due to negative perceptions from healthcare professionals (Park et al., 2021). Implicit bias, which refers to the automatic activation of stereotypes that influence judgment in unconscious and unintentional ways, is a key factor in developing these disparities (Park et al., 2021). This bias can manifest in subtle actions, such as the use of stigmatizing language in medical records, further reinforcing negative stereotypes and impacting the quality of care provided (Park et al., 2021).

Weight Bias: Weight bias and stigma have long been serious concern in healthcare settings, but it wasn't until the most recent Canadian Adult Obesity Clinical Practice Guidelines were published in 2020 that these issues were explicitly addressed. For the first time, weight bias, stigma, and discrimination were acknowledged as significant challenges in healthcare practice and policy, with the guidelines calling for healthcare providers to examine their own attitudes and beliefs regarding obesity. This recommendation was made in light of emerging evidence that such biases can seriously impact the quality of care provided to patients with obesity (Canadian Adult Obesity Clinical Practice Guidelines, 2020). As these biases often lead to discriminatory

practices, the guidelines advocate for healthcare professionals to assess how their personal attitudes could influence their approach to care, potentially compromising patient outcomes. Research has consistently shown that weight bias exists across various healthcare professions, including among primary care physicians, nurses, dietitians, and even medical students. A study revealed that more than half (53%) of women who were overweight or obese reported experiencing inappropriate comments from their physicians, making them the second most common source of weight stigma after family and friends. Nurses and dietitians were also identified as significant contributors to weight bias, with 46% and 37% of participants reporting similar experiences, respectively (Phelan et al., 2015). Such stigmatizing experiences can worsen the patient-provider relationship, resulting in diminished trust and less engagement from patients. Moreover, weight bias leads to poor obesity management, further deepening health disparities and hindering individuals' access to necessary care. Addressing weight bias in healthcare is crucial, as it not only improves patient care but also helps in fostering an inclusive, supportive, and respectful healthcare environment for all individuals, regardless of their body size.

Pregnant Women as Vulnerable Group: One of the most vulnerable groups of this issue are pregnant women, who deserve respectful and responsive care during pregnancy and delivery. In the United States, maternal death rates have been rising from 2018 to 2021, with more than 80% of pregnancy-related deaths being preventable. Native Hawaiian and Pacific Islander, Black, and American Indian and Alaska Native women experience the highest rates of pregnancy-related deaths. These groups also tend to have negative healthcare experiences, such as feeling unheard or mistreated during pregnancy and childbirth, which can affect their trust in healthcare providers and their willingness to seek care (Centers for Disease Control and Prevention, 2023).

A survey on maternity care found that 20% of women reported mistreatment during their maternity care. Disparities were clear: 30% of Black women, 29% of Hispanic women, and 27% of multiracial women reported mistreatment. The most common forms of mistreatment included receiving no response to requests for help, being shouted at or scolded, having their physical privacy violated, and being threatened with withholding treatment or engaged in unwanted treatment. These experiences, driven by a lack of respect or understanding from healthcare providers, can leave patients feeling disempowered and can significantly impact their mental and physical well-being (Centers for Disease Control and Prevention, 2023).

For pregnant women, communication is critical. Nearly half of expectant mothers reported holding back questions or concerns during their pregnancy or delivery. The reasons for this range from believing that their feelings were normal, to being embarrassed, or to fearing that their provider might think they were being difficult or overreacting. A healthcare provider who appears rushed or dismissive can further discourage patients from speaking up, leading to a lack of clarity in the care they receive (Centers for Disease Control and Prevention, 2023).

To improve maternity care, healthcare systems must prioritize patient-centered care, ensuring that every mother feels respected and that her values, needs, and desires are considered.

Providers must foster an environment where patients feel comfortable asking questions and expressing concerns, knowing they will be heard. Communities also play a vital role in raising awareness of respectful care and promoting health equity. When pregnant women, especially those from marginalized communities, are given the space to speak up, their health outcomes can improve, and the overall experience of care can become more positive and supportive (Centers for Disease Control and Prevention, 2023).

How Language Shapes Attitudes and Outcomes in Healthcare: Another issue in healthcare is the impact that certain language used by healthcare providers, even among colleagues, can have on attitudes and behaviors toward patients. The vocabulary used to describe patients, whether in front of them or not, can predispose healthcare providers to form negative judgments. For example, a study of emergency medicine physicians found that those who used the term "sickler" to describe patients with sickle cell disease were more likely to have negative attitudes toward these patients, which affected their adherence to guidelines for pain management (Park et al., 2021). Moreover, biased language can influence others who overhear or read such terms, further creating harmful stereotypes. Park et al. (2021) found that when physicians read a vignette using the term "substance abuser," as opposed to "having a substance use disorder," they were more likely to assign personal culpability and less likely to advocate for treatment. This illustrates the importance of being mindful of the language used within healthcare settings, as it can subtly shape behavior and influence the quality of care provided to patients. Moreover, The language used in medical records not only communicates clinical information but also implicitly conveys attitudes and judgments that can shape the care a patient receives. When stigmatizing or biased terms are included in a patient's chart, they can predispose other healthcare providers, especially physicians-in-training, to adopt similar attitudes and behaviors. For instance, providers may subconsciously alter their prescribing practices or engage with patients less empathetically if prior documentation reflects negative bias. This process becomes a subtle yet significant pathway through which prejudice is passed from one clinician to another, reinforcing systemic disparities. According to research, this highlights the need for upgraded awareness around medical documentation practices, emphasizing respectful, person-first language to support equitable, patient-centered care (Goddu et al., 2018).

Training Programs Addressing the Issue: Medical training programs in some countries have started addressing implicit bias in healthcare, with initiatives like workshops designed to help doctors recognize their own biases and develop better communication strategies (Dirks et al., 2022). Implicit bias, rooted in a patient's race, ethnicity, gender, socioeconomic status, or other prejudices, contributes to significant health inequities. For instance, Black patients are less likely to receive appropriate treatment for heart attacks and pain compared to non-Hispanic White patients and face higher rates of death due to childbirth-related complications (Dirks et al., 2022). Indigenous and non-White Hispanic patients are often stereotyped as being non-compliant with medical recommendations or having trouble understanding and communicating health information (Dirks et al., 2022). Women, in particular, are less likely to be referred for cardiovascular testing, and Indigenous women experience significant cancer disparities, often driven by perceived discrimination from clinicians (Dirks et al., 2022).

This issue of implicit bias is not limited to race or gender alone. LGBTQ+ individuals, especially gay men and lesbians, also face healthcare discrimination, which can result in poor healthcare access and lower-quality care (Dirks et al., 2022). Though these biases are often unintentional, they influence multiple levels, interpersonal, institutional, and societal, leading to poor communication, lower patient satisfaction, and diminished trust in healthcare providers (Dirks et al., 2022). From a personal perspective, addressing implicit bias in healthcare is not just a global concern but something that resonates with locals in the context of Armenia. Given the country's diverse demographic and socioeconomic challenges, ensuring equity in healthcare can be transformative for both patient outcomes and public trust. There are instances where marginalized groups, be they ethnic minorities, low-income individuals, or rural populations,

struggle to receive quality care, not due to a lack of need but because of existing biases in medical practices.

In Armenia, where healthcare accessibility and quality are ongoing concerns, the introduction of implicit bias training in medical institutions could dramatically improve the quality of care provided to all citizens, regardless of their background. Such changes would help to address inequities in patient-provider communication and improve healthcare outcomes, particularly for vulnerable groups.

Research suggests that improving clinician communication behaviors, especially through non-verbal skills like body language, eye contact, tone, and volume, can disrupt negative associations between clinician bias and patient outcomes (Dirks et al., 2022). This approach can encourage better relationships between patients and clinicians, ensuring a more equitable and respectful healthcare system. However, there remains a gap in understanding how clinicians perceive feedback methods intended to mitigate implicit bias (Dirks et al., 2022). To bridge this gap, Armenia's medical institutions might benefit from integrating informatics solutions such as feedback tools focused on patient-centered communication. Imagine the impact of a healthcare system in Armenia that is more attentive to eliminating bias, where every patient receives equal attention, respect, and care, regardless of their background. Another way that this issue can be addressed are structured resources like the one developed by the National Institute on Drug Abuse (NIDA), which offers a detailed guide titled "Words Matter: Preferred Language for Talking About Addiction." This resource provides healthcare professionals with a list of recommended terms, terms to avoid, and clear explanations covered in research. Its aim is to

shift the way we speak about individuals struggling with addiction, encouraging a move away from dehumanizing, blame-laden language and toward terminology that emphasizes dignity, personhood, and the need for care over punishment. More specifically, the list includes using person-first language, eliminating pejorative terms, choosing inclusive vocabulary, avoiding labels, and refraining from language that blames or undermines the patient. These principles are not just semantic suggestions, they have tangible implications for the quality of care patients receive and the attitudes healthcare professionals internalize. For example, replacing terms like "diabetic" or "schizophrenic" with "person with diabetes" or "person with schizophrenia" acknowledges the individual beyond their diagnosis. Similarly, substituting "the drug screen is dirty" with "the drug screen is positive" avoids judgment-related terminology. Avoiding labels like "noncompliant patient" and instead specifying "the patient is not taking medications" removes blame and promotes clinical objectivity. Moreover, refraining from adversarial language such as "the patient refused treatment" in favor of "the patient declined treatment" shifts the tone toward respect and neutrality. These small but powerful shifts in vocabulary can influence provider behavior, reduce implicit bias, and ultimately foster a more equitable healthcare environment (Healy, Richard, & Kidia, 2022). This kind of resource acknowledges that the words we choose have power, not just in how we make patients feel, but also in how we ourselves think and act.

Creating a similar guide in Armenia could have a meaningful impact. It would provide clinicians, medical students, and even policymakers with a shared framework for speaking about vulnerable populations, whether those facing addiction, mental health challenges, or chronic illnesses. More importantly, it would signal a cultural shift: one that values empathy, respect, and evidence-

based care. In a healthcare system where biases are often reinforced silently and unintentionally through everyday language, such a tool could help foster awareness and accountability, promoting a more inclusive and supportive environment for all patients (Healy, Richard, & Kidia, 2022).

What Matters Most to Patients When Choosing a Doctor: When selecting a doctor or primary care physician (PCP), patients tend to prioritize interpersonal and relational qualities over credentials or specialization titles. A study by Mercado et al. (2012), which gathered responses from over 850 racially diverse patients in family medicine (FM) and internal medicine (IM) clinics, revealed that good patient care was the most highly valued factor across all groups. This included a physician's ability to deliver effective treatment, take time with patients, and consider their overall well-being, not just their immediate symptoms. Close behind was the importance of strong communication skills: patients placed great value on doctors who listen attentively, explain things clearly, and maintain a respectful, two-way dialogue (Mercado et al., 2012). Notably, nearly half of the FM patients and over a third of IM patients did not know their physician's specific training background, and more than 50% were unfamiliar with the actual scope of their doctors' practices. This suggests that while formal qualifications are necessary, they are not always at the forefront of patients' decision-making. From a personal perspective, this points to a broader reality in healthcare: patients are most impacted by how they feel in the doctor's presence, whether they are heard, understood, and treated with dignity. In busy or resource-limited healthcare systems, these human-centered interactions often define the quality of care more than any diploma on the wall. As we examine this dynamic in Armenia, it will be important to consider whether similar patient priorities exist, or if cultural norms, resource

limitations, or social hierarchies lead to different expectations and tolerances when choosing a physician.

At the heart of all this is the fundamental truth that healthcare should be about healing, not reinforcing social divides. The research available from different parts of the world makes it clear: bias is not an unsolvable problem. When addressed through education, awareness, and systemic change, it is possible to create a medical system that truly serves everyone equally. If Armenia embraces these lessons, it could take meaningful steps toward ensuring that every patient, no matter their background, is treated with the fairness and dignity they deserve.

Public vs Private Hospitals: Patient Satisfaction: There is a study by Tengilimoglu, Kisa, and Dziegielewski (1999) that provides an in-depth exploration of patient satisfaction in Turkey, specifically comparing experiences in public versus private hospitals. The researchers found a clear distinction in how patients perceived the quality of care in the two sectors. Private hospitals were overwhelmingly favored by patients, particularly due to factors such as shorter waiting times, more personalized care, better overall comfort, and greater attentiveness from staff. The quality of service in private hospitals, including the perceived professionalism of healthcare providers, was highlighted as a major contributing factor to higher patient satisfaction levels. In contrast, patients in public hospitals expressed dissatisfaction due to longer waiting periods, perceived overcrowding, and staff shortages. Despite these challenges, some public hospitals were still praised for their highly qualified medical personnel and the availability of critical medical resources, which made a significant difference for patients needing urgent or specialized

care. This big contrast between the two sectors sheds light on the areas that require improvement within Turkey's healthcare system (Tengilimoglu et al., 1999).

In relation to this study, an observation was conducted as part of the research for this paper, which provides valuable insights into the Armenian healthcare system. It would be particularly interesting to examine the findings where patients in Armenia were asked to assess the effectiveness of public versus private clinics. Given the geographical proximity and similar socio-economic conditions of Turkey and Armenia, it is likely that many of the factors influencing patient satisfaction in Turkey would also resonate in Armenia. Comparing how patients in Armenia rate the effectiveness of healthcare in both sectors could provide further context and potentially reveal whether similar patterns emerge in Armenia. For instance, it would be insightful to understand whether Armenian patients express similar preferences for private clinics over public ones, particularly in terms of service quality, wait times, and staff professionalism. This comparative observation could offer essential insights into how Armenia's healthcare system might be improved by addressing common issues observed in public hospitals while promoting the strengths of private healthcare services. Furthermore, this research could provide a better understanding of regional healthcare dynamics, enabling policymakers in Armenia to adapt strategies that might improve patient satisfaction and the overall quality of care.

Research Questions

1. What types of stigmatizing language are commonly used in Armenian healthcare settings, and how do they vary across different patient demographics (e.g., social status, gender, ethnicity)?
2. In what ways do healthcare providers' biases and communication styles influence patient trust, satisfaction, and treatment outcomes?
3. How do healthcare professionals in Armenia perceive their own use of language, and to what extent are they aware of potential biases in their communication?
4. What interventions or training programs could be implemented to reduce discriminatory communication and improve patient-provider interactions in Armenia?

Methodology

This study employed a mixed-methods approach, combining in-person interviews and surveys to explore the use of stigmatizing language in Armenian healthcare settings. By gathering perspectives from patients of diverse backgrounds, including different genders, ethnic minorities, and varying social statuses, the research aimed to uncover how language contributed to healthcare disparities and affected patient trust and treatment experiences.

To address the first research question, which examined how stigmatizing language contributed to healthcare disparities among different social and ethnic groups, semi-structured interviews were conducted with patients who had encountered discriminatory language in healthcare settings. Participants were asked about their experiences, how language impacted their treatment, and whether it influenced their willingness to seek medical care in the future. Additionally, surveys were distributed to a broader group of patients to assess the prevalence of such experiences and their impact on healthcare access and satisfaction.

For the second research question, which sought to identify the types of stigmatizing language commonly used in Armenian healthcare settings and how it varied across demographics, interviews focused on patient experiences, asking participants to recall specific words, tones, or phrases that made them feel judged, disrespected, or dismissed. To supplement this qualitative data, surveys included predefined categories of stigmatizing language and asked respondents to indicate how frequently they had encountered each type in their interactions with healthcare providers.

The third research question investigated how healthcare providers' biases and communication styles influenced patient trust, satisfaction, and treatment outcomes. Patient interviews explored whether negative language affected their confidence in the healthcare system, their willingness to follow treatment plans, and their overall satisfaction with care. Survey questions assessed patient trust, using Likert-scale ratings to measure whether they felt respected or dismissed during medical interactions and whether they believed their demographic background influenced how they were spoken to.

To better understand both sides of the issue, a small number of interviews were also conducted with healthcare professionals. These interviews aimed to capture their perspectives, provide context for the language they use, and explore their awareness of how communication may impact patient experiences. However, the number of healthcare professionals interviewed was significantly lower than that of patients, and therefore, this component is presented as an observational insight rather than a basis for solid judgments or broad conclusions.

Observations

Addressing the Use of Labelling Terms in Armenian Healthcare Communication: As highlighted by Park et al., the language used to describe patients, whether directly to their face or not, can heavily influence healthcare providers' judgments and predispose them to negative attitudes. This is particularly problematic when terms carry inherent stigma, such as "sickler" for those with sickle cell disease or "substance abuser" for individuals with substance use disorders, as they develop harmful stereotypes. A similar phenomenon is seen in Armenia, where terms like "alcoholic" or "drug addict" are often used to describe patients struggling with substance use issues. These labels carry strong negative connotations and can influence how healthcare providers approach care, leading to less empathy and reduced quality of treatment. Just as in the examples given by Park et al., such terminology can inadvertently contribute to biased attitudes and hinder the provision of patient-centered care. Addressing and altering such language, both in professional settings and among colleagues, is essential to fostering a more respectful, compassionate, and unbiased healthcare environment in Armenia as well.

Another Armenian term that is extremely labelling and predisposing in healthcare settings is the widespread use of the word "hivand" to refer to patients. While this term is deeply rooted in medical discourse, it inherently carries a stigmatizing connotation. Directly translated from Armenian, "hivand" means "sick person" or "someone who is ill," which can contribute to a perception that a patient's identity is solely defined by their illness. This language can unintentionally reinforce negative stereotypes and diminish the dignity of individuals seeking medical care. Due to this, many Armenians, including healthcare professionals, often prefer

using the Russian term "пациент" instead, as "hivand" can sometimes come across as rude or too direct in certain contexts.

To address this issue, alternative terminology should be encouraged among healthcare professionals. A more neutral and respectful approach would be to use phrases such as "patient" or "individual receiving care." Medical institutions should revise official documents, medical records, and training materials to reflect these changes. Furthermore, workshops and awareness initiatives can help professionals transition away from stigmatizing language by educating them on the psychological impact of word choice in healthcare interactions.

Ultimately, eliminating stigmatizing language in Armenian healthcare settings requires a commitment to continuous education, systemic reforms, and cultural change. By prioritizing respectful and unbiased communication, Armenia's healthcare system can take meaningful steps toward ensuring equitable treatment for all patients, regardless of their social or economic background.

Discrimination Against Minorities in Armenian Healthcare Settings: Based on personal observations, minority groups in Armenia, particularly Yezidis and Indian residents, often face discriminatory attitudes when seeking healthcare. A troubling pattern has emerged where healthcare professionals, rather than offering support, have laughed at or outright refused to treat patients from these communities. One commonly cited reason is the unfamiliar scent of body oils traditionally used by many Indians, which some healthcare workers perceive as unpleasant. Unfortunately, instead of responding with cultural sensitivity or professionalism, this difference

is sometimes met with ridicule or avoidance. Such behavior reflects deeper issues of implicit bias and a lack of cultural competency within the healthcare system. These interactions not only discourage minorities from seeking care but also strengthen feelings of exclusion and mistrust toward healthcare institutions. Addressing these problems requires targeted training for healthcare providers on cultural awareness, as well as systemic efforts to ensure that every patient, regardless of ethnicity or background, receives respectful and equal treatment.

Observation-based Data Collection: Patient Perspective: As part of my capstone project, I conducted an observation-based data collection involving 108 participants. The data was gathered through an online survey that I circulated with the help of healthcare influencers, university peers, friends, and relatives. The participants, aged between 18 and 54, shared their personal experiences within the Armenian healthcare system, particularly focusing on the quality of communication they received from medical professionals.

Of the respondents, 65.7% were aged 18–24, making them the largest demographic group, followed by 25–34-year-olds, who made up 25%. The sample was predominantly female (80%), while the remaining 20% were male. To ensure male perspectives, especially those related to military medical evaluations, were represented, I also conducted individual interviews with several young men. Educationally, 76.9% of participants have higher education degrees, with the second major group (19.4%) having secondary education; the rest include respondents with PhDs, elementary schooling, or course-based qualifications. Half of the participants (50.9%) live in Yerevan, while the other half are from various regions across Armenia.

The responses reveal a consistent pattern of disrespectful, judgmental, and often discriminatory interactions, highlighting the urgent need for more empathetic, patient-centered communication practices. Below is a summary of key observations gathered from these testimonies.

A recurring and main issue is the lack of respectful communication, especially in emotionally or physically vulnerable situations. Phrases such as «Մաասէք, երբ հարմար կլինի կընդունենք» ("Wait, we'll see you when it's convenient for us") reflect an absence of patient-centered care and an abuse of authority. Instead of offering empathy, some healthcare workers project a sense of dominance and impatience.

In one case, a patient suffering from back pain was dismissed with a blatantly sexist and judgmental remark: "բա 3 երեխա ունես ինչ էիր ուզում" ("You have 3 kids, what did you expect?"). This kind of response not only invalidates the patient's pain but also blames them for their condition, a form of gender-based microaggression that discourages women from seeking help.

Another testimony involved body-shaming comments like "Վայ, գիրացել ես, սենց բաները սլիսի չուտես" ("Wow, you've gained weight, you shouldn't be eating these kinds of things"). These remarks reflect a form of medical fatphobia that shifts the focus from compassionate care to unsolicited judgment based on appearance. Rather than addressing the patient's actual medical needs, such comments foster shame, discomfort, and a sense of being unwelcome in a setting where support and understanding should be central. Unfortunately, this is not an isolated phenomenon. As mentioned in the literature review, nurses and dietitians were also identified as significant contributors to weight bias, with 46% and 37% of participants reporting similar experiences, respectively (Phelan et al., 2015). Such stigmatizing experiences can erode the patient-provider relationship, leading to diminished trust and less engagement in healthcare. When patients feel judged or misunderstood, they are more likely to delay or avoid seeking care

altogether. Moreover, weight bias contributes to poor obesity management, exacerbates existing health disparities, and limits equitable access to care (Phelan et al., 2015). Addressing weight bias in healthcare settings is essential not only for improving clinical outcomes, but also for restoring dignity, respect, and person-centered communication in the medical experience.

The issue of unprofessional internal dynamics was also raised. Some patients observed doctors making derogatory remarks about their colleagues in front of them, showing a clear lack of medical professionalism. These instances often led to "մուննաթով խոսելը", a culturally specific term denoting passive-aggressive or resentful speech directed at the patient.

There is also a significant dismissal of patient concerns, such as when a doctor remarked, "Քեզ մոտ այս կամ այն բանը չի ստացվի... չես մեռնի, սարքել ես հարց" ("Nothing's going to work for you... you're making a big deal out of nothing, you're not going to die"). Statements like this display a dangerous minimization of symptoms, which could lead to serious health risks due to misdiagnosis or delayed treatment.

One particularly troubling case occurred at Muratsan Hospital, where a parent brought in their 5-year-old daughter with severe abdominal pain. The surgeon responded with sarcasm:

«Սա, որ բան կերած չլիներ, ոտի վրա չէր կանգնի, սրան տարեք տուն, գիտեք թե սանատորիայա» ("If she hadn't eaten anything, she wouldn't be standing. Take her home, this isn't a sanatorium"). This response demonstrated a lack of empathy, poor diagnostic reasoning, and a complete disregard for pediatric care.

Additional examples shared by participants further emphasize the troubling patterns of unprofessional and inappropriate behavior within the healthcare system. One recurring issue involved healthcare workers taking calls on speakerphone while simultaneously treating another patient. This behavior not only compromises patient privacy but also conveys a clear lack of focus and empathy. Patients described feeling like they were being rushed or ignored, as the attention of the provider was visibly divided and their tone often irritated or dismissive. Such multitasking during consultations diminishes the quality of care and leaves patients feeling not taken seriously.

Another alarming pattern involved inappropriate remarks during sensitive medical situations. For example, during a miscarriage procedure, one patient recalled being told, "Այս վիճակով սարորհնակ ա որ հղիացել ես" ("It's strange that you got pregnant in this condition"), a comment that stemmed from the provider's judgment based on the patient's physical appearance, such as excess body hair. This kind of judgmental language during moments of emotional and physical vulnerability reflects a deep lack of sensitivity and professionalism. Rather than offering support, these comments alienate and shame patients, reinforcing stigmas that have no place in a clinical setting.

Labelling and stereotyping also emerged as significant concerns. A particularly striking account described a healthcare provider making a diagnosis based solely on appearance: "Բն տեսից երևում է որ նյարդային խնդիրներ ունես, խորը դեպրեսիայի մեջ ես, արի աֆոբազոլ նշանակեն" ("From your appearance, it's obvious you have psychological issues; I'll prescribe Afobazole"). This non-evidence-based conclusion was given without any proper psychological

assessment, undermining the seriousness of mental health diagnosis and care. Such comments preserve the harmful belief that visible traits alone can indicate psychological conditions, which risks misdiagnosis and discourages individuals from seeking future support.

Such statements clearly contribute to the stigmatization, infantilization, and dehumanization of patients, especially young women and mothers.

Sexist and ageist remarks were frequently noted, particularly toward young women. Some participants shared that they were spoken to in a humiliating or infantilizing manner, most notably being addressed with the phrase "Աղջիկ ջաւն." Literally translated, it means "dear girl" or "sweet girl," but the issue lies in the way it is used. While it may seem endearing on the surface, within the context of a clinical setting, especially when used by medical professionals, it often carries a patronizing and dismissive tone. Rather than conveying warmth or support, it can come across as belittling, reinforcing a power imbalance between doctor and patient. The phrase tends to reduce young women to their age or gender, ignoring their autonomy and the seriousness of their health concerns. For many, hearing "Աղջիկ ջաւն" during medical consultations felt like they were not being taken seriously, as if their identity as individuals with valid concerns was being overlooked in favor of a generalized, diminutive label. This subtle yet pervasive form of infantilization contributes to an environment where young women may hesitate to advocate for themselves or fully express their symptoms, ultimately impacting the quality of care they receive.

These patterns demonstrate a systemic issue where verbal abuse, stereotyping, and passive-aggressive communication undermine the trust and safety that should define the patient-doctor

relationship. This contributes to broader disparities in healthcare, especially for women, children, and those already facing socio-economic or emotional vulnerability.

In conclusion, discriminatory communication is not just a matter of etiquette, it directly influences healthcare outcomes. Patient dignity, mental well-being, and the accuracy of diagnosis can all be compromised when communication is disrespectful or biased. The Armenian healthcare system must prioritize communication ethics, empathy training, and accountability to foster a more equitable and supportive environment for all patients.

One of the main patterns I noticed from the observations was that two of the most vulnerable groups in the healthcare system appear to be *pregnant women* and *young men undergoing medical check-ups before military service*. In Armenia, compulsory military service is a legal obligation for all able-bodied male citizens, typically starting at the age of 18 and lasting for two years. This requirement is not only a formative experience for many young Armenian men but also a period that can carry profound implications for their physical and psychological well-being. Military service often involves exposure to physically demanding conditions, emotional stress, and, in some cases, inadequate medical care or delayed access to treatment. I interviewed three young men aged 18 and older who had recently gone through this process, and all of them described a lack of proper treatment and respect. Although they are officially supposed to receive prioritized care during these check-ups, in practice they often face dismissive and rude behavior, with phrases like "Տղա ջաֆ, սպասի" ("Boy, wait") being commonly used. Their concerns are not taken seriously, and even if they arrive at the scheduled time, they are often told to come back another day without proper explanation. This creates unnecessary stress and a sense of

neglect during a critical stage in their lives. These factors can shape and have shaped already how male patients perceive and engage with the healthcare system after their service, some may return with untreated health issues, while others may approach medical professionals with heightened distrust or reluctance due to negative past experiences. In the context of this study, it is important to recognize that the attitudes, health concerns, and healthcare-seeking behaviors of young male patients may be significantly influenced by their time in service. This dimension adds complexity to the findings, especially when interpreting patterns related to trust, communication, and perceived stigma in healthcare settings.

Similarly, pregnant women also reported facing judgmental and inappropriate comments from healthcare providers. They are often subjected to unsolicited remarks about their age, such as being told they are either too young or too old to be pregnant, which can feel shaming and intrusive. One disturbing example shared was during a non-viable pregnancy case, when a doctor commented on the patient's body hair, saying it was strange she had become pregnant "with that appearance." Others reported that medical staff often begin giving personal advice or making inappropriate jokes and assumptions without being asked, undermining their autonomy and emotional wellbeing. These experiences reflect a lack of professionalism and empathy, contributing to a healthcare environment where vulnerability is met with judgment rather than support. As noted in the literature, a survey by the Centers for Disease Control and Prevention (2023) revealed that 20% of women reported mistreatment during maternity care, Common forms of mistreatment included being ignored, shouted at, having their privacy violated, or feeling put into unwanted treatments. These findings emphasize the need to address systemic biases in maternity care to ensure all patients are treated with respect and dignity, which is

something very common also in Armenian healthcare system obviously and needs to be addressed.

Communication Behaviors That Caused Discomfort

When asked what specific behaviors or communication styles made them feel uncomfortable, the majority of respondents pointed to non-verbal cues and general attitudes of the medical staff. The most common issue cited was a dismissive or impatient attitude, mentioned by 67 respondents (65.7%). Closely following were concerns about facial expressions, with 60 participants (58.8%) noting that unfriendly or indifferent expressions made them feel uneasy. Similarly, 58 respondents (56.9%) reported that the tone of voice used by medical professionals contributed to their discomfort. Additionally, 21 participants (20.6%) stated that the use of inappropriate or unprofessional vocabulary created a negative impression.

A few respondents shared specific personal anecdotes that shed light on deeper concerns. These included being met with sarcasm or mockery, receiving emotionally insensitive comments during moments of vulnerability, or experiencing a lack of respect for personal space during intimate procedures. While these were mentioned by fewer people (1–2 per case), they provide critical qualitative insight into the depth of the issue.

Perceived Causes of Biased or Rude Behavior

To understand what may cause biased or rude behavior from doctors, respondents were asked to identify contributing factors. The most frequently cited reason was the social status of the patient, selected by 71 participants (65.7%). Many believed that patients from lower socioeconomic backgrounds are more likely to be treated with less respect. Appearance was also

a key factor, mentioned by 37 respondents (34.3%), suggesting that visible indicators like clothing, grooming, or perceived wealth influence how patients are treated. Gender and religion were also noted, with 23 (21.3%) and 17 (15.7%) respondents respectively identifying these as possible sources of biased communication.

Open-ended responses added further nuance. Some participants suggested that doctors' personal issues, such as emotional burnout, financial stress, or their own biases, might contribute to poor treatment. Others pointed to systemic problems like low salaries in public clinics, work overload, and a general lack of accountability. Several comments referred to an "attitude of superiority" or a "God complex" exhibited by some medical staff, which further alienated patients. These insights suggest that the issue is both personal and structural.

Public vs Private Clinics

As already discussed in the literature review, the study by Tengilimoglu, Kisa, and Dziegielewski (1999) highlights the notable differences in patient satisfaction between public and private hospitals in Turkey. The authors found that private hospitals were generally associated with higher patient satisfaction due to better service quality, more attentive and respectful staff, and improved overall conditions. In contrast, public hospitals were frequently criticized for long waiting times, overcrowding, and a lack of personalized care, although they were occasionally acknowledged for having competent medical professionals and necessary infrastructure (Tengilimoglu et al., 1999).

Building on these findings, the current research included an observation conducted in Armenia to explore whether similar patterns exist. Respondents were asked to identify where they believe discriminatory or rude communication is more likely to occur. Consistent with the patterns observed in Turkey, the majority of Armenian participants , 89 out of 95 (93.7%) , pointed to public institutions, such as polyclinics in Yerevan, as the primary settings for negative interactions. In contrast, only 20% of respondents mentioned private clinics, such as Astghik Medical Center. Some participants added that in their experience, the issue was more dependent on individual staff behavior rather than the status of the institution. Nonetheless, public clinics were overwhelmingly perceived as the environments where disrespectful or discriminatory communication was more prevalent.

These observations further support the conclusions drawn from the Turkish study, suggesting that patient dissatisfaction in public healthcare institutions may be a broader regional issue. The parallels between Turkey and Armenia underline the importance of improving communication standards, professional training, and institutional culture within the public healthcare sector to enhance patient experiences and reduce inequalities in care (Tengilimoglu et al., 1999).

Healthcare Professionals' Perspective

As part of my capstone project on bias and communication in healthcare, I found it essential not only to amplify the voices of patients who have experienced inappropriate or discriminatory behavior, but also to listen to healthcare professionals themselves. In doing so, I aimed to create a more holistic picture of communication dynamics within clinical settings. By surveying nine medical professionals from various specialties, I hoped to better understand how such behaviors

are perceived internally, whether they are recognized, and what justifications or reflections accompany them. These insights allow for a more nuanced and empathetic analysis that accounts for both patient vulnerability and professional pressures.

Reflection on Professional Backgrounds of Respondents

The nine professionals who responded to the survey represented a wide spectrum of medical fields, including neonatology, neurology, pharmacy, family medicine, rheumatology, and midwifery. This variety emphasizes that communication challenges and ethical dilemmas are not limited to a specific specialty but can arise across the healthcare system. The inclusion of clinicians with different scopes of practice and patient populations enriches the data, revealing that the intersection between communication and bias is a system-wide issue rather than an isolated concern. It also strengthens the credibility of the findings by drawing from a multidisciplinary pool.

When asked whether they had witnessed their colleagues displaying biased, discriminatory, or harsh communication, the majority of respondents (six out of nine) answered "No," while three selected "Sometimes." Notably, no one selected "Yes" outright, which may suggest either that such behaviors are not widespread in their environments or that there is hesitancy in recognizing or naming them. The absence of detailed examples may reflect either a normalization of subtle bias or a discomfort in admitting what might be seen as professional misconduct. The fact that nearly a third acknowledged having seen this type of behavior occasionally suggests that while it may not be dominant, it is certainly not nonexistent.

When asked whether discriminatory or harsh communication might discourage patients from seeking future care, nearly all respondents agreed, using phrases like "միանշանակ այո" ("definitely yes") and "այո, իհարկե" ("yes, of course"). One respondent noted that while patients might not avoid care altogether, they may switch providers or clinics, which still indicates a disruption in trust. As already mentioned research by Mercado et al. (2012) found that patients place the highest importance on good patient care when choosing a primary care physician. This includes receiving quality treatment, feeling that the doctor takes time with them, and being assured of their overall well-being. Good communication skills followed closely as the second most important factor, with patients expressing a strong preference for physicians who listen attentively, explain medical issues clearly, and speak with respect and empathy. However, in the Armenian context, some responses reflect a different dynamic. One participant noted, "կոպիտ էր, բայց կարևորը լավ մասնագետ էր" ("they were rude, but the important thing is they're a good specialist"), highlighting a tendency among patients to rationalize poor communication if the clinician is perceived as highly skilled. This suggests a concerning level of tolerance for mistreatment, likely rooted in professional hierarchies and limited patient empowerment. While our sample is too small to generalize, it does raise critical questions about how patients in Armenia weigh respect and communication against technical expertise, and whether the global emphasis on respectful care is truly reflected in local expectations.

Responses to whether professionals themselves had ever used discriminatory or harsh language were mixed and revealing. Some firmly denied doing so, emphasizing that their role is limited or that responsibility lies with the attending physician. However, several admitted that they sometimes shift to a stricter tone, especially when patients resist treatment or fail to realize the

seriousness of their condition. One response stood out: the participant described repeating information in a sterner voice when patients lacked understanding, suggesting an intent to help rather than harm. These answers reflect the moral gray areas professionals navigate, where urgency and patient non-compliance may influence tone. However, they also highlight a need for clearer guidelines and training on maintaining professionalism and compassion under pressure.

Two respondents reflected on what might cause stigmatizing or biased language in healthcare. One attributed it to the patient's own "անկիրթ և պահանջատիրական պահվածքը" (uneducated and demanding behavior), implying that frustration with patient attitudes can lead to less respectful communication. The other attributed it more generally to "մարդու էությունն է" (human nature), acknowledging that even professionals are prone to emotional reactions and judgments. These reflections illustrate how systemic stressors, interpersonal dynamics, and human fallibility intersect in healthcare communication. While understandable, these views also underscore the importance of accountability and ongoing efforts to foster respectful and bias-free environments, regardless of external triggers.

The evidence gathered from personal observations, patient testimonies, and literature underscores a critical and urgent need to address discriminatory and stigmatizing communication practices within the Armenian healthcare system. Whether through the use of labeling terms like "hivand" or "alcoholic," culturally insensitive behavior toward minorities, or dismissive, sexist, and body-shaming remarks, the patterns are consistent: harmful communication diminishes patient trust, discourages care-seeking, and undermines the core values of medical professionalism.

Language is not neutral, it shapes perceptions, reinforces stereotypes, and either builds or breaks the patient-provider relationship. When words belittle, infantilize, or judge, they not only cause emotional harm but can lead to misdiagnosis, poor treatment adherence, and ultimately, worse health outcomes. These issues are especially pronounced among vulnerable populations, including women, ethnic minorities, and individuals with mental health or weight-related concerns.

To bring about meaningful change, the Armenian healthcare system must take concrete steps to reform both institutional practices and everyday interpersonal dynamics. This includes updating medical terminology, incorporating empathy and communication ethics into medical education, and implementing regular sensitivity training for healthcare professionals. Cultural competency must also become a standard, not an exception, ensuring that all patients, regardless of background, feel respected, heard, and understood.

Above all, fostering a patient-centered healthcare environment requires a cultural shift, one that embraces dignity, respect, and accountability at every level of care. Only then can Armenia move toward a truly equitable and compassionate healthcare system.

Solutions and Recommendations

Addressing stigmatizing language in Armenian healthcare settings requires a many-sided approach that focuses on education, policy changes, and systemic reforms. While biases in medical communication may often be unintentional, their consequences on patient trust, treatment adherence, and overall healthcare experiences are significant. To foster a more inclusive and equitable healthcare environment, several targeted interventions can be implemented.

One of the most effective strategies is the introduction of anti-bias and cultural competency training for healthcare providers. Research has shown that unconscious biases, whether based on race, ethnicity, gender, socioeconomic status, or sexual orientation, shape medical decision-making and communication, often leading to disparities in care (Dirks et al., 2022). For instance, Black patients in the U.S. are less likely to receive appropriate treatment for pain or heart conditions and face higher rates of maternal mortality. Similarly, Indigenous and Hispanic patients are often perceived as non-compliant, and LGBTQ+ individuals continue to experience discrimination that affects the quality of their healthcare (Dirks et al., 2022).

By implementing mandatory training programs in medical institutions, healthcare professionals can become more aware of their implicit biases and develop strategies to mitigate them. These workshops can incorporate real-life case studies and patient testimonials to illustrate how stigmatizing language affects health outcomes. Additionally, interactive role-playing exercises can help doctors and nurses practice respectful communication in different patient

scenarios. Evidence suggests that improving clinician communication behaviors, particularly through non-verbal skills such as body language, tone, and eye contact, can disrupt the link between clinician bias and negative patient outcomes (Dirks et al., 2022).

Certainly, these anti-bias trainings should be prioritized and systematically implemented in Armenia. Given the significant impact language has on healthcare experiences, medical professionals must be equipped with the necessary skills to communicate in a more respectful and unbiased manner. One potential avenue for incorporating these trainings is through medical education. Institutions such as Yerevan State Medical University (YSMU) and other medical universities across Armenia should consider integrating courses on bias-free communication into their curricula. Early exposure to these principles can ensure that future healthcare professionals develop inclusive communication habits from the start of their careers.

Beyond training, standardized guidelines for inclusive communication should be established within Armenia's healthcare system. These guidelines would outline best practices for neutral and respectful language, discouraging the use of stigmatizing labels in both verbal interactions and medical records. Encouraging person-first language, such as referring to "a patient with diabetes" instead of "a diabetic", ensures that individuals are not solely defined by their medical conditions. Reviewing documentation practices to remove discriminatory descriptions will help prevent biases from being extended (Healy, Richard, & Kidia, 2022).

A particularly useful model is the resource developed by the National Institute on Drug Abuse (NIDA), titled "Words Matter: Preferred Language for Talking About Addiction." This guide

outlines recommended and discouraged terms, emphasizing the use of respectful, non-judgmental language. For example, replacing "the drug screen is dirty" with "the drug screen is positive" removes the implication of moral failing and shifts the focus to clinical observation. Similarly, changing "noncompliant patient" to "the patient is not taking medications" avoids assigning blame and promotes clinical objectivity (Healy, Richard, & Kidia, 2022). Creating a similar language guide in Armenian would provide clinicians, students, and policymakers with a shared framework for respectful communication and help catalyze a cultural shift toward empathy and accountability.

Another key initiative is integrating communication-focused courses into medical education curricula. Many healthcare professionals develop their language habits during medical training, making it essential to introduce these concepts early. Courses should emphasize patient-centered care, teaching students how to communicate with empathy, respect, and cultural sensitivity. Collaborations between medical institutions, linguists, and psychologists can result in evidence-based modules that highlight the psychological and emotional impacts of stigmatizing language. To measure the effectiveness of these interventions, regular patient feedback mechanisms should be established. Implementing anonymous patient surveys can provide valuable insights into how communication styles affect healthcare experiences. These surveys can be analyzed to identify patterns of stigmatizing language and guide further training initiatives. Moreover, encouraging patients to report instances of discriminatory communication without fear of retaliation can create a more transparent and accountable healthcare system (Dirks et al., 2022).

Lastly, public awareness campaigns can play a crucial role in shifting societal attitudes toward healthcare communication. By promoting respectful language and challenging harmful stereotypes, these campaigns can empower both patients and healthcare providers to advocate for better interactions. Community engagement through social media, workshops, and informational materials can further reinforce the importance of bias-free medical communication. A powerful example of social media activism in Armenia is the recent campaign against air pollution, which gained traction through influencer support and sparked nationwide conversation. A similar large-scale campaign focused on eliminating stigmatizing language in healthcare could significantly raise awareness and influence behavior change among professionals and the general public.

Limitations and Avenues for Future Discussions

While this capstone project offers valuable insights into the communication challenges within the Armenian healthcare system, several limitations must be acknowledged. First, the sample was heavily skewed toward younger, highly educated, and predominantly female participants, with 65.7% aged between 18–24 and 80% identifying as women. As a result, the experiences of older adults, male patients, and individuals with less formal education may not have been fully captured. Despite efforts to include male perspectives through additional interviews, the relatively small number of male respondents, particularly regarding military medical evaluations, suggests a need for broader representation. Similarly, while nine healthcare professionals were

surveyed, the small sample size and their possible reluctance to openly discuss workplace biases limited the depth of insider perspectives. Cultural norms around loyalty to colleagues and professional image may have influenced their responses, leaving some forms of bias unreported or underexplored.

Moreover, the nature of self-reported surveys and interviews means the data is inevitably colored by personal perceptions, emotional memories, and individual interpretations of events. Experiences of communication, especially those involving subtle disrespect or microaggressions, can be deeply subjective, making it challenging to generalize findings across the entire healthcare system. The emotional weight of recalling painful interactions may also have influenced the tone and focus of patient testimonies.

For future discussions, a more inclusive and diversified approach would be valuable. Expanding the participant pool to include a larger number of older adults, rural residents, male patients, and ethnic minorities could paint a fuller picture of communication dynamics across different layers of Armenian society. Additionally, engaging a wider range of healthcare providers, especially through anonymous interviews or focus groups, could encourage more candid reflections on systemic challenges and personal biases. Long-term studies that follow patients' experiences over time, rather than capturing isolated incidents, would offer richer insights into the long-term impact of communication quality on health outcomes and trust in the system. Finally, integrating observational studies inside clinical settings, while ethically complex, could help bridge the gap between self-reported experiences and actual behaviors,

providing a more grounded understanding of the real-world interactions between patients and providers.

Ultimately, this project represents a first step toward amplifying patient voices and acknowledging the emotional dimensions of healthcare communication. But meaningful, lasting change will require continuous, compassionate dialogue, not only between patients and doctors, but also within society at large, as we rethink what dignity, respect, and empathy should look like in every clinical encounter.

Conclusion

The literature presented in this review makes one thing unmistakably clear: implicit bias is not an abstract concept limited to academic discussions, it is a lived reality for countless patients around the world, including in Armenia. It silently infiltrates the medical encounter through language, assumptions, body language, and institutional norms. It affects not only how care is provided, but also who is heard, who is believed, and ultimately, who survives. Across diverse examples, from weight bias to the mistreatment of pregnant women, from stigmatizing language in patient charts to inadequate treatment of marginalized groups, the consequences of bias are measurable and deeply personal.

While healthcare is intended to be an equalizer, it too often becomes a reflection of the broader social hierarchies it exists within. Vulnerable populations, be they patients with obesity, women of color, individuals struggling with addiction, LGBTQ+ individuals, or rural and

socioeconomically disadvantaged groups, face systemic barriers that compromise their safety, dignity, and trust in the healthcare system. These challenges are not simply logistical or clinical, they are human and ethical, rooted in how providers perceive and interact with their patients.

Yet, this review also points to a path forward. With increasing awareness and empirical evidence, there is now a growing momentum to confront these biases head-on. Training programs that focus on self-awareness, cultural humility, and communication are a promising start, but they must be embedded into a larger cultural shift, one that values empathy as much as expertise and actively dismantles inherited prejudices. Policy updates, educational reforms, and inclusive clinical guidelines are essential steps, but change must also happen in the everyday interactions between providers and patients.

In the Armenian context, where healthcare reform is a serious issue, the need for such transformation is urgent. Addressing implicit bias here means recognizing the specific contours of marginalization, whether based on region, ethnicity, income, or social identity, and working actively to eliminate them from the fabric of healthcare delivery. Doing so will not only improve health outcomes but restore something far more fragile: the trust that people place in those charged with their care.

Ultimately, the message is simple but powerful: healthcare must begin and end with respect. A system that sees patients not as categories, risks, or burdens, but as whole human beings, is a system where healing becomes truly possible. Implicit bias may be unconscious, but addressing it must be intentional and the time for that intention is now.

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