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The Role of Implicit Bias on Racial/Ethnic Health Disparities and Its

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The Role of Implicit Bias in Creating Racial Health Disparities

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Introduction
Health disparities between groups of people exist for a variety of factors-access to care, socioeconomic factors, and genetics to name a few. But do disparities between racial/ethnic groups exist because of factors in the individual clinical encounter such as clinician prejudice and discrimination? The 2002 report by the Institute of Medicine (IOM) found that health disparities between racial/ethnic groups exist even when insurance status, income, age and severity of conditions are controlled for.

Background
Implicit or unconscious bias is a preference for or aversion to a group that may not align with declared beliefs but will influence behavior. These associations are developed from a very young age, and even people who have egalitarian intentions have implicit cognitions. In the health field, these automatic categorizations become convenient in stressful situations, but clinical decision making based on stereotypes and assumptions rather than complete information tend to harm minority patients.

Purpose of study
The purpose of this integrative literature review is to describe if implicit bias based on race/ethnicity is found among health care professionals and its impact on health outcomes.

Methods
An integrative literature review was conducted using CINAHL Complete, using the keywords implicit bias OR unconscious bias AND health disparity*. Inclusion criteria were: 1) original study published after 2006 2) measured implicit bias in a health profession 3) disparities related to race/ethnicity. 6 articles met the inclusion criteria

Results
The Implicit Association Test was used in all studies to measure implicit bias, and many articles included self-reported explicit attitudes towards different ethnicities. Every article found an implicit preference for non-Hispanic Whites, ranging from weak to moderate to strong. These implicit measures were stronger than the explicit measures in all articles that included it. Effect of implicit bias on treatment outcomes were mixed. Schae et al (2009) found higher levels of implicit bias were correlated with lower levels of positive affect, less emotionally responsive communication, and higher levels of verbal dominance towards Black and Hispanic patients than Whites. Sabin et al found that vignettes of cases given to physicians did not produce a correlation between implicit bias and treatment recommendations.

Table 1. Summary of Studies

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Title</th>
<th>Study Design</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schae, R., Schae, A., Cooper</td>
<td>2013</td>
<td>Implicit Correlates of Implicit Racial Bias and Their Relationship to Communication</td>
<td>Qualitative study, 100 Black, 100 White.</td>
<td>Implicit bias was related to stronger pro-White implicit bias.</td>
</tr>
<tr>
<td>Ibarra, N., Greenwald, P.</td>
<td>2009</td>
<td>Physician’s Implicit and Explicit Attitudes and Their Relationship to Treatment</td>
<td>Qualitative study, 100 Black, 100 White.</td>
<td>Participants with lower implicit bias were more likely to receive equivalent treatment.</td>
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<tr>
<td>Whitelaw, J., Greenwald, P.</td>
<td>2008</td>
<td>Cultural Competency, Race, and the Importance of Racial Bias in Medicine</td>
<td>Qualitative study, 100 Black, 100 White.</td>
<td>Participants with lower implicit bias were more likely to receive equivalent treatment.</td>
</tr>
<tr>
<td>Bynner, N., Greenwald, P.</td>
<td>2007</td>
<td>An Investigation of Associations Between Negative Racial Biases and Prevention of Medical Students and Health Care Professionals</td>
<td>Qualitative study, 100 Black, 100 White.</td>
<td>Participants with lower implicit bias were more likely to receive equivalent treatment.</td>
</tr>
<tr>
<td>Paolucci, C., Migliore, M., Lin, J., et al.</td>
<td>2014</td>
<td>The Role of Bias in Emergency Department Visits in Patients with Racial/ethnic Disparities</td>
<td>Qualitative study, 100 Black, 100 White.</td>
<td>Participants with lower implicit bias were more likely to receive equivalent treatment.</td>
</tr>
</tbody>
</table>


Recommendations for Practice & Research
• Combat implicit bias being passed on to students through a “hidden curriculum” of offender-stereotypic comments from faculty or preceptors;
• Assess implicit bias in pre-professional students as well as faculty members;
• Include quality articles and training in curriculum for perspective taking and individualizing, and reflecting on clinical situations where activation of bias may have occurred;
• Conduct more research on the impact of implicit bias on direct treatment outcomes;
• Conduct more research on the effectiveness of strategies to combat implicit bias in educational settings as well as clinical practice.

Conclusion
The existence of unconscious presuppositions that influence the way that providers treat patients have implications for clinical practice and particularly education of pre-professionals. We cannot ignore the role that systemic discrimination plays in individual encounters, and we must be willing to admit that unconscious categorizations occur. When nurses claim beneficience as a guiding ethical principle yet see patients being treated differently without a basis in patient data, they are claiming a role in racial health disparities instead. As nurses we must look for the root causes of racial health disparities, because this phenomenon reflects the bias that some racial groups’ lives are less valuable than others. The future of nursing as a noble profession will require a diverse, intentional, and brutally honest population to be truly patient-centered.