Nursing Leadership Must Confront Implicit Bias as a Barrier to Diversity in Health Care Today

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Implicit bias can prevent diversity and inclusion in organizations; however, attempts to mitigate its damage in health care have not always been successful. Nursing leadership struggles with integrating these topics into organizational nurse training programs. Implicit bias is common and can be activated unknowingly, despite a nurse's best intention, and can result in health disparities and poor outcomes for patients. Nursing leadership must raise awareness of implicit bias and help all nurses, from novice to senior, recognize its existence as a barrier to diversity, and create a safe environment to bring concerns, identify triggers, and invest in education and training.

Many people from marginalized populations continue to be at increased risk of getting sick and dying from illnesses because of systemic health and social inequities. Historically, health care experiences are common to many people within these populations because social determinants of health have prevented them from having fair opportunities for health equity.

Cultural and linguistic barriers are also apparent in patients' health care experiences as nurses provide care, education, and case management to an increasingly disparate patient population. Nurses working in diverse populations must learn skills to help them recognize, assess, and mitigate implicit biases affecting the workplace. Implicit bias is a barrier to diversity and health equity. Unintentional discrimination through implicit (unconscious) bias can result in poor decision-making in health care.[1] Strategies to mitigate implicit bias must be introduced during nursing education before nurses graduate and begin working in the clinical area. Thereafter, nurse leaders are well positioned "to address and mitigate the negative influence of unconscious bias within organizations."[2(p.1)] This paper presents a call to action for nursing leadership to commit to address implicit bias and build diverse and inclusive organizations at all levels of nursing from early nurse education and ongoing after graduation. The consequences of unconscious bias in health care cannot be ignored.

KEY POINTS

- **Unintentional discrimination is caused by implicit bias (unconscious).**
- **Implicit bias can result in health disparities and poor outcomes for patients.**
- **Nurse leaders are in the position to address implicit bias through ongoing nursing education in a patient care environment.**

IMPLICIT BIAS: A BARRIER TO DIVERSITY

Implicit bias (unconscious bias) may be innate in mental shortcuts that help to assess and react to situations quickly. Unconscious bias is an inclination to judge without question.[3] Mental shortcuts can often be based on approaches that worked in the past, and now can help to quickly develop strategies without deliberation in new situations with previously encountered groups of people.[4]

Historically, bias was regarded as deviant, conscious, and intentional. The National Center for Cultural Competencies[5] defines conscious (explicit) bias as "a person is very clear about his or her feelings and attitudes, and related behaviors are conducted with intent."[6] Unconscious (implicit) bias "operates outside of a person's awareness and can be in direct contradiction to a person's beliefs and values" (*Table 1*).

Today, human biases are largely referred to as unconscious (implicit) and unintentional—

"…persistent, unintentional prejudiced behavior that clashes with our consciously held beliefs."[8] Because implicit bias is unconscious, it can create an inclination to judge without question. According to Yudkin and Van Bavel,[9] "Implicit bias is not about bigotry per se." It is "grounded in a basic human tendency to divide the social world into groups."[9(p.1)]

UNCONSCIOUS BIAS CHARACTERISTICS

The following characteristics are adapted from Marcelin et al[10(p.S69)]:

- Attitudes or stereotypes that unknowingly alter our perceptions or understanding of our experiences, thus affect our behavior interactions and decision-making.
- Strategies to mitigate are largely multifactorial, but involve bias awareness, culture change, countering stereotypes, and intentional group diversification.

Implicit biases have the potential to be infinitely more dangerous than people ever imagined them to be—operating like computer bugs to get beyond the best intellectual firewalls and capable of creating tremendous interpersonal damage—without a person's conscious intent. "The devil's finest trick is to persuade you that he does not exist."[11]

Because implicit bias is unconscious, it happens through a person's brain making very quick judgments and opinions of people and circumstances without one realizing. These appraisals can be influenced by one's background, cultural environment, and personal experiences, and can result in feelings and attitudes towards others based on race, ethnicity, age, appearance, accent, etc.[1]

Quinn et al[12] discussed "microaggression"—consequence of unconscious bias—as "the brief and commonplace daily or verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious slights and insults to the target person or group." The transgressor of the microaggression is usually unaware that he/she has engaged in a demeaning exchange. "Unconscious bias can lead to health disparities including under treatment of conditions like pain, cardiovascular disease, asthma and mental health in racial and ethnic minorities."[12]

THE IMPACT OF IMPLICIT BIAS IN HEALTH CARE

Implicit bias can unconsciously influence the way information about an individual is processed, leading to unintended disparities that could have real consequences in medical school admissions, patient care, faculty hiring, and promotion opportunities.[10] Fitz-Gerald and Hurst[13] reviewed 42 studies that evaluated the impact of implicit bias in health care. Twenty-seven articles focused on racial and or ethnic bias, and 10 studies included gender, age, and weight, and 35 of the studies (83%) demonstrated evidence of implicit bias in health care professionals. Hall et al[14] reviewed other studies and found implicit bias to be particularly related to patient–provider interactions and health outcomes. Because of research findings that the biases of health care providers can have negative consequences on patient care, nurse leaders have an obligation to help all nurses recognize the impact implicit biases might have on their nursing practice.

THE DIMENSIONS OF DIVERSITY AND UNCONSCIOUS BIAS IN NURSING

The increasing influx of immigrants and minorities in the United States, and expanding globalization have created a need to increase diversity in all levels of nursing. Nurse leaders must embrace diversity as a help to stimulate and enhance student learning and achievement;[15] but others feel that diverse students demand excessive energy and time.[16] Implicit bias can be a barrier to achieving diversity outcomes in academic nursing, as well as across all levels of nursing. Faculty of color play important roles as mentors for minority students and faculty peers, and they also promote excellence in schools of nursing, leading to improved student outcomes in the areas of cultural competence, humanism, and professionalism.[17,18] Addressing the advantages, disadvantages, and benefits of dealing with a diverse group of students, depicts a profound impact on the prospects of future nursing practice.[19]

RECOGNIZING TRIGGERS OF IMPLICIT BIAS

Nurse leaders are part of the access and delivery of equitable health care regardless of location of the care provided. As such, nurse leaders have a role in recognizing and mitigating care inequities. Unconscious biases are judgments that are often based on mistaken, inaccurate, or incomplete information. Nurse leaders continually must be aware of triggers that indicate when they should take action and counter bias by interrupting a situation (*Table 2*).

INTERNAL PROGRAMS TO TACKLE IMPLICIT BIAS: VALUING DIVERSITY THROUGHOUT A MULTISITE HEALTH CARE SYSTEM

A multisite health care system demographic area has a population of approximately 1.2 million people that includes a large city and many smaller surrounding town in another county. The demographic breakdown is:

- 39% African American
- 43% Caucasian
- 13% Hispanic
- 5% Other (recent refugees from other countries

Table 1. Implicit Bias Types[7]

Harmful types of implicit bias	
Affinity bias	Positive bias toward people that are like us in some way. Example: Women or men who socialize in the same groups.
Ageism	Discrimination of a person on the basis of age. Usually affects women more than men.
Bandwagon bias	My friends don't like someone or a group, so I won't like them either. Example: a person may be snubbed by a member of a group (clique), so all members of the group follow that behavior even though they know nothing about the target of the snubbing.
Confirmation bias	Finding any information that meets or agrees with our beliefs and ignoring the information that supports an opposing belief. Example: Members of political parties.
Deaf and or visually impaired	Often need assistance to function normally, but individuals are often assumed to be abnormal. Example: Many agency and organization directives to clients point to "online" ways to solve a problem (password, etc.). In some cases, there are no vocal alternatives for visually impaired and no visual alternatives for deaf persons.
Gender identity	LGBTQ individuals suffer exclusion, discrimination, and stigma, which are social determinants of health. Example: A nurse taking care of a transgendered person was very curious and asked personal questions, "I first thought you were a real woman. Do you take hormones? Have you had the surgery yet?" This questioning upset the patient and caused great anger.
Halo/horns effect	When we like a characteristic of someone, we assume that every attribute of this person is positive. Or we perceive someone negatively when we hear something unfavorable. Example: A manager who often taps a person for opinions or help; or a manager who is referred to negatively by an employee.
Emotional, behavioral, disability bias	Learning disabled, mentally disabled, and physically disabled individuals often suffer stigma and exclusion. Example: Lack of understanding can cause hurt to patients suffering a disability.
Name/religious bias	When a person is judged by name and background only. Example: Resume review, not meeting in person. Different religious groups dress differently (Muslim).
Perceptual bias	The perception that nurses "eat their young." Example: New nurses often experience this bullying at the hands of more experienced coworkers.
Racial bias	Racial prejudice and discriminatory behavior. Example: During the Covid-19 pandemic, when African-American individuals do seek care, the assumed bias and lack of trust in providers play a big role in continuation and quality of care.

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Table 1. (continued)

Harmful types of implicit bias	
Socioeconomic bias	Some neighborhoods are considered bad because of crime, gangs, or poverty. Example: Patient overhead health care staff speaking negatively of someone that grew up in a "bad, hood area." The patient grew up in a similar neighborhood, and this caused the patient more stress.

LGBTQ, lesbian, gay, bisexual, transgender and queer or questioning.

The "Other" group accesses health care at the general hospital.

The health care system's objective is to staff its affiliate hospitals and nursing homes with an employee mix that mirrors the population served. The general hospital is making progress toward that goal, but the current mix falls short, making diversity education a priority for all clinical and ancillary staff.

New health care system employees learn about the health care system's 5 values from day 1 of hire. Diversity is an integral value. The health care system strives to treat all patients, residents, visitors, and each other with kindness, integrity, and respect, values that are reinforced through informal coaching and a variety of formal training experiences.

As the health system's chief nursing education and diversity officer, I have worked closely with the learning and development team to develop a series of courses focused on foundational leadership skills. The series, which comprises 7 courses, was initially launched to nurse leaders throughout the system in 2016. A prominent course in the series is Diversity & Inclusion: From Hiring to Inclusion, which looks at aspects of diversity from a human resources perspective. The course, developed in conjunction with a nationally recognized expert in diversity, has a goal to encourage all nursing leaders to consider the dynamics of diversity when making hiring decisions, and emphasizes the importance of input from a diverse team when facing challenges.

Another program is Better Together, a 6-hour course designed for nursing leaders across the health care system, with a focus on how diversity and unconscious bias can affect patient and resident care. Better Together was piloted by the system's long-term care (LTC) division and includes classroom lecture, role plays, and scenario discussions. In developing the Better Together curriculum, learning and development staff interviewed more than a dozen nurses and other leaders in LTC to learn about the specific challenges they face from a diversity perspective. Realistic scenarios based on these real challenges were developed in order to spur group discussion and problem-solving. Trigger phrases and words that nurses unconsciously used, were identified and discussed. Nurses realized that often they were not aware of their use of these triggers, which included: "that patient is a regular here," "ignore her, she is a complainer," "he is a pain," and other degrading references to patients or patient behaviors. Participants reported that they felt better equipped to handle incidents on their teams where diversity, unconscious bias, and social equity could play a role in the delivery of patient care.

My final example is specific to nurse leadership training. On an ongoing basis, we conduct an internal training program for nurses we identify as high potential for leadership roles, in the spirit of growing our teams from within. The Accelerated Nurse Leadership Cohort program began in 2016 with a group of 35 accomplished nurses from a variety of backgrounds. In subsequent programs, we have adjusted the session topics and bolstered the role of team capstone projects to tackle important, relevant challenges. For each cohort, however, the topics of diversity, unconscious bias, and equity are woven throughout the classroom sessions and capstone projects. Looking back on the roster for our first program, I recognize names of people who have moved into more senior roles and nurses who I work with now on a daily basis.

For the future, we will continue to update and expand these existing courses, and build new ways for our staff to understand and celebrate the dimensions of diversity. We are staffing an office of diversity, equity and inclusion, and our goal is to reach every employee in the health system at least once per year with the message of the importance of diversity in our workplace.

MITIGATING UNCONSCIOUS BIAS IN HEALTH CARE

Mitigating unconscious bias requires an intentional multidimensional approach and may operate parallel with strategies to increase diversity, inclusion, and equity.[20,21] Lessening unconscious bias is becoming increasingly important with nursing leadership across all of health care. Strategies to accomplish this goal can have a positive influence across all groups of

Table 2. Nurse Leaders Can Recognize Implicit Bias Triggers

Triggers that help nurse leaders recognize implicit bias		
Trigger	**Description**	**Bias behavior**
Repetitively visiting patient with many complaints.	Known as a "frequent flyer" patient that constantly appears in a health care facility for many different reasons.	"Oh no, not again, your turn to see that patient." Health care staff laughing and discussing this patient in a negative way.
Recurring patient with many complaints looking for medication.	Drug seeker continually shows up with excuses to see a doctor for any reason that might result in medication, looked upon as having an ulterior motive.	Nurses and health care team members disappear. Negative accusations about this individual and often refusals to be involved in care because of fear of being associated with drugs.
Visual differences in patients cause unfounded judgments by the staff.	A prevailing bias is present when the noncompliant patient such as an obese individual is looked upon as noncompliant, or someone who will never make lifestyle changes. Other visually different patients can include impoverished, homeless, or different skin colors. Patients' medical complaints can be ignored because of unfounded judgment.	Nurses and other health care team members use derogatory, accusatory language when referring to the noncompliant patient.
Individual hanging around a medical facility daily and for long periods of time demanding to see a doctor because of complaints of pain.	A drug addict will stay in an emergency department until seen and may appear agitated.	Nurses avoid all contact with this patient out of fear and refuse to be involved.
Other patients in waiting area are nervous and upset by this angry patient.	The troublemaker patient arrives with a confrontational attitude and may be known to the staff.	Nurses engage in a reactive or confrontational way to this patient instead of calming. The situation often worsens.
Patient demands to be seen immediately because of time or any other reason and constantly complains in front of others. Patient has no patience.	Difficult patients are not unusual in medical facilities and often create chaos wherever they are in any department.	Nurse is overheard saying to others, "I don't want to take care of that nagging person again."
Person exhibits loud use of derogatory language in front of others.	Inappropriate language. Patient continually using derogatory language and or cursing to others in area. No one can seem to calm this patient.	Nurses are unable to calm the patient and as a result refuse to be involved in care.
Person presents from a known "bad, hood area" of a town, and staff shows fear.	Patient lives in a "bad zip code" or lower socioeconomic neighborhood. Some zip codes represent challenging neighborhoods where crime or gangs are known to be present.	Nurses and other health care team members discuss how this patient lives in a bad zip code in the area and "is dangerous." Team members object to having to care for this patient.

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Table 2. (continued)

Triggers that help nurse leaders recognize implicit bias

Trigger	Description	Bias behavior
Systemic exclusion occurs with specific appearances or attitudes.	Transgender patients are often looked upon as strange and ignored for lack of understanding.	Groups of coworkers gather to discuss and laugh at or be disgusted by this type of patient.
Patient is presenting treatment complaints to the nurse or other health care team member.	"Constant complainer" patient is looked upon by staff as not a serious complaint.	Nurses and other health team members refer to a patient during handoff or rounding as "Old so and so is here complaining again."
Interviewee of color is passed over immediately by interviewer.	Interviewee, who is of color deemed "not a good fit for hire"	Team discusses interviewees and one, who is African-American, is passed over without further review.

Table 3. Organizational and Personal-Level Strategies

Strategies to mitigate unconscious bias

Organizational	Individual	Organizational and individual
Debriefing	Debriefing	Debriefing
Leadership commitment to culture change	Self-reflection on personal biases	Intentionally diversify experiences
Meaningful diversity training	Question and actively counter stereotypes	Cultural humility and curiosity

individuals affected by bias. These strategies can be implemented at organizational and individual levels or combined[10] (*Table 3*).

Researchers report that positive contact within a group is associated with reduction in implicit bias in health care, and that this bias may fade when health care training features opportunities for positive contact spanning group boundaries: provider to patient, and student to faculty.[22,23] Interventions can reduce implicit bias among health care providers; however, there is evidence that pre-licensure nurses may be more open to learning about their own biases, and accepting responsibility for changing them when faculty activate and affirm goals and commitment to provide equal care, before the nursing students engage in self-reflection activities.[24]

Scientists have developed strategies that are shown to mitigate implicit biases such as: counterstereotypic imaging, emotional regulation, habit replacement, increasing opportunities for contact, individuation, mindfulness, partnership building, perspective taking, and stereotype replacement.

The Joint Commission,[25] the Institute for Healthcare Improvement,[26] Devine and colleagues,[27] and Burgess and colleagues[28] offer recommendations for how nurses can practice self-interventions to mitigate implicit bias that may lead to health care disparities (*Table 4*).

EDUCATIONAL FRAMEWORK

Sukbera and Watling[29] developed an educational framework to integrate implicit bias-informed curricula into ongoing nursing education. The authors' framework suggests that nursing leaders use the following principles[29]:

- Create a safe and nonthreatening learning context.
- Present information about the science of implicit bias (opportunities exist throughout a nursing education curriculum where this information can be included).
- Ask nursing participants to:
  - Review literature regarding the impact of implicit bias on behaviors and patients.
  - Identify students' own explicit biases and stereotypes and plan conscious efforts to overcome bias.

Table 4. Self-Interventions to Decrease Implicit Biases[4]

Strategies for nurses to practice self-interventions	
Recommended by	**Strategy and description**
The Joint Commission[25]	Emotional regulation: Controlling thoughts and emotions during clinical encounters. Nurse reflects on negative reactions (dislike, fear, frustration) to patients from vulnerable groups.
Institute for Healthcare Improvement[26]	Partnership building: Working with patients as equals toward the common goal of helping them achieve good health.
	Perspective taking trying to understand the perspective of the patient. Nurse thinks about what the patient is thinking and feeling.
	Counterstereotypic imaging: Nurse imagines the stereotyped person as the opposite of the stereotype and replaces unconscious bias with a positive image (mindfulness).
	Individuation: Nurse attempts to learn about the personal history of the individual to see develop a therapeutic relationship (patient-centered care) instead of seeing the patient with a group.
	Increasing opportunities for contact with people from different groups: Nurse develops relationships with members of a different group with the goal of dissolving stereotypes.
	Stereotype replacement: Nurse consciously replaces negative images of a group with positive images and commits to respond with compassion in the future (self-reflection).
Devine and colleagues[27]	Habit replacement: Nurse focuses on bad habits to be broken and develops and uses self-interventions to replace the bad habit of biased thinking with a good habit of accepting and caring about each patient.
Burgess and colleagues[28]	Mindfulness: Nurse takes time to calm thoughts and feelings. P.A.U.S.E.: • Pay attention to what is actually happening beneath the judgments and assessments • Acknowledge your own reactions, interpretations, and judgments • Understand the other possible reactions, interpretations, and judgments that may be possible • Search for the most empowering, productive way to deal with the situation • Execute your action plan

- Consider ways their own biases are influenced by formal and informal environmental and cultural influences.

NURSING LEADERSHIP CAN RECOGNIZE AND ADDRESS UNCONSCIOUS BIAS

1. Identify the damaging effects of unconscious bias (inequitable health care and disparate patient outcomes).
2. Recall the *Code of Ethics for Nurses*[30] and the values that bought you to nursing: autonomy, beneficence, justice, and nonmaleficence.

a. Case example: A patient arrived who acted effeminate and wanted to be called by a female name because he identified as female. The nurses were all making fun of him/her. The nurse manager overheard the nurses discussing the patient and asked what the diagnosis was and what he wanted to be called. When the nurse manager went to see the patient, she felt terrible for him because he had recently struggled with gender identity. The nurse leader was quite upset with her nurses but returned to the nurses station and calmly educated the nurses to please respect his wishes as they had no idea what he was going

through to be comfortable enough to request that people respect his gender identity.

DISCUSSION

Unconscious bias is common, persistent, and can be activated quickly and unknowingly despite a nurse's best intentions. "Unrecognized and unmanaged unconscious bias can lead to health disparities, resulting in potentially negative consequences for patients."[31(p.62)] Nurses and other health care team members believe that unconscious bias sets up a barrier to diversity and leads to disparity.

Recommendations for mitigating unconscious bias by the Institute of Medicine include: a need for more advanced continuing education of registered nurses; nurses leading innovations in health care and being appointed to decision-making bodies; all nurses practicing to the full extent of their education and training; a more diverse nursing workforce and faculty; and more interprofessional collaboration among nurses, physicians, and other members of the health care team in the educational and clinical environments. Mitigation also includes debriefing of the person or group responsible for the bias that is very difficult to eliminate, but nurse leadership can interrupt it. Courage and willingness are necessary to be the change that is needed to interrupt implicit bias and ensure health equity.

CONCLUSION

Nursing leadership must raise awareness of implicit bias and offer support and help at all levels of nursing to recognize its existence as a barrier to diversity. Nurse leaders at all levels must take action to interrupt unconscious bias work toward achieving the goal of health equity.

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