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California: Implicit Bias for Healthcare Providers (341)

Author: Lauren Robertson, BA, MPT
Contact Hours: 2.5
Cost: $19

Course Summary

This course describes the influence of unconscious biases on the delivery of healthcare services in the United States. It describes personal, interpersonal, institutional, structural, and cultural barriers to inclusion and discusses power dynamics and organizational decision-making.

Information is provided about the effects of historical and contemporary exclusion and oppression of minority communities as well as corrective measures to decrease implicit bias in healthcare. The course discusses ways to improve communication across identities, including racial, ethnic, religious, and gender identities.

There is a discussion of health inequities within the perinatal care field, including the impact of implicit bias on maternal and infant health outcomes as well as information about reproductive justice. The course concludes with a discussion of programs and practices designed to remedy the effects of implicit bias in the patient care setting, in healthcare research, and in healthcare organizations.

Course Objectives

1. Define implicit and explicit bias.
2. Relate 5 ways in which the historical impact of structural racism has contributed to implicit bias in healthcare services.
3. Describe 3 ways in which other forms of historical discrimination have impacted access to healthcare in the United States.
4. Define reproductive justice.
5. Describe 3 tests used to evaluate the presence of implicit bias in healthcare.
6. Discuss 4 ways to improve communication skills to reduce bias in healthcare.
7. Relate 3 policies designed to remedy the impact of implicit bias in healthcare.

1. Bias, in All Its Forms

Humans have developed many automatic responses to help us move through our daily lives efficiently and without conscious thought. We don't think about how our bodies maintain balance, when to withdraw our hand from a hot stove, or why it's important to avoid rotten food. We have developed automatic and reflexive responses that allow us to function efficiently, without conscious thought.

Implicit biases might be viewed in this light. They occur below the level of consciousness, using information developed from our life experiences and habits. They help us to make sense of the world, allowing us to classify individuals into categories quickly and automatically. Although efficient and even easy, biases have caused considerable harm to people who are the target of unconscious bias, leading to discrimination and lack of access to the benefits available to members of society who do not experience these biases.

Over time, expressions of explicit bias have declined, but implicit bias has remained unrelenting. Healthcare providers may still hold negative explicit and implicit biases against many marginalized groups of people. Implicit bias permeates the healthcare system and affects patient–clinician communication, clinical decision making, and institutionalized practices (Vela et al., 2022).

Higher education systems, including medical schools and academic hospitals, have been affected by the discrimination and bias that have long permeated healthcare. A complex system of discrimination and bias causes devastating health inequities that persist despite a growing understanding of its root causes. These biases hinder improvement in healthcare provider diversity, which has long been recognized as an important mechanism for reducing disparities (Vela et al., 2022).

Test Your Knowledge

You may find it helpful to try these 10 "True or False" questions first before reading the course. The answers are at the end of the question list.

1. **Implicit bias** is a conscious process based on intentional mental associations.
2. **Health equity** means that everyone has a fair and just opportunity to be as healthy as possible.
3. **Structural racism** refers to ideologies, practices, processes, and institutions that produce and reproduce differential access to power and to life opportunities along racial and ethnic lines.
4. **Cultural sensitivity** is a respect for another person's strengths, culture, and knowledge.
5. A type of unconscious bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group or person is called **perception bias**.
6. Evidence shows that interventions focusing on social determinants of health rarely lead to better health outcomes.
7. **Perception bias** is a type of unconscious or implicit bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group a person "belongs" to.
8. Historically embedded structural racism is a fundamental cause of health inequities in the United States.
9. Measures of implicit bias rely on the assumption that automatic associations between two concepts will influence behavior in a measurable way.
10. Bias training has been shown to be more effective when the approach is multipronged, designed with context and professional identity in mind, and when people work and train together.

Answers: Questions 1 and 6 are False; all the others are True.

What is Implicit Bias?

Implicit bias is an attitude or internalized stereotype that affects a person's perception, action, or decision-making in an unconscious manner. It can contribute to unequal treatment based on characteristics such as race, ethnicity, nationality, gender, gender identity, sexual orientation, religion, socioeconomic status, age, or disability (Michigan.gov, 2021, September 24). What is troubling for healthcare professionals is the possibility that biased judgment and biased behavior can affect patient care (FitzGerald et al., 2019).

Implicit bias is widespread, even among individuals who explicitly reject prejudice. It persists through structural and historical inequalities that have been slow to change (Payne et al., 2019). Decades of research has demonstrated that discrimination, driven by implicit bias, impacts healthcare access, trust in clinicians, care quality, and patient outcomes (Dirks et al, 2022).

What is Explicit Bias?

Explicit or conscious bias, unlike implicit bias, occurs when we are aware of our prejudices and attitudes toward certain groups. This can lead to positive or negative preferences for a particular group.

Explicit forms of bias include preferences, beliefs, and attitudes of which people are generally consciously aware, personally endorse, and can identify and communicate (Vela et al., 2022). Explicit bias can lead to unequal treatment, lack of access to care, and influence differential diagnostic and treatment decisions.

What are Stereotypes?

Stereotypes are fixed, oversimplified beliefs about a particular group or culture. They occur when we categorize people by age, gender, race, or other criteria (Brusa et al., 2021). In the healthcare setting, stereotyping can occur when a provider categorizes a patient in a certain way, regardless of whether the individual in question fits the stereotype (Galanti, 2019).

Recognizing stereotypical thoughts can have a powerful impact on bias. Putting yourself in the shoes of the other person, creating a non-stereotypical alternative to a particular stereotype, and seeing the person as an individual can reduce bias.

When people are exposed to or are invited to think about traits or behaviors that counter their stereotypes, they became less prejudicial toward that social group. Equality of status, social and institutional support, pleasant contact, and intergroup cooperation often produce positive results (Brusa et al., 2021).

What is Perception Bias?

> Well, I found out that race runs deeply throughout all of medical practice. It shapes physicians' diagnoses, measurements, treatments, prescriptions, even the very definition of diseases. And the more I found out, the more disturbed I became.
>
> Dorothy Roberts
>
> University of Pennsylvania

Perception bias is a type of unconscious or implicit bias that occurs when a perception is skewed based on inaccurate and overly simplistic assumptions about a group a person “belongs” to. This may include biases or stereotypes about age, gender, ethnicity, and appearance. These attitudes, beliefs, or stereotypes can affect a provider’s ability to make sound medical decisions.

Perception biases can create a conflict between what a person believes and what they want to do (FitzGerald and Hurst, 2017). Providers may feel they can overcome biases through sheer will power. They may feel that bias does not occur among professionals and experts, or they may believe that they are impartial and immune to bias. They may perceive bias as only associated with corrupt or malicious people or with “bad apples” rather than systemic issues. Although research has shown this to be incorrect, they often feel that bias is eliminated by technology, instrumentation, automation, or artificial intelligence (Dror, 2020).

What is Diagnostic and Treatment Bias?

> The use of racial terms to describe epidemiologic data perpetuates the belief that race itself puts patients at risk for disease, and this belief is the basis for race-based diagnostic bias. Rather than presenting race as correlated with social factors that shape disease or acknowledging race as an imperfect proxy for ancestry or family history that may predispose one to disease, the educators we observed portrayed race itself as an essential—biologic—causal mechanism.
>
> Amutah, et al., 2021, New England Journal of Medicine

Many biases have been described in the healthcare literature, and many of these have been shown to influence decisions (Featherston et al., 2020). Patient-provider interactions, treatment decisions, patient adherence to recommendations, and patient health outcomes can be influenced by bias. This can lead to an unintentional form of discrimination that affects decision-making structurally and systematically and is hard to identify and uncover (Nápoles et al., 2022).

Studies have shown that implicit racial bias profoundly influences clinical decision-making. Its affects nonverbal behaviors such as eye contact and posture and has been shown to influence the quality of physicians' interpersonal communication with African American patients and, in turn, patients' trust and perceptions of their physicians (van Ryn et al., 2015).

Definitions

- **Bias**: a tendency to prefer one person or thing over another.
- **Diversity**: ways in which we differ.
- **Equality**: when each individual has the same rights, resources, and opportunities.
- **Equity**: all individuals have equal access to healthcare services, regardless of their race, ethnicity, socioeconomic status, gender, sexual orientation, or other characteristics.
- **Explicit (conscious) bias**: conscious, intentional discrimination against certain groups.
- **Implicit (unconscious) bias**: bias that is outside a person's consciousness.
- **National origin discrimination**: Unfavorable treatment due national origin, ethnicity, or accent.
- **Prejudice**: a bias, opinion, idea, or belief about something; an assumption or dislike for a person or group simply based on the person's membership in that group.
- **Racial discrimination**: treating a person adversely due to race or characteristics associated with that race, such as hair texture, facial features, or skin color.
- **Structural racism**: the history and reality of racism that combines to create a system that negatively impacts communities of color.
- **Stereotype**: beliefs and opinions about the characteristics, attributes, and behaviors of members of a group; a generalization, often exaggerated, or untrue.

2. The Impact of Historical and Structural Racism

> If you find race-specific medicine surprising, wait until you learn that many doctors in the United States still use an updated version of a diagnostic tool that was developed by a physician during the slavery era, a diagnostic tool that is tightly linked to justifications for slavery.
>
> Dorothy Roberts
> University of Pennsylvania

Historical racism and structural inequalities have contributed to a longstanding mistrust of the medical system among marginalized communities. Historical power imbalances have had profound consequences on certain racial and ethnic groups: early deaths, unnecessary disabilities, and enduring injustices and inequalities (Global Health 50/50, 2020).

Structural racism promotes public policies, institutional practices, cultural representations, and other norms that perpetuate racial and ethnic inequity. It is rooted in a hierarchy that privileges one race over another, influencing institutions that govern daily life, from housing policies to police profiling to incarceration (Muramatsu and Chin, 2022).

Over centuries, structural racism has become entrenched, influencing the way medicine is taught and practiced as well as the functioning of healthcare organizations (Geneviève et al., 2020). The unequal burden of COVID-19 on underserved populations has forced the medical community to reckon with uncomfortable truths about its role in perpetuating structural racism in modern society. A race-conscious conversation in medicine is evolving that acknowledges race as a social construct that creates and upholds barriers underlying health disparities (Santos, Dee, and Deville, 2021).

Online Resource: Dorothy Roberts: The problem with race-based medicine [14:27]

Source: TEDMED, 2015

https://www.ted.com/talks/dorothy_roberts_the_problem_with_race_based_medicine

Diagnostic tools developed over time can reflect the impact of structural racism. During the COVID pandemic, pulse oximetry was used extensively, and critical treatment decisions were made partly based upon a person's oxygen saturation. For some patients, life-saving therapies were delayed because pulse oximeters **over-estimated** oxygen saturation levels in darker-skinned individuals. There is evidence that, for Black and Hispanic patients, undetected low oxygen levels led to delays in receiving therapies such as remdesivir and dexamethasone, and in many cases, led to no treatment at all (Fawzy et al., 2022).

Although pulse oximetry is a fundamental tool used in diagnosis and management decisions, the device's lack of accuracy in certain populations has not been adequately investigated. This is even though the issue has been recognized for several decades and was highlighted in a 2020 safety communication by the Food and Drug Administration (Fawzy et al., 2022).

Adding to the problems, pulse oximeters have migrated out of the acute care setting and are now available and affordable to the average consumer for home use. The expanded use of a differentially inaccurate device potentially exacerbates racial and ethnic health disparities (Fawzy et al., 2022).

The Impact of Colonial Medicine

Colonial medicine refers to the medical practices and treatments that were used during the period of colonization by European powers in the Americas, Africa, and Asia. It was based on traditional European medical practices and was heavily influenced by the beliefs and practices of the colonizing power.

Colonial medicine focused on 3 areas: (1) protecting European health, (2) maintaining military superiority, and (3) supporting extractive industries.* Colonial medicine emphasized malaria, yellow fever, sleeping sickness, and other specific diseases, focusing on bacteriological approaches to disease control (Global Health 50/50, 2020). This was achieved through vaccination campaigns, quarantine measures, and the construction of hospitals and clinics.

***Extractive industries**: Companies and activities involved in the removal of resources for processing and sale such as oil, sand, rock, gravel, metals, minerals, and other material.

While colonial physicians and scientists made substantial contributions to medicine, they worked almost entirely on health issues that were unique to the colonies. In doing so, they established a focus on infectious diseases exclusive to the colonies (Global Health 50/50, 2020).

In the post-colonial periods, European and American special interest groups have used their leverage to shape a continuing focus on diseases through, for example, public-private partnerships for drug development. Virtually all major pharmaceutical manufacturers either produced or have evolved from firms that supplied medicines to sustain colonialism (Global Health 50/50, 2020).

Medical knowledge and practices brought by European colonizers had an impact on traditional medical practices of Indigenous communities living in the Americas that continues to this day. Indigenous peoples were forced to abandon traditional medical practices and adopt Western treatments, which were sometimes ineffective or even harmful. Colonial policies led to the displacement, forced relocation, and murder of Indigenous populations, the effects of which continue to impact the health and well-being of Indigenous communities today.

Anti-cholera vaccination, Calcutta, 1895. Wellcome Collection. Public domain.

The Impact of Slavery

> The systemic discrimination that has impacted Black health dates back to the first ships carrying enslaved Africans across the Atlantic. The colonial narrative of hierarchy and supremacy exists to this day, and has translated, centuries later, into gaping health disparities.
>
> Meghana Keshavan, *STAT Health*, June 9, 2020

It has been many years since the abolition of slavery, yet its legacy remains. Social injustices related to historical trauma and structural racism continue to negatively impact the health of many low income and minority communities. These mechanisms contribute to high disease burdens, difficulties accessing healthcare, and a lack of trust in the healthcare system (Culhane-Pera et al., 2021).

There has been a long history of unethical treatment of Black research subjects in medical research, exacerbating this lack of trust. Cases of medical malfeasance and malevolence persisted, even after the establishment of the Nuremburg code* (Jones, 2021).

***Nuremburg code**: A set of medical-ethical principles for human experimentation developed after World War II. It established the absolute requirement for voluntary consent for medical experiments involving human beings.

Medical ethicist Harriet A. Washington details some of the most egregious examples of unethical treatment of Black subjects in her book "Medical Apartheid." In the notorious *Tuskegee Study of Untreated Syphilis in the Negro Male*, the government misled Black male patients to believe they were receiving treatment for syphilis when, in fact, they were not. That study went on for a total of 40 years, continuing even after a cure for syphilis was developed in the 1940s (Jones, 2021).

Group of men who were test subjects in the Tuskegee Syphilis Experiments. Wikimedia. Public domain.

Perhaps less widely known are the experiments J. Marion Sims performed on enslaved women in the United States in the 1800s. The experiments earned Sims the nickname the "father of modern gynecology." Sims performed experimental surgery on enslaved women without anesthesia or even the basic standard of care typical for the time. Historian Deirdre Cooper Owens elaborates on this case and many other ways Black women's bodies have been used as guinea pigs in her book "*Medical Bondage*" (Jones, 2021).

Sims experimented on Anarcha, a 17-year-old slave, over 30 times. His decision not to give anesthesia was based on the racist assumption that Black people experience less pain than their White peers—a belief that persists among some medical professionals today (Jones, 2021).

Impact of Colonization and Slavery on Native Americans

> Early travelers to the American West encountered unfree people nearly everywhere they went—on ranches and farmsteads, in mines and private homes, and even on the open market, bartered like any other tradeable good. Unlike on southern plantations, these men, women, and children weren't primarily African American; most were Native American. Tens of thousands of Indigenous people labored in bondage across the western United States in the mid-19th century.
>
> Kevin Waite
> *The Atlantic*, November 25, 2021

The impact of colonization on the health of Indigenous peoples has been atrocious. When European explorers arrived in the Americas in the late 1400s, they introduced diseases for which the native people had little or no immunity. The impact was rapid and deadly for people living along the coast of New England and in the Great Lakes regions. In the early 1600s, smallpox alone (sometimes intentionally introduced) killed as many as 75% the Huron and Iroquois people.

In North America, colonizers did not consider Indigenous people to be "people" at all. They did not consider their laws, governments, medicines, cultures, beliefs, or relationships to be legitimate. The colonizers believed that they had the right and moral obligation to make decisions affecting everybody, without consultation with Indigenous people. These beliefs and prejudices were used to justify the acts and laws that came into being as part of the process of colonization (Wilson, 2018).

Colonization led to loss of cultural practices, language, traditional medicines, and ways of knowing and being. With forced assimilation, health inequities grew while traditional healing practices were forcibly replaced (Coen-Sanchez et al., 2022). Indigenous people have been exposed to racist reproductive policies, limited access to reproductive health services, and environmental contamination (Yellow Horse et al., 2020).

Did You Know. . .

> In 1970, the *Family Planning Services and Population Research Act of 1970*, led to nearly one in four Native American women of childbearing age being sterilized without their consent. This policy remained in effect until 1976 (Yellow Horse et al., 2020).

Extractive industries have had a lasting impact on the health and well-being of Indigenous communities worldwide. Even during normal operations of mining and energy projects, community health is often a concern (Bernauer and Slowey, 2020).

Historically, uranium extraction has significantly affected some Indigenous communities. There is substantial evidence that living near an abandoned uranium mine is associated with reproductive damage. Abandoned uranium mines are not only associated with environmental contamination, but also closely related to structural inequalities such as a higher percentage of households without complete plumbing and access to safe water (Yellow Horse et al., 2020).

The Impact of COVID-19 on Native American Communities

The COVID-19 pandemic exposed many disparities in minority communities. Many members of these communities live in multigenerational households, have greater reliance on public transportation, and have more front-line occupations with higher risk of COVID-19 exposure (Diop et al., 2021).

COVID-19 cases and death rates among Native Americans communities fluctuated through the course of the pandemic. Throughout the U.S., counties with higher population proportions of Native Americans had much higher death rates in May and June of 2021. Death rates tended to be lower after vaccine boosters became available (Bergmann et al., 2022). Structural factors such as lack of access to safe water for frequent hand washing and a shortage of personal protective equipment exacerbated difficulties related to infection control and prevention (Yellow Horse et al., 2020).

American Indian, Alaska Native and Native Hawaiian persons had the highest incident cases and deaths per 100,000 population of any race/ethnicity in the United States. Throughout the country, Native Americans were more likely to be hospitalized and die than White patients. This remained true over every “surge” or sharp increase in cases (Bongiovanni et al., 2022).

San Francisco State University Associate Professor of Biology Wilfred Denetclaw, a Navajo man raised in the traditional Navajo way of life and teachings, shared the story of the Navajo Nation’s resilience during the pandemic. The Navajo government closed reservation borders during the height of the pandemic, instigated weekend curfews, and reached out to the University of California San Francisco and Health, Equity, Action, Leadership for health worker reinforcements.

When vaccines became available, former Navajo president Jonathan Nez advocated strongly for vaccinations using Navajo culture to emphasize the importance of vaccination as a protective shield against COVID-19. The community took the message to heart and now vaccination rates are among the highest across the United States (Rajan, 2022).

Did You Know. . .

At the start of the pandemic, the Navajo Nation had the highest COVID-19 infection rate anywhere in the United States. Intergenerational trauma, social isolation, lack of transportation, crowded multigenerational households, shortages in funding and supplies, widespread poverty, and an overworked healthcare workforce contributed to this disparity.

Now, the Navajo Nation is one of the safest places in America, due to its emphasis on collective responsibility, high vaccination rates, and public health measures. According to Jonathan Nez, [former] Navajo Nation president, "While the rest of the country were saying no to masks, no to staying home, and saying you're taking away my freedoms, here on Navajo, it wasn't about us individually," he said. "It was about protecting our families, our communities and our nation."

Rachel Cohen, How the Navajo Nation Beat Back COVID, *The Nation*, January 14, 2022

Historical Racism and the Asian American, Native Hawaiian, and Pacific Islander Communities

The history of structural racism against Asians in the U.S. is untold. Since the arrival of the first wave of Chinese immigrants in the 1850s, the U.S. has viewed Asians as "perpetual foreigners." Xenophobia led to the *Chinese Exclusion Act of 1882*, the first and only U.S. immigration law that targeted all people of a specific ethnic or national origin (Muramatsu and Chin, 2022).

The trauma associated with the forcible removal and internment of more than 110,000 people of Japanese ancestry in early 1942 has affected subsequent generations. The severe economic effects of forced removal, loss of homes and land, loss of education and career advancement, and years of confinement led to early deaths among those interned and loss of inheritance, homes, and land for their children (Nagata, Kim, Wu, 2019).

For Native Hawaiian and Pacific Inlanders (NHOPI), access to healthcare services is an ongoing issue. Among the nonelderly population, 13% of NHOPI people were uninsured in 2019. Compared to Asian and White Americans, NHOPI people are less likely to have private coverage and more likely to be covered by Medicaid, with half (50%) of NHOPI children being covered by Medicaid or the Children's Health Insurance Program (CHIP) (Pillai, Ndugga, and Artiga, 2022).

Understanding the experiences of Asian Americans, as well as Native Hawaiians and Pacific Islanders is of particular importance, given the levels of racism and discrimination related to the COVID-19 pandemic. There has been a significant uptick in hate incidents against Asian people with many Asian Americans reporting deteriorating mental health due to both the pandemic and violence against Asian people (Pillai, Ndugga, and Artiga, 2022).

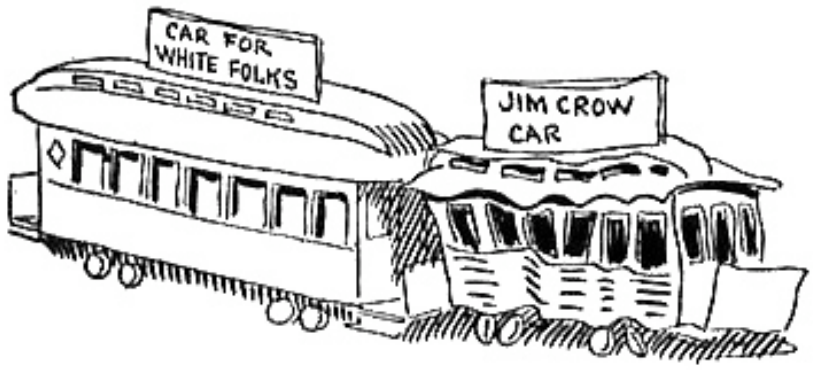
A 2021 Kaiser Family Foundation survey of Asian community health center patients found that 1 in 3 respondents reported experiencing more discrimination since the COVID-19 pandemic began and that many reported a range of negative experiences due to their race or ethnicity, ranging from receiving poor service to being verbally or physically attacked (Pillai, Ndugga, and Artiga, 2022).

The Development of the U.S. Healthcare System

In the mid-1800s, partly due to the impact of the Civil War, the U.S. healthcare system experienced rapid growth and development. With the end of slavery and the onset of the Jim Crow era*, racist policies became embedded in the structuring and financing of the U.S. healthcare system (Yearby, Clark, & Figueroa, 2022). After the Civil War—and continuing for more than a century—non-White people experienced a lack of services, discrimination, and the effects of a healthcare system that provided inferior healthcare to minorities, people of color, and Indigenous people.

***Jim Crow era**: Statutes and ordinances established in 1874 to separate the White and Black races in the American South. Hospitals, and orphanages, and prisons were segregated as were schools and colleges.

In 1896, the landmark Supreme Court decision *Plessy v. Ferguson* ruled that "separate-but-equal" laws that segregated public facilities were legal. The services and facilities for Blacks and other minorities were consistently inferior, underfunded, and inconvenient as compared to those offered to Whites—or did not exist at all. And while segregation was literal law in the South, it was also practiced in the northern U.S. via housing patterns enforced by private covenants, bank lending practices, and job discrimination, including discriminatory labor union practices (Howard University, 2018).



1904 caricature of "White" and "Jim Crow" rail cars by John T. McCutcheon. Public domain.

In the early 20th century, public hospitals--established in the late 18th and early 19th centuries by volunteers and religious organizations—began to grow and change. These changes were largely fueled by the growth of the labor movement and the rising demand for healthcare services among working-class Americans. The 1940s began an era of massive public health construction projects, funded through a combination of taxpayer dollars and charitable donations.

The *National Labor Relations Act of 1935* led to higher wages, benefits, and health insurance for those represented by unions. However, it did not apply to service, domestic, and agricultural workers, and it allowed unions to discriminate against racial and ethnic minorities employed in industries such as manufacturing. These workers were more likely to be relegated to low-wage jobs that failed to provide health insurance (Yearby, Clark, & Figueroa, 2022).

In 1946, the federal government enacted the *Hospital Survey and Construction Act* (Hill-Burton Act), which provided funding for the construction of public hospitals and long-term care facilities. Although Hill-Burton mandated that healthcare facilities be made available to all without consideration of race, it allowed states to construct racially separate and unequal facilities (Yearby, Clark, & Figueroa, 2022).

Federal programs such as the *Medical Assistance for the Aged* program (also known as Kerr-Mills), provided healthcare to the poor, but "were underfunded and few states participated, especially states with large populations of Black Americans" (Yearby, Clark, & Figueroa, 2022). In 1960, Kerr-Mills extended medical benefits to a new category of "medically indigent" adults aged 65 or over. Eligibility and benefit levels were left largely to the States, meaning the poorer the state, the poorer the program. By linking medical assistance for the aged with public assistance, Kerr-Mills inadvertently created a program associated with social stigma and institutional biases. Nevertheless, Kerr-Mills served as an important precursor to Medicaid.

Impact of Medicaid, Medicare, and the Affordable Care Act

With the development of Medicare and Medicaid programs, people who did not have health insurance began to have access to healthcare coverage. This played an important role in addressing limited healthcare access for racial and ethnic minority populations. Medicare funding provided powerful financial leverage for the early and proactive efforts of the *Office for Civil Rights* to secure the racial integration of hospitals, which encouraged hospitals, and providers to begin to address the needs of underserved communities.

Medicare and Medicaid reflect however, the racial paradox of the safety net: It is a product of a structurally racist health system in which racial and ethnic minority groups were disproportionately excluded from employer-sponsored health insurance, yet it is also an important, if limited, tool for filling this gap (Yearby, Clark, & Figueroa, 2022).

Medicaid remains the largest public health insurance provider in the U.S., with more than 80 million enrollees (Commonwealth Fund, 2022). Because Medicaid is highly fragmented and decentralized—with the federal government, states, and even localities making decisions about how to fund, design, and administer it—there are numerous places where inequities can occur including benefits offered, waivers required for work-reporting requirement, provider payments, outreach efforts, and program administration (Commonwealth Fund, 2022).

Medicaid and the *Children's Health Insurance Program* (CHIP) are the primary sources of coverage for many children of color. Medicaid covers about 30% of Black, American Indian/Alaska Native, and Native Hawaiian or Other Pacific Islander nonelderly adults, and more than 20% of Hispanic nonelderly adults, compared to 17% of their White counterparts (Guth and Artiga, 2022).

The *Affordable Care Act* (2014) expanded Medicaid to adults with incomes up to 138% of the federal poverty level. Medicaid expansion has been linked to increased access to care, improvements in some health outcomes, and reductions in racial disparities in health coverage (Guth and Artiga, 2022).

In the states that have not yet adopted Medicaid expansion, more than 2 million people fall into a coverage gap, with incomes too high to qualify for Medicaid but too low to qualify for marketplace subsidies. Nearly 60% of people in the coverage gap are people of color. Uninsured Black adults are more likely than their White counterparts to fall into the gap because most states that have not expanded Medicaid are in the South where a larger share of the Black population resides (Guth and Artiga, 2022).

The *American Rescue Plan Act*, enacted in March 2021, includes a temporary fiscal incentive to encourage states to take up the expansion. The *Build Back Better Act* would temporarily close the Medicaid coverage gap by making low-income people eligible for subsidized coverage under the *Affordable Care Act* in states that have not expanded Medicaid (Guth and Artiga, 2022).

In California, after the state accepted Medicaid expansion, there has been a 58% decrease in the number of uninsured people (Healthinsurance.org, 2023).

3. Additional Forms of Historical Discrimination

Structural racism, slavery, discrimination, and colonial medicine have historically impacted access to healthcare in the United States. But other forms of historical discrimination disproportionally affect many groups, including people with low incomes, immigrants, people with chronic conditions, and people with mental health conditions (Corscadden et al., 2018). Historical discrimination is related to *social determinants of health* such as lack of access to health insurance, redlining and gentrification, rural health disparities, LGBTQ discrimination, gender discrimination and violence, and health inequities in perinatal care.

Online Resource: Social Inequalities in Health (NIH) [3:02]

https://www.youtube.com/watch?v=roAQHn5rEoQ

Social Determinants of Health and Access to Healthcare Services

Social determinants of health are conditions in the environment that affect a person's health, functioning, and quality-of-life. Resources that enhance quality of life, such as safe and affordable housing, access to education, public safety, availability of healthy foods, local health services, and environments free of life-threatening toxins can have a significant influence on population health outcomes (ODPHP, 2022). Social determinants of health affect people throughout the lifespan.

Social determinants of health are often grouped into the 5 domains illustrated above. Source: ODPHP.

Most Americans are unaware of these social determinants, do not understand what causes them, and do not necessarily find them to be unfair. In 2008–2009, a national survey showed that 73% of respondents were aware of health differences between the poor and middle-class people, but less than half reported awareness of health differences between White and Black Americans. Many respondents placed the responsibility for poor outcomes on individual behaviors such as smoking, diet, and exercise, as well as access to clinical care, and less on the social determinants of health. Understanding how social determinants affect health equity has led healthcare organizations and providers to recognize the need to address persistently poor health outcomes that affect certain groups (Towe et al., 2021).

Access to Health Insurance

Access to comprehensive health insurance is a key factor in whether, when, and where people get medical care. Uninsured people are far more likely than those with insurance to postpone or forego healthcare. Being uninsured can have severe financial consequences, with many unable to pay their medical bills, resulting in medical debt (Guth and Artiga, 2022).

Despite most people of color having a full-time worker in the family, they may be employed in low-wage jobs that are less likely to offer health insurance. While private insurance is the largest source of health coverage for people across racial and ethnic groups, people of color are less likely to be privately insured than White people (Guth and Artiga, 2022).

Redlining and Gentrification

Redlining and gentrification are historical social practices that we may not consider as contributing to gaps in health. Redlining is a practice in which lenders deny mortgages to eligible buyers solely because of their race. This practice, once widespread, assured that people of color were denied the right of home ownership and upward economic mobility that millions of White people enjoyed (Julian, Hardeman, and Huerto, 2020).

Redlining has been succeeded by gentrification, whereby wealthier middle-class people move into urban areas and displace people who have lived in a neighborhood for years. Both redlining and gentrification perpetuate poverty in communities of color. As such, many Black and low-income Americans live in communities where clean water isn't guaranteed, and social distancing is nearly impossible in crowded homes. Redlining and gentrification greatly impacted the racial inequities seen during the COVID-19 pandemic (Julian, Hardeman, and Huerto, 2020).

Rural Healthcare Disparities

Rural populations make up approximately 19% of the U.S. population. These areas have heightened mortality rates from several chronic diseases compared to urban populations. A lack of rural hospitals and clinics, lack of access to specialty services, and high turnover rates among healthcare providers create significant health discrepancies for rural communities. Additionally, higher rates of poverty, behavioral risk factors, larger proportions of older adults and people with disabilities, and lower rates of insurance and education create disparities (Nuako et al., 2022).

Medically underserved areas (MUA) are areas where certain populations—usually rural—are subject to a lack of primary care and have high levels of poverty, infant mortality, and large numbers of elderly residents. More than 11,000,000 in California live in an area with a shortage of primary healthcare providers. This means that people in these areas do not have primary care doctors, must drive long distances for healthcare services, and often do not have access to specialty services. California has the largest number of medically underserved *areas* and medically underserved *populations* in the country (Garner, 2022).

Discrimination in LGBTQ+ Healthcare

LGBTQ+ individuals face significant disparities in physical and mental health outcomes. Compared to their heterosexual counterparts, LGBTQ+ patients have higher rates of anal cancer, asthma, cardiovascular disease, obesity, substance abuse, cigarette smoking, and suicide (Morris et al., 2019).

Sexual minority women report fewer lifetime Pap tests, transgender youth have less access to healthcare, and LGBTQ+ individuals are more likely to delay or avoid necessary medical care compared to heterosexual individuals. These disparities are due, in part, to lower healthcare utilization by LGBTQ+ individuals (Morris et al., 2019).

Perceived discrimination from healthcare providers and denial of healthcare altogether are common experiences among LGBTQ+ patients and have been identified as contributing factors to health disparities. Disparities in healthcare access and outcomes experienced by LGBTQ+ patients are compounded by vulnerabilities linked to racial identity and geographic location (Morris et al., 2019).

4. Gender Discrimination

Gender is an important and often overlooked social determinant of health (Alcalde-Rubio et al., 2020). Factors related to gender include health system discrimination and bias, inequitable societal norms and practices, differential exposure to disease, disability, and injuries, and biases in health research.

Historically, women have been victims of bias and discrimination in medical diagnosis, treatment, and care. Compared to men, women are less likely to be diagnosed with a non-psychosomatic illness, have their pain treated, and have their symptoms taken seriously. Women were also excluded from clinical trials until the early 1990s.

Women are less likely than men to be referred for cardiovascular testing, and indigenous women in particular report perceived discrimination by clinicians as a reason for not seeking recommended cancer screening. Indigenous and non-white Hispanic women have been stereotyped as being non-compliant with clinical health recommendations, having risky health behavior, and difficulty understanding or communicating health information (Dirks et al, 2022).

There has been a long history of forced and coerced sterilization of women throughout the world. Throughout the early 20th century, countries passed laws authorizing the coerced or forced sterilization of those they believed should not be permitted to procreate. The practice targeted marginalized populations, including people diagnosed with a mental illness, disabled persons, racial minorities, poor women, and people living with specific illnesses, such as epilepsy. In the U.S., more than half of the 50 states had laws permitting the sterilization of people with specific physical illnesses, Native Americans, and African Americans (Patel, 2017).

Did You Know. . .

> From the 1910s through the 1950s, and in some places into the 1960s and 1970s, tens of thousands—perhaps hundreds of thousands—of American women were detained and forcibly examined for sexually transmitted infections. The program was modeled after similar ones in Europe, under which authorities stalked “suspicious” women, arresting, testing, and imprisoning them.
>
> Inside these institutions, the women were often injected with mercury and forced to ingest arsenic-based drugs, the most common treatments for syphilis in the early part of the century. If they misbehaved, or if they failed to show “proper” ladylike deference, these women could be beaten, doused with cold water, thrown into solitary confinement—or even sterilized.
>
> Scott W. Stern, America's Forgotten Mass Imprisonment of Women Believed to Be Sexually Immoral, 2019

Health Inequities in Perinatal Care

Recognizing the need to humanize birth, the World Health Organization and leading maternity care scholars have incorporated respectful maternity care as a central tenet of high-quality care, regardless of birth setting, technology, or resources available in the country. Person-centered maternity care is defined as “care that is respectful of and responsive to women’s preferences, needs, and values and is a core component of quality maternity care” (Ibrahim et al., 2022).

The term “higher quality maternity care” describes perinatal care that is respectful and facilitates a level of autonomy preferred by the birthing person. In keeping with the self-identification of study participants, we employ the term “women” throughout this manuscript though we recognize that not all people who give birth identify as women and have varying gender identities and preferences for language (Ibrahim et al., 2022).

Black and Indigenous women in the U.S. are significantly more likely to die within a year of giving birth and experience disproportionately higher rates of severe maternal morbidity. Nearly half of these maternal events are preventable through improving quality of care. Inequities in the quality of preconception, prenatal, intrapartum, and postpartum care may contribute to racial disparities in maternal health outcomes. Notably, when mode of delivery is disaggregated by race, Black women in the U.S. have the highest rates of cesarean birth, despite similar predisposing factors (Ibrahim et al., 2022).

Improving maternal health and health equity is a key priority of the U.S. Surgeon General, and the U.S. Department of Health and Human Services. Racism and racial discrimination are linked to poor health, and specifically, negative birth outcomes for women of color and their infants. Mistreatment during pregnancy and childbirth has been associated with both short- and long-term adverse mental health outcomes that include pain and suffering, postpartum depression and post-traumatic stress disorder, fear of birth, negative body image, and feelings of dehumanization (Ibrahim et al., 2022).

Reproductive Justice

At U.N. conferences in 1994 in Cairo and in 1995 in Beijing, participants considered the status of women, population, and development. They adopted the principles of *reproductive justice*, i.e., that it is a fundamental right to be able to control the number and timing of childbearing. This requires access to family planning information, contraceptive services, and abortion. However, developing country surveys show that as many as a quarter of women who want to either delay or stop childbearing altogether lack access to contraception or have concerns about the safety and side effects of available methods (Speidel and Sullivan, 2023).

Reproductive justice calls for the right to have children or not have children, to choose their number and timing, and the right to live in supportive environments that provide reproductive rights, equal opportunities for women, education, fair wages, housing, and healthcare. Advocates warn against repeating the past coercive history of some family planning/population programs––notably mandatory birth limitation and forced abortions in China and involuntary sterilization in India and the U.S. (Speidel and Sullivan, 2023).

The concept of reproductive justice represents a significant shift from traditional notions of reproductive rights, specifically in its inclusion of the impact of contextual and structural factors on reproduction. As described by Ross and colleagues, “The ability of any woman to determine her own reproductive destiny is directly linked to the conditions in her community and these conditions are not just a matter of individual choice and access. For example, a woman cannot make an individual decision about her body if she is part of a community whose human rights as a group are violated, such as through environmental dangers or insufficient quality health care” (Fleming et al, 2019).

The recent Supreme Court ruling overturning Roe v. Wade has already affected pregnancy-related healthcare for many women. It has also impacted OB/GYN training in the states that have restricted or are poised to restrict abortion services. This means hospitals will no longer offer vital training used to manage miscarriages and other pregnancy-related complications.

5. Evaluating the Presence of Implicit Bias in Healthcare

Evaluating the **presence** of implicit bias starts by collecting and analyzing data and examining outcomes for different racial, ethnic, and socioeconomic groups. Information gathered from surveys, interviews, and focus groups can help healthcare leaders identify the presence of bias within their organizations.

Reviewing healthcare policies and procedures helps an organization evaluate the extent of potential barriers to access or discriminatory practices. Comparing data and findings from California to national benchmarks for healthcare access and delivery can help identify significant disparities (KHIP, 2020).

According to a 2023 *California Health Policy Survey*, half of Californians report skipping or delaying healthcare due to cost in the past 12 months. Of those who skipped or delayed care, half of them say their condition got worse as a result. More than a third report having medical debt, and of those, about 20% report owing $5,000 or more. Californians with lower incomes are more likely than those with higher incomes to report medical debt (Bailey et al., 2023).

In terms of equity, more than half of Californians experienced at least one negative interaction with a healthcare provider in the last few years. Black and Latino/x Californians were more likely to report having negative experiences than White and Asian Californians (Bailey et al., 2023).

Measuring Implicit Bias

Measures of implicit bias rely on the assumption that automatic associations between two concepts will influence behavior in a measurable way. Two of the most common implicit measures are (1) the *Implicit Association Test* (IAT) and (2) *sequential priming procedures* (Elek and Miller, 2021). Bias questionnaires are also commonly used to help healthcare providers identify and acknowledge conscious and unconscious biases.

The Implicit Association Test

Implicit bias is often measured with the *Implicit Association Test* (IAT), a publicly available response latency test that pairs images and value-laden words (Gonzalez et al., 2021). Although primarily used in research, the IAT can be useful in other settings as an interactive exercise intended to illustrate implicit bias. A variety of IATs (e.g., on gender, sexuality, race, religion, weight, skin tone, age, disability, and more) are available for free from Harvard's *Project Implicit* (Elek and Miller, 2021).

Project Implicit: Identifying Bias

Project Implicit has developed a series of IATs are designed to measure associations that either reinforce or contradict your conscious beliefs. An IAT may suggest that you have implicit associations based on race, religion, sexual orientation, age, disability, or other criteria. IATs can be useful in identifying potential biases, attitudes, and associations, but these tests alone should not be expected to overcome the impact of biases of the test taker.

How do IATs Work?

The IAT measures the strength of associations between concepts (e.g., African American people, gay people) and evaluations (e.g., good, bad) or stereotypes (e.g., athletic, clumsy). When performing an IAT, you are asked to quickly sort words into categories that are on the left- and right-hand side of the computer screen by pressing different keys.

A person is said to have an implicit preference for thin people, for example, if the person is faster to respond when the word "thin" is connected to "good" words, such as "happy" or "wonderful," rather than "bad" words, such as "painful" or "terrible."

What Should I Know Before Taking the IAT?

Project Implicit recommends that IATs be used as an educational tool to develop awareness of implicit preferences and stereotypes, not as a tool for making judgments, such as whether to hire a person. However, research has shown that individuals who are made aware of their implicit biases may be motivated to avoid letting the biases affect their behaviors.

Source: DOJ, Nd

Sequential Priming Procedures

Sequential priming procedures are intended to demonstrate that when two concepts are associated in a person's memory, one of those concepts facilitates the recall or recognition of the other. For example, when people are presented with one concept (e.g., a picture of an apple), they are faster at identifying the next concept (e.g., a picture of a banana) when they associate the two concepts in memory (e.g., as fruits). Priming procedures work even if the primes are flashed on a screen so quickly that they are not consciously detected by the respondent (Elek and Miller, 2021).

In one common use of this tool, respondents are briefly presented with a Black or White face immediately before a positive or negative target word appears on the screen. They must then identify, as quickly as possible, the meaning of the presented word as "good" or "bad." Respondents with racial bias more quickly identify negative words as "bad" and more slowly identify positive words as "good" when that word appears immediately after the presentation of a Black face (Elek and Miller, 2021).

Bias Questionnaires

Bias questionnaires are self-assessment tools designed to help healthcare providers identify and acknowledge conscious and unconscious biases. Bias questionnaires can cover various types of biases, such as racial and ethnic biases, gender biases, age biases, and others. The questions vary in format, but most commonly include Likert-scale items or open-ended prompts. The results can be used for individual reflection and self-improvement or as part of ongoing diversity and cultural competence training in healthcare organizations. The goal is to promote awareness and reduce the impact of bias on patient care and outcomes.

The following questionnaire, developed by the National Center for Cultural Competence at Georgetown University is an example of a simple tool that can be used to self-assess individual biases (NCCC, Nd).

Do my biases:	1. Impact the amount of time I spend with patients?	Yes No
	2. Influence how I communicate with patients and their families?	Yes No
	3. Hamper my ability to feel and express empathy for my patients?	Yes No
	4. Affect the types of treatment and medications I recommend?	Yes No
	5. Interfere with my capacity to interact positively with my patients and their families?	Yes No
Do you ever perceive that you are less comfortable with patients who are of a different race than you?		Yes No
Do you know whether (or believe) your colleagues and other staff with whom you routinely work think your attitudes and behaviors demonstrate bias? If so, are you open to discussing these issues with them to elicit their point of view?		Yes No
Have patients or their families, directly or through surveys, raised concern about your attitude or the way you communicate with them?		Yes No

Answering yes to any of these questions indicates that you could benefit from interventions to confront and mitigate the impact of bias within your practice setting.

6. Reducing Implicit Bias

One of the most effective ways to reduce implicit bias is to increase awareness of its existence and its impact on outcomes. This can be accomplished through education and training on topics such as unconscious bias, cultural competency, and diversity and inclusion.

Implementing procedures that support objective decision-making--such as standardized protocols and algorithms, may help reduce the influence of implicit bias. However, a study published in 2019 expressed growing concern that algorithms may reproduce racial and gender disparities via the people building them or through the data used to train them (Obermeyer et al., 2019).

Increasing the diversity of the healthcare workforce can reduce implicit bias by exposing providers to a broader range of cultural experiences and perspectives. This can involve initiatives such as targeted recruitment and retention efforts, as well as training programs that promote cultural competency and sensitivity.

Did You Know. . .

> Minority health professionals are underrepresented in the workforce and health professions faculty. Only 6.2% of medical students identify as Hispanic or Latinx, and only 8.4% as Black or African American (Vela et al., 2022).

Data analytics can identify differences in outcomes and can help organizations develop targeted interventions to address disparities. This involves tracking metrics such as patient satisfaction, readmission rates, and health outcomes by race, ethnicity, and other demographic factors.

Engaging with patients and communities can reduce implicit bias by promoting cultural understanding and sensitivity. This involves initiatives such as community outreach and education, patient feedback, and the inclusion of patient advocates and community representatives in healthcare decision-making.

Health Equity

> Health equity means that everyone has a fair and just opportunity to be as healthy as possible.
>
> Robert Wood Johnson Foundation

Health equity is based on the idea that health is influenced by a wide range of social, economic, and environmental factors, such as income, education, housing, and access to healthcare. These factors create unfair and unjust differences in health outcomes between different groups of people.

Health equity initiatives aim to eliminate these differences by addressing the root causes of inequities and by ensuring that everyone has access to the resources and opportunities necessary to achieve good health. Looking at healthcare through a “health equity lens” is an important first step. This approach can reduce implicit bias by encouraging healthcare providers and organizations to be more conscious of the social, economic, and cultural factors that affect the health outcomes of different populations.

Effective communication is critical to good clinical interactions. Poor communication between providers and patients affects care outcomes and care quality. Good communication means both parties can speak without being interrupted, ask questions, express opinions, and understand what the other means (Kwame and Petrucka, 2021).

Miscommunication has been shown to be a consistent communication-related barrier in nurse-patient interaction, which often leads to misunderstandings. Additional communication-related barriers include language differences between patients and providers, poor communication skills, and patients' inability to communicate due to their health state, dementia, or end-of-life care contexts (Kwame and Petrucka, 2021).

Communicating Across Cultures

Knowledge, attitudes, and skills that increase communication between different cultures is a key component of good communication. This requires a self-examination of one's own cultural and professional background. It encourages healthcare providers to manage prejudices and stereotypes that may affect their behavior when interacting with someone from a different culture (Gradellini et al., 2021).

In the U.S., there is a high degree of linguistic diversity, with more than 59 million residents speaking a language other than English at home. Among these, more than 25 million people live in "linguistic isolation"—in which no one in a household over 14 years of age speaks English very well (NCCC, Nd).

Understanding the languages spoken most frequently in your service area is important. Good cross-cultural communication means providers are aware of language differences, avoid assumptions about a person's cultural or linguistic background, and avoid jargon. A single list may not be enough because the most common non-English languages vary greatly from area to area. For instance, Spanish is in the top ten languages in nearly all U.S. counties, while Turkish is in the top ten in 12 U.S. counties, Laotian in 125, Navaho in 74, Serbo-Croatian in 58, and Portuguese in 229 (AHRQ, 2018).

Online Resource: Components of Intercultural Communication [3:06]

https://www.youtube.com/watch?v=NLFjgylSXZA

Employing Culturally and Linguistically Appropriate Services (CLAS)

Prior to 2000, only a few independently developed standards were available for the evaluation of cultural competence and linguistically appropriate services in healthcare. In 2000, the U.S. Office of Minority Health developed the *Culturally and Linguistically Appropriate Service (CLAS) Standards*, which serve as a national standard for healthcare in the United States (CDC, 2014).

Updated in 2013, the CLAS Standards utilize a broad definition of culture, encompassing not only race and ethnicity but also language, spirituality, disability status, sexual orientation, gender identity, and geography. The Standards have 3 sections: (1) Principle Standard, (2) Governance, Leadership, and Workforce, and (3) Communication and Language Assistance, which provide a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services (OMH, 2022).

The entire CLAS Standards can be accessed here.

Using Language Assistance Services

Language assistance services facilitate communication for patients as they move through healthcare organizations. Examples of language assistance services include oral interpretation, translation of written documents, signage, and wayfinding symbols. Individuals with language needs can include those with limited English proficiency and those who are deaf or hard of hearing. Language assistance services should be provided at no cost to the patient (HHS, 2022).

When interpretation and translation services are not provided, there is strong evidence that patients with limited English proficiency are adversely impacted. Poor communication contributes to a patient's lack of understanding of their health condition and recommended treatment. Adverse impacts can include:

- Incomplete and inaccurate health history
- Misdiagnoses of health and mental health conditions
- Misuse of medications
- Repeat visits to physician offices or emergency departments
- Lack of informed consent (NCCC, Nd)

In the example that follows, the failure of an organization to provide language assistance services (or the doctor's failure to use available services) led to a frustrating experience for the doctor, the hospital, and the patient, and his family.

Case: Mr. Louis and His Granddaughter

Mr. Louis just celebrated his 70th birthday with his family and neighbors with lots of great food, music, and dancing. He kept everyone up late, telling stories about his childhood in Haiti. Mr. Louis was grateful to have so many loved ones close by, but he still misses Haiti after moving so many years ago.

Soon after his birthday, Mr. Louis visited his physician for a checkup. After his physician sent him for additional testing, Mr. Louis was diagnosed with prostate cancer. Let's see what happens during Mr. Louis' appointment with the oncologist, Dr. Emily Parker.

The Initial Appointment

Mr. Louis brought his granddaughter, Suzy, to his oncology appointment at the hospital to help him speak with the oncologist. He knows some English, but he was worried that he would not understand everything that the doctor might say. Plus, Mr. Louis was nervous and wanted his granddaughter there for support.

Once the appointment began, though, Dr. Parker and Suzy did all the talking. Mr. Louis did not get a chance to speak, and he did not understand most of what Dr. Parker and Suzy were saying. After a few minutes, Suzy seemed to be arguing with Dr. Parker. This embarrassed Mr. Louis, but he stayed quiet.

After the First Appointment

After the appointment, Suzy explained to her grandfather in French that, to treat his cancer, he would undergo a procedure the next week that would implant radioactive seeds. Suzy told Mr. Louis that the procedure was simple, painless, and without side effects. She did not mention what else the doctor said or what she seemed they seemed to be arguing about during the visit.

Back at home, Mr. Louis began to worry about this procedure. He researched the procedure online and talked with his friends about it. He learned that the procedure did have side effects, including the possibility of incontinence. Remembering how Suzy had argued with the doctor, Mr. Louis wondered whether or not she had told him the truth about her conversation with Dr. Parker.

The Surgical Appointment

The next week, Mr. Louis and Suzy arrived at the admissions office at the hospital. “No surgery,” said Mr. Louis firmly. The admissions clerk looked up in surprise, and Suzy quickly started talking to her in English. She explained that Mr. Louis did not really understand the issue and that he really did want the surgery.

Suzy asked to sign the papers for her grandfather, but the admissions clerk explained that without legal standing, Suzy was not eligible to do so. Mr. Louis continued to quietly say, "No surgery." The admissions clerk had no idea what to do. The surgical staff called to say that they were waiting for Mr. Louis. Suzy glared at her grandfather.

The clerk spent almost half an hour trying to find a hospital staff member who spoke French, but no one was available. The surgery staff called again, saying that if Mr. Louis did not arrive shortly, they would have to reschedule his procedure.

Exasperated, Suzy insisted that Mr. Louis undergo the procedure. She said, “The hospital has people ready to do this. All those people's time will just be wasted. Come on, just sign the paper and we can get you upstairs.” Mr. Louis said again, “No surgery.” Suzy had no choice but to take him home.

Mr. Louis’s Response

“I depended on my granddaughter to help me with my oncology appointment. But she did not tell me the truth about the surgery and my options to treat my illness. I am really angry that I came very close to having a surgery I did not want! It was so frustrating to not be able to communicate directly with my doctor. All I wanted was someone who could listen to me and explain my options.”

Mr. Louis’s Doctor Responds

“These days, I see a lot of patients who don't speak English very well or at all. I'm used to communicating with a family member or friend instead of the patient. In fact, I ask patients to bring someone who can interpret for them. It’s so much easier that way!”

“But when I heard about Mr. Louis' situation from our admissions clerk, I was shocked! I did not recommend the procedure that Suzy scheduled for her grandfather. I actually suggested “watchful waiting” as Mr. Louis’ treatment option. But, during the consultation, his granddaughter insisted that Mr. Louis undergo the procedure. “Now that I think about it, I didn’t speak much with Mr. Louis since Suzy seemed to be in charge. I thought I was doing the right thing by speaking with the family member that Mr. Louis brought with him. Now knowing that Mr. Louis did not want surgery scares me. I wish I had been able to speak directly with Mr. Louis without his granddaughter interfering.”

Conclusion

Offering language assistance services, including a competent medical interpreter, helps patients with limited English proficiency understand and make informed decisions about their medical care. Unfortunately, Mr. Louis almost had a surgery that he did not want, and the surgery could have caused side effects about which he had not been informed. Operating on a patient who did not want surgery or who was not aware of potential adverse effects could have serious liability implications for the doctor and the hospital.

Furthermore, the hospital had a surgery team and room sitting idle because a patient was scheduled for a procedure that he did not want. In this case, the cost of providing a trained interpreter would have been significantly less than the costs that the hospital incurred from this.

Think About It

- How would you feel if this happened to you or a family member?
- Could this happen at your organization?
- Does your workplace offer communication assistance?

Source: HHS, 2022

7. Remedying the Impact of Implicit Bias

To remedy the impact of implicit bias, consider social determinants that can be changed and improved, such as opportunities for quality education, good paying jobs, access to quality clinical care, healthy foods, green spaces, and secure and affordable housing. Education and training on implicit bias should be offered to all members of the community, including law enforcement, educators, and healthcare professionals. This can help healthcare providers understand the impact of bias on marginalized groups.

Diversifying hiring practices and actively seeking out and recruiting candidates from underrepresented groups creates a more inclusive and equitable workplace. Supporting community organizations that promote equality and inclusion and that provide job training, education, and other services to marginalized groups can help remedy the impact of bias.

Policies that encourage individuals to report incidents of bias or discrimination are important. Once an incident has been reported, healthcare organizations must provide support and resources to address and remedy the situation. Holding individuals and organizations accountable for actions that perpetuate bias or discrimination can go a long way toward mitigating the impact of implicit bias.

Diversity, Equity, and Inclusion (DEI) Initiatives

Educating the healthcare workforce is one of the first and most common approaches to fostering cultural competence and reducing bias in the workplace (Guerrier, 2022). The extent to which training is effective in reducing bias depends on the duration and frequency of the training, the level of interaction and engagement of participants, and the design and delivery of the training program.

Diversity, equity, and inclusion (DEI) initiatives are provided in most healthcare organizations in the United States. These programs promote an appreciation and respect for differences and similarities in the workplace, including encouraging respect for the perspectives, approaches, and competencies of coworkers and clients. Inclusion helps people feel valued for their unique qualities while promoting collaboration within a diverse group.

Source: University of Michigan, used with permission.

National Research Programs

The National Institutes of Health is working to reduce bias in healthcare by addressing the lack of diversity that has plagued healthcare research in the past. The program, called *All of Us*, is enrolling a large group of people that reflect the diversity of the United States. This includes people who haven't taken part in--or have been left out of--health research before.

All of Us welcomes participants of all backgrounds and walks of life, from all regions of the country, whether they are healthy or sick. The program is a national effort to accelerate health research by exploring the relationship between lifestyle, environment, and genetics (Mapes et al., 2020). *All of Us* hopes to improve what is called *precision medicine* by building a diverse database that can inform thousands of studies on a variety of health conditions. The goal is to create more opportunities to:

- Base care on the individual.
- Consider a person's environment, lifestyle, family health history and genetic makeup.
- Give providers the information they need to make customized recommendations for people of different backgrounds, ages, and regions.
- Provide information about how to be healthier.
- Reduce healthcare costs by matching the right person with the right treatment the first time.

NIH, 2021, July 16

Another program from the National Institutes of Health is the *UNITE Initiative,* which is working to identify and address structural racism within the scientific community. *UNITE* aims to establish an equitable and civil culture within the biomedical research enterprise and reduce barriers to racial equity in the biomedical research workforce. To reach this goal, UNITE identifies opportunities, makes recommendations, and develops and implements strategies to increase inclusivity and diversity in science. (NIH, 2023, May 23).

Health Literacy Programs

Health literacy programs help people obtain, process, and understand basic health information and services needed to make appropriate health decisions. Research by the *Institute of Medicine* (IOM) indicated that over 90 million people residing in the U.S. have difficulty understanding and acting on health information (NCCC, Nd).

The view of health literacy as solely the responsibility of a patient has expanded to include healthcare professionals and healthcare systems. To improve health literacy, healthcare organizations must remove systemic barriers when communicating health information to patients and the community and understand the broader socio-cultural contexts in which health literacy is experienced (NCCC, Nd).

Implying that an individual or community is responsible for increased risk of adverse outcomes is counterproductive. Some members of disproportionately affected groups may be unable to follow health recommendations due to inequitable resource allocation or a lack of inclusive infrastructure (CDC, 2022, August 2).

Sustaining the Gains

Bias training is most effective when it is designed with context and professional identity in mind. Training in teams helps individuals feel comfortable sharing their biases and accepting their vulnerabilities. Training that enhances collaboration and openness reinforces behavioral change (Sukhera, 2020).

Sustaining the effects of bias education and training requires visible support of organizational leaders. Rather than focusing exclusively on training others, leaders must consider their own approaches to equity and diversity. Leaders who model a more inclusive approach and integrate bias training with other initiatives are more successful than those who rely on training alone (Sukhera, 2020).

Source: CDC.

Case: Katherine and Her Mother in Spain

My mother came to visit me when I studied abroad in Spain. One rainy day while we were sightseeing, she slipped on some marble steps and fell to the ground, hitting her head. She was in pain and seemed disoriented, so I decided we should go to the hospital.

While we were waiting to be seen by the doctor, I was so scared. I had asked the women at the front desk if there was anyone who spoke English, but they said no. Even though I had been studying in Spain for several months, I hadn't learned anything about medical issues and felt uncomfortable speaking in Spanish with the staff. As I waited for her name to be called, I kept looking up medical terms in Spanish on my phone and writing them down in case I needed them. I was afraid my mother had a concussion from hitting her head during the fall. Knowing that any errors I made in Spanish could possibly affect the doctor's decisions really upset me.

During the consultation, I was the mediator between my mother and anyone who came into the examination room. I could tell my mother was frustrated and worried by her inability to communicate with anyone, and I was afraid that I wasn't using the correct terms to describe what happened to her with the medical staff.

The doctor mentioned something about medical tests and medications she would prescribe, and so we're waiting in the intake room again with all the other patients. How can I be sure they correctly understand what happened? I'm not sure what's going to happen next. My mother is so important to me. I just want to be sure she is healthy and that there were no complications.

Think About It

- How would you feel if this happened to you?
- Do you think someone could have a similar experience when seeking care at your organization? If so, who would that person be?
- What would happen if someone with language assistance needs entered your organization today?
- Would their story sound like Katherine and her mother's?

HHS, 2022

8. Concluding Remarks

Implicit bias, lack of cultural competency, structural racism, and intentional historical discriminatory policies have affected equal access to healthcare for many groups of people in the United States. Until recently, many people were not aware of the attitudes and prejudices that have created these barriers and disparities.

The COVID pandemic brought healthcare inequities into sharp focus. Illness and death hit minority communities, nursing homes, rural communities, and Indigenous communities with terrible ferocity. Among frontline workers, women, minorities, and people of color were disproportionately affected.

As the population of the U.S. has become more diverse, the need for culturally competent training has become an imperative. From a practical standpoint, reducing implicit bias and improving cultural competence will have a positive effect on outcomes and costs. Eliminating health disparities will save billions of dollars by reducing healthcare costs, improving productivity, and saving lives.

Research has shown that addressing implicit bias and improving cultural competency is possible. Understanding the effects of colonial medicine, slavery, and Jim Crow provides a basis for examining structural issues that have been slow to change.

Despite this growing interest in reducing implicit bias and improving health equity, many racial and ethnic minority groups continue to experience disproportionate rates of infectious and chronic diseases and their associated risk factors (Jibrel, 2021). These entrenched negative influences on health in some communities have compounded over generations (Towe et al., 2021). Achieving health equity will eliminate gaps in healthcare access, quality of care, and, most importantly, the social and environmental determinants of health (MDHHS, 2019).

[Continue to next page for references]

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[Continue to next page to start quiz]

Quiz: California Implicit Bias (341)

Passing score is 80% or above.

1. Implicit bias is a conscious process based on *intentional* mental associations.
    a. True
    b. False

2. A type of unconscious bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group or person is called perception bias.
    a. True
    b. False

3. Studies have shown that implicit racial bias rarely influences clinical decision-making.
    a. True
    b. False

4. Historically embedded structural racism is a fundamental cause of health inequities in the United States.
    a. True
    b. False

5. Colonial medicine focused on:
    a. Protecting European health.
    b. Maintaining military superiority.
    c. Supporting extractive industries.
    d. All of the above.

6. Social injustices impact the health of many low income and minority communities, contributing to high disease burdens, difficulties accessing healthcare, and a lack of trust in the healthcare system.
    a. True
    b. False

7. For Indigenous people in North America, colonization:
    a. Led to loss of cultural beliefs and traditional healing practices.
    b. Exposed Indigenous people to racist reproductive policies.
    c. Exposed people to widespread environmental contamination.
    d. All of the above.

8. With the end of slavery and the onset of the Jim Crow era*, racist policies became embedded in the structuring and financing of the U.S. healthcare system.
    a. True
    b. False

9. The Affordable Care Act Medicaid expansion is linked to increased access to care, improvements in some health outcomes, and reductions in racial disparities in health coverage.
    a. True
    b. False

10. Social determinants of health are:
    a. Do not significantly affect a person's health or quality-of-life.
    b. Conditions in the environment that affect a person's health, functioning, and quality-of-life.
    c. In the U.S., are not generally responsible for health disparities.
    d. Related to income, but not other factors such as education or health access.

11. Despite most people of color having a full-time worker in the family, they are often employed in low-wage jobs that are less likely to offer health insurance.
    a. True
    b. False

12. Reducing pregnancy-related discrepancies in Black and American Indian/Alaska Native women can be accomplished by:
    a. Identifying and addressing implicit bias and structural racism in healthcare and community settings.
    b. Engaging communities in prevention efforts.
    c. Supporting community-based programs that build social support and resiliency.
    d. All of the above.

13. Reproductive justice is the fundamental right to be able to control the number and timing of childbearing.
    a. True
    b. False

14. According to the California Health Policy Survey Black and Latino Californians are more likely to report having negative experiences than White and Asian Californians.
    a. True
    b. False

15. Implicit association tests measure the strength of associations between concepts and evaluations or stereotypes.
    a. True
    b. False

16. Health equity means that everyone has a fair and just opportunity to be as healthy as possible.
    a. True
    b. False

17. The adverse impact on patients with limited English proficiency when interpretation and translation services are not provided can include:
    a. Incomplete and inaccurate health history.
    b. Misdiagnoses of health and mental health conditions.
    c. Misuse of medications.
    d. All of the above.

18. Diversity, equity, and inclusion means:
    a. Everyone is invited to the party.
    b. Everyone gets to contribute to the playlist.
    c. Everyone has the opportunity to dance.
    d. All of the above.

19. Bias training has been shown to be more effective when it is designed with context and professional identity in mind, and when people work and train together.
    a. True
    b. False

[Continue to next page for answer sheet]

Answer Sheet: California: Implicit Bias, 2.5 contact hours (341)

Name (Please print)_____

Date _____

Passing score is 80%

1. _____	11. _____
2. _____	12. _____
3. _____	13. _____
4. _____	14. _____
5. _____	15. _____
6. _____	16. _____
7. _____	17. _____
8. _____	18. _____
9. _____	19. _____
10. _____	

[Continue to next page for course evaluation]

Course Evaluation: California Implicit Bias

Please use this scale for your course evaluation. Items with asterisks * are required.

1 = Strongly agree 2 = Agree 3 = Neutral 4 = Disagree 5 = Strongly disagree

*Upon completion of the course, I was able to:

1. Define implicit and explicit bias. 1 2 3 4 5

2. Relate 5 ways in which the historical impact of structural racism has contributed to implicit bias in healthcare services. 1 2 3 4 5

3. Describe 3 ways in which other forms of historical discrimination have impacted access to healthcare in the United States. 1 2 3 4 5

4. Define reproductive justice. 1 2 3 4 5

5. Describe 3 tests used to evaluate the presence of implicit bias in healthcare. 1 2 3 4 5

6. Discuss 4 ways to improve communication skills to reduce implicit bias in healthcare. 1 2 3 4 5

7. Relate 3 tests designed to evaluate the presence of implicit bias in healthcare. 1 2 3 4 5

*The author(s) are knowledgeable about the subject matter. 1 2 3 4 5

*The author(s) cited evidence that supported the material presented. 1 2 3 4 5

*Did this course contain discriminatory or prejudicial language? Yes No

*Was this course free of commercial bias and product promotion? Yes No

*As a result of what you have learned, will make any changes in your practice? Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

*Do you intend to return to ATrain for your ongoing CE needs?

_____Yes, within the next 30 days. _____Yes, during my next renewal cycle.

____Maybe, not sure. _____No, I only needed this one course.

*Would you recommend ATrain Education to a friend, co-worker, or colleague?

_____Yes, definitely. _____Possibly. _____No, not at this time.

*What is your overall satisfaction with this learning activity? 1 2 3 4 5

*Navigating the ATrain Education website was:

_____Easy. _____Somewhat easy. _____Not at all easy.

*How long did it take you to complete this course, posttest, and course evaluation?

_____60 minutes (or more) per contact hour _____59 minutes per contact hour

_____40-49 minutes per contact hour _____30-39 minutes per contact hour

_____Less than 30 minutes per contact hour

I heard about ATrain Education from:

_____Government or Department of Health website. _____State board or professional association.

_____Searching the Internet. _____A friend.

_____An advertisement. _____I am a returning customer.

_____My employer. _____Social Media

_____Other _____

Please let us know your age group to help us meet your professional needs

_____18 to 30 _____31 to 45 _____46+

I completed this course on:

_____My own or a friend's computer. _____A computer at work.

_____A library computer. _____A tablet.

_____A cellphone. _____A paper copy of the course.

Please enter your comments or suggestions here:

[Continue to next page for registration and payment]

Registration and Payment, CA Implicit Bias (341)

Please answer all of the following questions (* required).

*Name: _____

*Email: _____

*Address: _____

*City and State: _____

*Zip: _____

*Country: _____

*Phone: _____

*Professional Credentials/Designations:

_____

*License Number and State: _____

Payment Options

You may pay by credit card, check or money order.

Fill out this section only if you are paying by credit card.

2.5 contact hours: $19

Credit card information

*Name: _____

Address (if different from above):

*City and State: _____

*Zip: _____

*Card type: Visa Master Card American Express Discover

*Card number: _____

*CVS#: _____ *Expiration date: _____