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Racial implicit bias is defined as prejudiced notions based on unconscious attitudes and stereotypes founded on race. In addition, implicit bias has the ability to influence one's behavior, affect, thinking, and judgement (FitzGerald & Hurst, 2017; Maina et al., 2018). Racial implicit bias remains as a contributing factor to healthcare disparities as morbidity and mortality rates among minority may increase when minority patients perceive the healthcare experience as discriminatory and or negative (Forsyth et al., 2014; Hagiwara et al., 2013; Haywood et al., 2014). Although, nursing students are preparing to become frontline healthcare providers, there are few racial implicit bias studies that include nursing students. The purpose of this study was to describe the perspectives of nursing students regarding racial implicit bias against minority patients and its impact on patient care. Using a qualitative descriptive methodology, the perspectives of the participants were attained through focus groups. Participants were recruited from two Historically Black College or University (HBCU), a state university, and a community college. Using semi-structured questions, guided by the Levels of Racism framework, five focus groups were held, totaling 25 participants. After thematic analysis of the interview transcripts, two themes were revealed. Theme 1: Some were not certain, but all certainly recognized discrimination, and were angered. Theme 2: Reflection brings emotion and increased awareness of discrimination. Implications for practice, education, research, and theory within the nursing discipline are presented.

PERSPECTIVES OF NURSING STUDENTS REGARDING

RACIAL IMPLICIT BIAS

by

Shirley Etienne

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Approved by

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APPROVAL PAGE

This dissertation, written by Shirley Etienne, has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

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CHAPTER I

INTRODUCTION

Implicit bias is described as discriminatory or prejudiced notions based on attitudes and stereotypes, which exist below the surface of one's consciousness (Greenwald & Krieger, 2006). These stereotypes and attitudes are founded on characteristics such as race, age, or gender (FitzGerald & Hurst, 2017). Therefore, racial implicit bias is defined as prejudiced notions based on unconscious attitudes and stereotypes founded on race. In addition, implicit bias has the ability to influence one's behavior, affect, thinking, and judgement (FitzGerald & Hurst, 2017; Maina, Belton, Ginzberg, Singh, & Johnson, 2018). For example, racial implicit bias within the context of healthcare can be manifested in various ways such as, minority patients waiting long to be seen, healthcare professionals dominating the conversation with the minority patient, or healthcare professionals being less patient centered with minority patients and more patient centered with Caucasian patients during medical encounters (W. J. Hall et al., 2015).

For over a decade, racial implicit bias has been studied, and evidence supports that racial implicit bias does exist among healthcare professionals (FitzGerald & Hurst, 2017; W. J. Hall et al., 2015; Maina et al., 2018). Not only were healthcare professionals found to have some level of racial implicit bias, it was also similar to the levels of the general population (FitzGerald & Hurst, 2017; W. J. Hall et al., 2015). Another point to

address includes, racial implicit bias in healthcare poses a great concern due to its covertness, which may not be easy for one to recognize. Scholars noted individuals might have difficulty with recognition and control of racial implicit bias (FitzGerald & Hurst, 2017; W. J. Hall et al., 2015). This is significant, especially in the context of healthcare. When minority patients receive poor quality of care based on race, this may result in increased negative outcomes for an already vulnerable population, which contributes to healthcare disparities (FitzGerald & Hurst, 2017). In addition, if racial implicit bias is difficult to acknowledge and control, then attention is needed to effectively address racial implicit bias in healthcare.

Statement of the Problem

Racial implicit bias in healthcare is one of the contributing factors to healthcare disparities (Fiscella & Sanders, 2016). Healthcare disparities are health differences that are related to social, economic, and/or environmental disadvantages. Health differences include access to care, quality of care received, and health outcomes. In addition, healthcare disparities adversely effects groups that have systematically endured greater social and, or economical barriers to health based on characteristics that are historically linked to discrimination or exclusion, such as race, ethnicity, socioeconomic status, sexual orientation, gender identity, mental illness, or religion (US Department of Health & Human Services, 2019). Racial implicit bias may adversely influence the healthcare professional's affect, behavior, and or thinking such as communication that is not patient-centered or treatment decisions that are not based on clinical presentation during medical encounters with minority patients (Fiscella & Sanders, 2016; Institute of Medicine,

2003). As a result, minority patients may perceive the healthcare experience as discriminatory and or negative. In addition, minority patients do not trust the healthcare provider. When a patient does not trust the healthcare provider, they may not adhere to treatment regime or discontinue seeking care (Forsyth, Schoenthhaler, Chaplin, Ogedegbe, & Ravenelli, 2014; Hagiwara et al., 2013; Haywood et al., 2014). This type of patient-healthcare provider interaction can directly contribute to disparities in quality of care, morbidity, and mortality rates among minorities. For example, according to the Agency for Healthcare Research and Quality (2017) report, disparities among minority patients were noted in quality of care when compared to Caucasians. For overall quality of healthcare measures, 19% were better, 83% remained the same, and 74% were worse when comparing African Americans with Caucasians. Similar trends were noted with Hispanics. Only 27% of quality of care measures improved, 72% were the same, and 46% were worse (Agency for Healthcare Research & Quality, 2017).

Lack of treatment adherence and not seeking care are manifested by negative health outcomes such as poor control of chronic illnesses (Fiscella & Sanders, 2016). Poor health care outcomes such as increased morbidity and mortality rates among minorities have been noted as health disparities. For example, The U.S. Department of Health and Human Services (2019), reported 103.4% of diabetes related deaths for African Americans, 75.8% for Hispanics, and 64.3% for Caucasians. In addition, disparities were also reported for management of diabetes, as 24.3% of African American, 28.3% Hispanics, and only 11% of Caucasians had a hemoglobin A1c greater than 9%. This demonstrates that poor management of diabetes and deaths are

significantly higher among minorities in comparison to Caucasians. It has also been made clear that health care disparities remain a problem and racial implicit bias is a contributor.

The racial implicit bias research has provided evidence on the existence of racial implicit bias in healthcare, its negative impact on the patient-healthcare provider medical encounter, and how it contributes to healthcare disparities. In addition, findings suggest that certain factors, such as positive experiences with minority patients or negative role modeling from mentors can positively or negatively influence racial implicit bias (van Ryn et al., 2015). However, many of the studies included physicians, residents, and medical students but few on nursing students. As nursing students prepare to enter a profession that is considered a front-line care provider in the health system, it is imperative to include nursing students in racial implicit bias research.

Purpose of the Study

Nurses, frontline healthcare providers, need to provide care to diverse populations. According to the American Hospital Organization (2019), the U.S. is predicted to become a majority-minority country by 2045, due to the daily growth in diversity. Therefore, it is vital to respond to the healthcare needs of growing diverse populations (National League of Nursing [NLN], 2016). Responding to health needs includes effectively managing racial implicit bias as contributor to healthcare disparities among minority patients. It is imperative to examine nursing students before they become registered nurses regarding their clinical learning experiences. Therefore, the purpose of this study was to describe the perspectives of nursing students regarding racial implicit bias against minority patients and its impact on patient care. A qualitative descriptive

design was used to describe the nursing students' perspectives of racial implicit bias against minority patients during their clinical learning experiences. The findings of this study have identified the necessary actions that are needed to prepare the nurse generalist that is equipped to effectively address and manage racial implicit bias and understand its contributions to healthcare disparities during their practice.

When registered nurses are equipped to effectively address racial implicit bias, acknowledge its contribution to healthcare disparities, and provide appropriate care to diverse populations, the patient-healthcare professional interaction may significantly improve. Therefore, the patient will have a positive perception of the experience, trust the nurse, adhere to treatment, and better manage chronic illness. This can begin to reduce disparities in quality of care, morbidity and mortality rates among minority patients.

Theoretical Framework

There is a call to use a framework that allows for inquiry with a critical lens to address the multiple layers of race and its contributions to race related health inequities (Bridges, Keel, & Obasogie, 2017; Ford & Airhihenbuwa, 2010; Freeman et al., 2017; J. M. Hall & Fields, 2012). Therefore, the Levels of Racism framework was used as the framework to guide this study. The framework provided an understanding for racism based on three levels: institutionalized, personally mediated, and internalized (see Appendix A). In addition, the Levels of Racism framework includes understanding the relationships between the levels, creating new hypotheses regarding disparities in race related health outcomes, and designing interventions that are effective in addressing the disparities (Jones, 2000).

Institutional racism is defined as a racial disparity in access to resources, opportunities, and services of society such as healthcare, education, employment, or income. Due to its structural foundation, institutions function based on structural racism being routine practice. In addition, it has been normalized, legalized, and noted as an inherited disadvantage. Therefore, there is failure to act when action is needed (Jones, 2000).

Jones (2000) defines personally mediated racism as prejudice and discrimination. Prejudice is further elaborated as difference in assumptions about one's intentions and abilities based on race. Discrimination is treating one differently based on race. In addition, personally mediated racism can be purposeful or unintentional and include acts of omission or commission (Jones, 2000). This can be manifested in various ways such as poor service, no service or failure to communicate options. Internalized racism is when one belonging to the stigmatized race, accepts the negative messages, regarding their self, as truth. This may be manifested in several ways, such as not valuing self or others of the same race, embracing white culture and rejecting own culture, or accepting limitations (Jones, 2000). Jones (2000) also described the relationship between the levels. For example, acts of personally mediated racism continue due to the structures that are in place through institutionalized racism. The structures remain in place because individuals fail to act, which is reflected in personally mediated racism. Internalized racism results from the societal views from personally mediated racisms and the systems of privilege from institutional racism (Jones, 2000).

Strengths of this framework includes how the concept, personally mediated racism speaks to racial implicit bias, as it specifically mentions that these attitudes or discriminatory acts based on race can also be unintentional (Jones, 2000). It also best captures the interactions between the patient and healthcare professional (Plaisime, Malebranche, Davis, & Taylor, 2017). Additionally, this framework allows for examining the multiple levels associated with discrimination. Therefore, the Levels of Racism framework was used to guide the research question and semi-structured focus group questions of this study, to facilitate answering the question, "What are the perspectives of nursing students regarding racial implicit bias and its impact on patient care in healthcare settings?" The semi-structured focus group questions elicited responses that described their experiences with minority patients receiving care that was different based on race during their clinical experiences (see Appendix B). The framework also allowed a more critical analysis exposing the multiple layers that are associated with discrimination such as racial implicit bias.

Research Question

What are the perspectives of nursing students regarding racial implicit bias and its impact on patient care in healthcare settings?

Definition of Terms

The following definitions were used for this study:

1. Racial implicit bias: thoughts and or feelings that are present unconsciously, in which individuals have difficulty with recognition and control. Racial implicit bias can be manifested is various ways such as, minority patients

waiting long to be seen, providers dominating the conversation with the patient, or being less patient centered (W. J. Hall et al., 2015).

2. African American: "A person having origins in any of the Black racial groups of Africa" (U.S. Census Bureau, n.d.).
3. Nursing student: A student that is currently enrolled in a traditional pre-licensure registered nurse program and has completed at least one semester of a clinical learning experience in a hospital setting.
4. Minority: "A person who is of a race or ethnicity other than White or Caucasian" (U.S. Census Bureau, 2012).

Assumptions

The following assumptions were made for this study:

1. Nursing students can recognize when minority patients experience racial implicit bias.

Delimitations

The following delimitations were carried out to ensure that the research questions were answered:

1. Students from different types of pre-licensure programs will be recruited as participants.
2. Participants must have at least one semester of clinical experience to ensure observing minority patients experiencing racial implicit bias.
3. Participants must be willing to participate in a focus group regarding racial implicit bias towards minority patients.

Significance of the Study

Evidence points out that despite the efforts that have been made, health disparities persist and racial implicit bias contributes to healthcare disparities by negatively affecting the healthcare experiences of minority patients (Agency for Healthcare Quality Research, 2017a; Fischella & Sanders, 2017; Murphy, Xu, Kochanek, Curtin, & Arias, 2017). In addition, the racial implicit bias research identified that medical students should be studied before becoming physicians in order to better prepare physicians to manage racial implicit bias. In addition, factors such as poor role modeling and negative experiences with minority patients can negatively influence racial implicit bias among medical students (van Ryn et al., 2015). Therefore, research to address the patient-healthcare professional encounters in relation to racial implicit bias, should also include nursing students who will soon be frontline providers of care.

The paucity of nursing students in racial implicit bias research supports the significance of this study in which a critical lens was used to study nursing students and their perspectives of racial implicit bias, as they are learning to become registered nurses. The nursing discipline is deeply rooted in the nurse-patient relationship; therefore, it will be beneficial to better understand how nurses can address racial implicit bias and its contribution to healthcare disparities. The findings of this study can begin to shed light on the needed nursing curricular changes, add to the body of knowledge, and inform administrators of education and practice how to effectively address racial implicit bias in healthcare, which then ultimately impacts health disparities. This study also addresses national goals, such as Healthy People, eliminating health disparities (US Department of

Health and Human Services, 2019). In addition, this study serves as a response to the Institute of Medicine and National League for Nursing's call to address healthcare disparities by preparing current and future healthcare professionals to address racial implicit bias, acknowledge its relationship with healthcare disparities, and provide care for the needs of all populations. (Institute of Medicine, 2003; National League for Nursing, 2016).

Summary

An overview of this qualitative study was provided along with the contributions makes to nursing science. An in-depth understanding about the perspectives of nursing students regarding racial implicit bias towards minority patients is lacking. A qualitative descriptive methodology through focus groups and the Levels of Racism framework, was used as a critical lens to examine the perspectives of nursing students provided new knowledge that can be used to explore the actions need to prepare the nurse generalist in addressing racial implicit bias and acknowledging its contribution to health care disparities within the nurse-patient relationship. The following chapter will provide a literature review using a broad to specific approach, from implicit bias to racial implicit bias.

CHAPTER II

REVIEW OF THE LITERATURE

In 2002, The Institute of Medicine (IOM) reported that racial implicit bias among healthcare professionals contributes to healthcare disparities (Institute of Medicine, 2002). Healthy people 2020 defines healthcare disparities as health differences that are related to social, economic, and/or environmental disadvantages (US Department of Health & Human Services, 2019). Health differences include access to care, quality of care received, and health outcomes. Evidence supports that racial implicit bias among healthcare professionals may be difficult to recognize and can negatively affect the minority patient's healthcare experience (FitzGerald & Hurst, 2017; W. J. Hall et al., 2015). Additionally, when a minority patient perceives the experience as discriminatory, this may result in a lack of trust in the healthcare professional, treatment non-adherence, and negative healthcare outcomes such as increase morbidity and mortality rates among minorities (Fiscella & Sanders, 2016; Forsyth et al., 2014; Hagiwara et al., 2013; Haywood et al., 2014). Therefore, it is imperative that all healthcare disciplines, including nursing, respond by effectively addressing racial implicit bias and its role in healthcare disparities. Therefore, the purpose of the literature review is to identify what is known regarding racial implicit bias in healthcare and nursing students. An additional purpose includes identifying any gaps and opportunities in the research literature.

The literature review included several strategies. Using a broad to specific approach, in addition to racial implicit bias, general studies on implicit bias such as gender, income, sexuality, mental health, and weight were reviewed. A Boolean search was performed, using the keywords “implicit bias” and “research” in the PubMed database. The review only included research studies that were within the last five years that pertained to gender, income, sexuality, weight, mental health, and race. Then, each study was thoroughly reviewed, noting the population sample size, method and or measures, and key findings. Next, the databases CINAHL, PubMed, and SCOPUS were used to review studies that specifically examined racial implicit bias in healthcare. Then, a Boolean search was utilized including the following keywords: “African American” or “Black” or “minority” and “health personnel” and “implicit bias” or “unconscious bias” or “attitudes.” The review only included research studies. Then, each article was thoroughly reviewed, noting the population, sample size, method and or measures, and key findings. Using a comparing and contrasting process, an analysis of the studies was performed, and resulted in various themes and conclusions. As the focus of the proposed study is on racial implicit bias, the literature review will first discuss general implicit bias studies, then transition to studies that specifically examined racial implicit bias in healthcare and healthcare education. Lastly, the review will conclude with a discussion on gaps and opportunities that have been identified.

Income and Gender Implicit Bias

In this review, it was noted that implicit bias existed regarding income and gender (M. Harris, Macinko, Jimenez, & Mullachery, 2017; Daughtery et al., 2017). The

M. Harris et al. (2017) study examined whether good was associated with poor or rich countries among 321 healthcare researchers and practitioners. Their findings suggested that fewer participants agreed that poor countries are as likely to produce quality research. Therefore, research that is well designed and robust may not be considered due to implicit bias. In another study, Daughtery et al. (2017) explored if there is an association with implicit gender bias and decisions to cardiovascular tests among 503 cardiologists. The findings included that gender implicit bias did exist, and participants with more gender bias, rated angiography as more useful for men compared to women (). The study results suggest that implicit bias may influence how health treatment decisions are made. Which then may contribute to health disparities, as this may result in negative health outcomes for patients that are not considered for treatment. The results of both studies demonstrate that implicit bias can influence how decisions are made.

Sexuality Implicit Bias

The implicit bias literature also provides evidence of the existence of anti-gay and lesbian bias and that certain factors can influence bias (Burke et al., 2015; M. A. Morrison, Trinder, & Morrison, 2018; Phelan et al., 2017). For example, Burke et al. (2015) assessed the amount of gay and lesbian bias among first year medical students and examined if empathy and prior contact influenced bias. The study findings included, 81% of 2,088 medical students, exhibited negative implicit bias and 45% exhibited negative explicit bias against gay and lesbians. In addition, the findings suggested that a high amount of contact and favorable contact influenced positive explicit and implicit attitudes (Burke et al., 2015). Another study had similar findings. Phelan et al. (2017) examined

whether factors such as school curriculum, role modeling, diversity climate, and contact with sexual minorities influence bias among against gay and lesbian people among graduating students. Their findings also suggested that less implicit and explicit bias was associated with more favorable contact with LGBT faculty, students, residents and patients. In addition, greater implicit bias was associated with more faculty role modeling of discriminatory behavior (Phelan et al., 2017). This study finding suggests that certain interventions such as exposure and institutional culture may influence one's implicit bias in a positive or negative direction. These study findings are promising, as it may be possible to strategically design health education curriculum to prepare students to effectively address implicit bias before becoming practitioners.

Mental Health Implicit Bias

In addition to exposure, studies have examined language as a factor that may influence implicit bias regarding mental health (Ashford, Brown, & Curtis, 2018a, 2018b; Sandhu, Arora, Brasch, & Streiner, 2018; Stull, McGrew, Salyers, & Ashburn-Nardo, 2013). For example, Ashford, Brown, and Curtis (2018a) explored if implicit bias was influenced by certain terminology used when referring to substance abuse among the general public. A scale was used to assess the comfort level of the general public towards individuals with a substance use disorder. Vignettes were used to portray negative terms such as "substance abuser" and positive terms, such as "a person with a substance abuse disorder." The study findings concluded that the participants associated terms such as addict or abuser as negative (Ashford, Brown, & Curtis, 2018a). Sandhu et al. (2018) compared mental health explicit and implicit attitudes among undergraduate students,

medical students and psychiatrists. An additional study aim determined whether implicit bias is associated with education level, exposure to, and personal experience with mental illness. Using the mental illness IAT, the implicit bias of the participants. The study results included mental illness IAT mean scores of 0.27 among undergraduate students, 0.33 among medical students, and 0.06 among psychiatrists. The study findings suggested that exposure to or experience with a mental illness influenced less implicit and explicit bias to mental illness, as the psychiatrists have the lowest mean scores (Sandhu et al., 2018). Another study had similar findings. Stull et al. (2013) explored to what degree does Assertive Community Treatment (ACT) practitioners exhibit explicit and implicit mental illness bias. The physical illness and mental illness IAT were used to measure implicit bias among 154 participants from the disciplines of social work, nursing, education, psychiatry, and psychology.

Findings included implicit and explicit preferences for mental illness compared to physical illness. It also suggested that the amount of exposure that the participants have working with the mentally ill influenced their bias (Stull et al., 2013). These studies also support that exposure may influence one's implicit bias in a positive direction.

Weight Implicit Bias

Similar to mental health implicit bias, studies on weight bias have also suggested that implicit bias does exist, and one's bias can be influenced in either a negative or a positive direction. The existence of negative weight implicit bias is well documented. Implicit and explicit weight bias exists among practitioners, physicians, parents, children, nurses, and medical students (Lund, Brodersen, & Sandoe, 2018; Lydecker, O'Brien, &

Grilo, 2018; Matharu et al., 2018; Phelan et al., 2014; Phelan et al., 2015; Robstad, Siebler, Soderhamn, & Fegran, 2018; Sabin, Marini, & Nosek, 2012; Sabin, Moore, Noonan, Lallemand, & Buchwald, 2015). Phelan et al. (2014) examined the degree of explicit and implicit weight biases compared to biases against other groups and find factors that may predict bias among first year medical students. Using the weight IAT, the study findings included, out of 4732 students, 74% showed implicit weight bias and 67% showed explicit weight bias. The findings suggested that there might not be any pressures to appear unbiased, as there is a high percentage of students of both implicit and explicit bias against weight (Phelan et al., 2014). In another study, Matharu et al. (2018) explored medical students' explicit and implicit bias towards obese people, viewpoint on obesity as a civil rights issue, and medical management of an obese elderly woman pre and post an intervention. Prior to and after the intervention, 193 medical students from three different schools took the obesity IAT. The interventions included a standard lecture discussing bias, advocacy, and personal statements from individuals that experienced bias. The second intervention included narratives of women and their weight in the context of social discrimination. This study was of interest because, the findings included that the implicit and explicit bias did not significantly change after the intervention. The explicit weight bias mean score was 43.7 before the intervention and 44.4 afterwards. The implicit weight bias mean score was 0.52 before the intervention and did not change at all afterwards.

Another example includes the Phelan et al. (2015) longitudinal study that examined factors in medical schools that influence change in implicit and explicit weight

bias among medical students. The findings demonstrated greater explicit bias increase was associated with observing more discrimination or negative comments about obese patients by faculty. In addition, a reduction in implicit bias was associated with more skill providing weight loss counseling to patients. Lastly, a decrease in implicit and explicit bias was associated with more favorable interactions with obese patients (Phelan et al., 2015). The study findings reveal the need to ensure that health education curricula effectively address implicit bias prior to students becoming practitioners, as implicit bias can influence how an individual makes decisions.

Factors such as ethnicity and exposure may influence implicit weight bias. For example, Hart, Sbrocco, and Carter (2016) explored ethnic differences in implicit fat bias among 517 women. The anti-fat IAT and a racial identity attitude tool was used to measure weight bias and ethnic identity. All of the participants showed significant anti-fat biases. However, African American participants with high ethnic identity had a less anti-fat bias, and Caucasian participants with high ethnic identity showed a greater anti-fat bias. The study findings may suggest that weight may be culturally acceptable among African American women. This study is of particular interest, as it examined women that may be representative of patients. Other studies demonstrated the existence of anti-weight implicit bias among healthcare professionals such as registered nurses and physicians (Robstad et al., 2018; Sabin et al., 2012; Sabin et al., 2015). As the other studies examined medical students and healthcare professionals, the Hart et al. (2016) study may shed light on the possibility of cultural differences among patients and healthcare professionals regarding weight. Therefore, the differences in weight bias among

healthcare professionals and African American female patients may result in non-adherence to medical treatment, which then contributes to healthcare disparities (Fiscella & Sanders, 2016).

Racial Implicit Bias

Like weight implicit bias, there is evidence to support the existence of racial implicit bias among individuals, even in children (A. M. Gonzalez, Baron, & Steele, 2017; A. M. Gonzalez, Dunlop, & Baron, 2017; Kaisa-Newheiser, & Olson, 2012; Qian et al., 2016; Setoh et al., 2017; Williams & Steele, 2017). Study findings included racial implicit among children was noted to exist early in development (A. M. Gonzalez, Dunlop, & Baron, 2017; Qian et al., 2016; Williams & Steele, 2017). For example, Qian et al. (2016) studied implicit racial bias among 3- to 5-year-olds and adults in China and Cameroon. Children as young as three years old had implicit biases in favor of their own race. Chinese children showed biased against Blacks and Caucasians and Cameroonian children had biases against Chinese and Caucasians.

Not only does racial implicit bias exists among individuals, including children, but another finding noted in the racial implicit bias research literature included how implicit bias can negatively influence decision-making. This was noted in several areas such as law, finances, and even selecting a doctor (Greene, Hibbard, & Sacks, 2018; Kutuba, Li, Bar-David, Banaji, & Phelps, 2013; M. Morrison, DeVaul-Fetters, & Gawronski, 2016; Stanley, Sokol-Hessner, Banaji, & Phelps, 2011). For example, Stanley et al. (2011) explored the relationship among one’s implicit racial bias and his or her estimations of trustworthiness of others using a game that involved money offers from a

Caucasian or African American face and the Race IAT to measure implicit bias. The findings included that participants had a stronger pro-White implicit bias, viewed white faces as more trustworthy and accepted offers from Caucasian faces versus African American faces. Kutuba et al. (2013) had similar findings from their study. The study examined if race contributes to differential likelihood of rejection of objectively equal unfair monetary offers. The study also used a game to measure how monetary offers were accepted and rejected; and the race IAT to measure bias. Participants accepted more offers from Caucasians than African Americans. In addition, participants that required larger offer amounts in order to accept offers from African Americans had higher implicit racial bias scores against African Americans (Kutuba et al., 2013). Both study findings suggested that racial implicit bias might influence how financial decisions are made (Kutuba et al., 2013; Stanley et al., 2011).

The M. Morrison et al. (2016) study also demonstrated how racial implicit bias can negatively influence decision-making. The study examined whether legal professionals are effective in screening jurors for racial bias during a simulated voir dire, and "stacking the jury" in their favor. Voir dire is a process in which potential jurors are questioned about their background, opinions, knowledge of the case, and ability to serve on a jury. The sample included 10 practicing prosecutors and 10 defense lawyers that assisted with the development of the questions through an online survey, 299 participants that answered those questions, and completed a race IAT as potential jurors and then a sample of 143 legal professionals, randomly assigned as defense or prosecuting lawyer. The attorneys were presented with a case of either an African American defendant and a

Caucasian victim or a Caucasian defendant and African American victim. They were presented with 22 jurors and had to eliminate ten. The participants were then provided with the questions that were asked, and then given the responses that they requested for each of the jurors to assist with making their selections. The results included, when the defendant was African American, and the victim was Caucasian, the defense lawyer kept jurors with lower levels of racial implicit bias. In contrast, the jurors kept by the prosecutor had higher levels of racial implicit bias. The study findings suggested that it is possible that the implicit bias of a juror influences legal outcomes and that legal professionals may rely on these biases to win their cases (Morrison et al., 2016).

Racial implicit bias can also influence one's view and manifest as being for or against a group. This review included studies that resulted in negative or positive associations with racial groups (Bianchi, Hall, & Lee, 2018; Devaraj, Quigley, & Patel, 2018; Gundermir, Homan, de Dreu, & van Vugt, 2014; Lundberg, Neel, Lassetter, & Todd, 2018). For example, Gundermir et al. (2014) wanted to determine if pro-White leadership bias exists and discover strategies that reduce pro-white leadership bias among university students. The authors conducted four small studies using the IAT to measure ethnicity organizational role and single attribute bias. Overall, the results included leadership roles and traits were more strongly associated with Caucasian majority group members compared to ethnic minorities. It also noted that bias can be decreased by dual levels of identification, and therefore resulting in decisions that are not reflective of pro-white bias (Gundermir et al., 2014).

Another example includes Devaraj et al.'s (2018) secondary data analysis from the National Longitudinal Study of Youth that examined the associations among skin tone, height, and gender with income. The study results included that darker skin tone is associated with lower income. Even with education, higher cognitive ability, a gap in income still exists. The findings of this study suggest implicit racial bias and discrimination may exist in the workplace (Devaraj et al., 2018).

Lundberg et al. (2018) also had findings that included negative associations with African American men. The study explored whether implicit stereotypes that link African American young men versus Caucasian men with violence and criminality extend to older African American men versus Caucasian men among 168 undergraduate students. The researchers used a sequential priming task. A black or white face was the prime and a tool or weapon was the target. Participants consistently associated African American faces with dangerous objects. The results suggest that implicit biases link African American men to danger ranging from youth to older adults (Lundberg et al., 2018).

Factors that may influence one's racial implicit bias was also noted. Factors may include a specific intervention, an experience, or some type of previous exposure. Study findings concluded that factors can have a negative or positive impact on racial implicit bias (Amodio & Hamilton, 2012; Amodio, & Swencionis, 2018; Chae et al., 2017; Lee, Lindquist, & Payne, 2017; Pinkston, 2016; Whitford & Emerson, 2018). For example, the Whitford and Emerson (2018) study determined if an intervention could improve racial implicit bias of pre-service teachers by measuring racial implicit bias before and after a specific intervention among 34 Caucasian female undergraduate students in a teacher

preparation program. The intervention included reading 10 experiences of explicit racism faced by African American student peers on the same campus. The results of the study included the group that received the intervention, had a significant decrease in racial implicit bias mean score. Therefore, findings of this study suggest that an empathy intervention can positively influence racial implicit bias (Whitford & Emerson, 2018). In contrast, the findings of the Amodio and Hamilton (2012) study provide evidence of factors that may increase racial implicit bias. The study examined how intergroup anxiety affect the activation of implicit racial evaluations and stereotypes with African Americans compared to Caucasians, among 34 female Caucasian students. The students believed that they were going to be partnered with another student, either "Latisha" or "Meagan" to discuss a questionnaire that was previously filled out about discrimination. The participants that were partnered with "Latisha" reported greater anxiety and had higher racial implicit bias scores compared to those partnered with "Megan" (Amodio & Hamilton, 2012). The results of this study suggest that one's intergroup anxiety may influence implicit bias, and therefore influence one's perception or behavior.

Embodiment was noted as another influencer of racial implicit bias. The use of virtual embodiment in racial implicit bias studies ranged from using the rubber hand illusion to using virtual reality to substitute one's body by a life sized virtual one of another race. The rubber hand illusion involved placing a dark-skinned rubber hand on a Caucasian person, hiding their other hand, and then simultaneously applying stimuli to both hands, which creates the illusion of ownership of the rubber hand. Studies have provided evidence that embodiment can positively influence racial implicit bias

(Banakou, Hanumanthu, & Slater, 2016; Hasler, Spanlang, & Slater, 2017; Maister, Sebanz, Knoblich, & Tsakiris, 2013). For example, a study explored whether there is a reduction of racial implicit bias that lasts after virtual embodiment, and if the effect is influenced by the number of exposures to virtual embodiment among 90 female university students. The participants took the race IAT before and after the virtual embodiment and a body ownership scale after each embodiment experience. The findings of the study suggested that the black embodiment does reduce implicit bias, even one week after exposure (Banakou et al., 2016). These findings may also be suggestive of possible interventions that help with racial implicit bias.

Racial Implicit Bias in Healthcare

Thus far, the implicit bias research literature has provided evidence that racial implicit bias does exist, it can influence one's view, impact how one makes decisions, and factors can positively or negatively influence one's racial implicit bias in many different areas such as law, finances or employment. Similar findings were also noted in studies that examined racial implicit bias in healthcare. Most of the studies focused on racial implicit bias among healthcare providers. Most of the studies used physicians in various specialties as participants. However, a few studies included nurses and genetic counselors. Consistent with the previously noted studies, racial implicit bias exists among healthcare providers (Blair, Havranek, et al., 2013; Blair, Steiner, et al., 2013; Blair et al., 2014; Hirsh, Hollingshead, Ashburn-Nardo, & Kroenke, 2015, Oliver, Wells, Joy-Gaba, Hawkins, & Nosek, 2014; Sabin, Nosek, Greenwald, & Rivara, 2009; Schaa et al., 2015). For example, Tajeu et al. (2018) designed a quantitative study that explored differences

in implicit racial bias among 107 healthcare workers by race and occupations. The participants were categorized as MD/RN nurse or physician or non-MD/RN, which included lab technicians, phlebotomists, medical assistants, and licensed practical nurses. Study results included Caucasian participants had higher mean racial implicit bias scores of moderate to strong preference for Caucasians compared to African Americans and other participants. In addition, physicians and registered nurses had higher levels of implicit bias preference for Caucasians. Another study noted that small to moderate amounts of implicit preference for Caucasians existed among oncologists. Penner et al. (2016) measured racial implicit bias among a sample of 18 oncologists and resulted in scores that were significant and suggested a small to moderate level of racial implicit bias against African Americans. Additionally, T. J. Johnson et al. (2016) wanted to determine if cognitive stressors influenced levels of racial implicit bias among pediatric emergency department residents. This study is of interest, because in addition to determining that racial implicit bias existed, the study findings identified factors that influence levels of bias. A sample of 91 pediatric emergency department residents were given a cognitive stressor tool and took the Race IAT before and after their scheduled work shift. Findings suggested that cognitive stressors such as fatigue or shift busyness were associated with higher levels of racial implicit bias (prowhite/antiblack) and increased from pre-shift to post shift (T. J. Johnson et al., 2016). The study findings do provide support for the existence of racial implicit in bias in healthcare and the urgency that is needed to effectively address it as does contribute to healthcare disparities.

Racial Implicit Bias and Communication

Another significant finding that was noted in this review included the impact of racial implicit bias and communication between healthcare providers and African American patients (Blair, Steiner, et al., 2013; Cooper et al., 2012; Hagiwara et al., 2013; Hagiwara, Slatcher, Eggly, & Penner, 2017; R. L. Johnson, Roter, Powe, & Cooper, 2004; Penner et al., 2016; Penner et al., 2009; Scha et al., 2015).

Some studies explored the association between provider racial implicit bias and communication during the during the patient-healthcare provider medical interaction (Cooper et al., 2012; Hagiwara, Lafata, Mezuk, Vrana, & Fetters, 2019; Hagiwara et al., 2013, 2017; R. L. Johnson et al., 2004; Penner et al., 2016; Scha et al., 2015). Hagiwara et al. (2017) explored how physicians' racial bias is related to their word use during medical interactions with African American patients. The authors have cited other works that provides evidence to support the use of certain words and its association with social dominance and discordant interactions. The frequent use of words that are associated with social dominance include personal pronouns such as we, us, or ours. The use of anxiety-related words may suggest anxiety when interacting with people from different social groups due to concerns of a negative interaction (Hagiwara et al., 2017). The medical encounters were video recorded and the Race IAT was used to measure racial implicit bias. The study findings included participants with higher levels of racial implicit bias were likely to use first-person plural pronouns compared to physicians with low levels of racial implicit bias. In addition, there was a significant positive association with racial implicit bias and anxiety-related words. The study findings suggest that physicians

with implicit racial bias have a higher sense of status, therefore become socially dominant during interactions with African American patients. Additionally, the study findings imply that physicians with higher levels of implicit bias have expectations of negative behavioral consequences or evaluations when they have interacted with an African American patient (Hagiwara et al., 2017).

In another study, Hagiwara et al. (2013) examined the influence of racial attitudes on the dynamics and consequences of racially discordant medical interactions. The medical interactions were recorded (voice recorder) and the talk time (the amount of time each participant spent talking) was coded. Findings included that physicians with negative racial implicit bias talked more compared to physicians with less racial implicit bias (Hagiwara et al., 2013). Additionally, patients that experienced past discrimination talked more during the medical encounter. Lastly, patients that talked more during the medical encounter were less likely to adhere to the physician's treatment recommendations (Hagiwara et al., 2013). These findings were similar in the R. L. Johnson et al. (2004) study that explored associations between patient race/ethnicity and patient-physician communication during medical visits. The medical encounters were audio recorded and coded by independent raters. This study found that physicians talked more and were less patient- centered during visits with African American patients compared with Caucasian patients. In addition, patient rating scores were used to evaluate physician positive affect. The study found that ratings for the providers' positive affect were lower during visits with African American patients compared to Caucasian patients.

Another study examined the relationship between racial implicit bias among genetic counselors (GC) and their communication during simulated genetic counseling sessions (Schaa et al., 2015). The study design included trained, simulated clients to interact in either a prenatal or cancer videotaped session with a GC. The study findings suggested GCs with a stronger preference for Caucasians were significantly less dominant in sessions with Caucasian simulated clients. In addition, GCs with a stronger preference for Caucasians showed lower levels of rapport building and positive affect with African American and Hispanic simulated clients. Lastly, greater implicit preference towards Caucasians were significantly related to ratings that were more positive by Caucasian simulated clients (Schaa et al., 2015). The study findings highlight how racial implicit bias can influence communication. The findings also serve as examples of how differences between the patient-healthcare provider communication may lead to patient non-adherence, which is a potential contributor to healthcare disparities (Fiscella & Sanders, 2016). In a final analysis, the study findings regarding communication and racial implicit bias shed light on specific communication behaviors from healthcare professionals that negatively impacts the healthcare experience of the minority patient. Although these findings are promising in understanding the impact of racial implicit bias in healthcare, the studies do not include nursing students. Communication with diverse patients is an essential part of nursing education; therefore, an opportunity to include nursing students in racial implicit bias research is noted.

Racial Implicit Bias and Patient Perception

Racial implicit bias among healthcare providers not only negatively influences communication during the patient and healthcare provider encounters; it also negatively influences the patient's view of the provider. Studies also provided data such as patient ratings of the clinician, patient satisfaction, and trust of the physician (Cooper et al., 2012; Hagiwara et al., 2013; Penner et al., 2016; Schaa et al., 2015). Overall, higher racial implicit bias scores influenced the patients' perception of the medical encounter. However, in contrast, two studies only used the patient's perception to explore influence or relationship between health care provider racial implicit bias and the reaction or perception of African American patients (Blair, Steiner, et al., 2013). For example, the Blair, Steiner, et al. (2013) study's aim was to explore if a client's perception of care is related to the provider's implicit bias in an established provider-client relationship. The researchers surveyed 2,908 patients of providers that have been previously assessed for implicit bias, with the Patient Care Assessment Survey (PCAS). The findings included a negative association between African American patients' evaluation of provider with preference for Caucasians over African Americans. Therefore, the higher the provider's preference for Caucasians over African Americans, the lower the African American patients rated the provider.

In another study, Penner et al. (2009) explored the role that physician explicit and implicit bias plays in influencing reactions of patients and physicians in racially discordant medical interactions. The African American patients completed tools to measure feelings of being on the same team, physician warmth and friendliness scale, and

patient satisfaction. Overall, results included patient responses that were more negative with providers that had higher levels of racial implicit bias. Although the evidence provided by the studies discussed above lend support for association between the minority patient's negative perception of the healthcare provider and healthcare disparities, the studies do not include nursing students.

Racial Implicit Bias, Treatment Decisions, and Clinical Assessments

This review also included studies that examined whether racial implicit bias among healthcare providers influenced patient treatment decisions (Blair et al., 2014; Green et al., 2007; Haider et al., 2014; Haider, Schneider, Sriram, Dossick, et al., 2015; Hirsh et al., 2015; Oliver et al., 2014; Puumala et al., 2016; Rojas, Walker-Descartes, & Laraque-Arena, 2017; Sabin & Greenwald, 2012; Sabin, Rivara, & Greenwald, 2008). There were some studies that suggested treatment decisions made by health care providers were associated with racial implicit bias (Haider, Schneider, Sriram, Dossick, et al., 2015; Green et al., 2007; Sabin & Greenwald, 2012; Sabin et al., 2008). For example, Haider, Schneider, Sriram, Dossick, et al. (2015) explored if there is a correlation with race and social class bias with patient management decisions among 215 surgical clinicians, surgeons, residents, fellows, and interns. The study design included clinical vignettes and Race IAT to measure the surgeons' level of racial implicit bias and clinical decisions. The study found that treatment decisions did not correlate with IAT scores, however, the treatment decisions that were made reflected the influence of race and social class with the treatment decisions. For example, the clinical vignette of a young African American mother with right, lower quadrant pain favored the diagnosis of

pelvic inflammatory disease versus appendicitis when compared to the Caucasian patient in same clinical vignette. The study findings suggest that the participants may have statistical discrimination in assessment of the patients. Statistical discrimination takes place when the healthcare provider is uncertain about a clinical diagnosis and behaves differently based on the patient's race or ethnicity, specifically when an illness is associated with a certain ethnic group or race (Haider, Schneider, Sriram, Dossick, et al., 2015).

In another study, Green et al. (2007) examined whether physicians show implicit racial bias and determined whether the level of bias predicts thrombolysis recommendations for African American and Caucasian patients with acute coronary syndromes. Clinical vignettes were used in the study, in order to assess thrombolytic treatment decision among 220 medical residents. Green et al. found that the residents showed implicit bias favoring Caucasians and found African Americans to be less cooperative in general, especially regarding health treatment adherence. In addition, with an increase of favoring Caucasians, there was a likelihood to implement thrombolytic treatment, but not with African Americans. The aim of the Sabin et al. (2008) study was to determine if implicit racial bias existed among pediatricians, if there were differences in explicit bias and implicit bias, and if implicit bias is related to quality of care. Clinical vignettes were also used to determine treatment recommendations among pediatricians. The four clinical vignettes included urinary tract infection (UTI), attention deficit disorder (ADHD), asthma, and pain. Sabin et al. (2008) found that pediatricians had small implicit preference for Caucasians in comparison to African Americans. The study

found a treatment difference regarding UTI. African American patients were recommended treatment at home and Caucasians were recommended hospitalization for days of antibiotic treatment.

Sabin and Greenwald (2012) explored associations between the implicit racial attitudes of pediatricians and treatment recommendations by patients' race. The UTI, ADHD, asthma and pain clinical vignettes were also used to determine treatment recommendations among pediatricians. The study findings included that pediatricians had weak racial implicit bias, moderate racial medical compliance, and racial quality of care implicit bias. Also, treatment recommendations did not show any significant difference by race except for UTI. The Caucasian patient was more likely to remain hospitalized (Sabin & Greenwald, 2012). These findings were comparable to Sabin et al. (2008).

In contrast, other study findings suggested that health care provider racial implicit bias did not affect the treatment decisions (Blair et al., 2014; Haider et al., 2014; Hirsh et al., 2015; Oliver et al., 2014; Puumala et al., 2016). For example, the Blair et al. (2014) study aim was to determine if clinicians' implicit bias has a relationship with hypertension treatment among African American and Latino patients. The findings showed that 42% of the physicians showed strong to moderate bias against African Americans, 51% showed strong to moderate bias against Latinos. However, variations in treatment intensification, medication adherence, and hypertension control were not significantly different from Caucasians and were not associated with clinician implicit bias (Blair et al., 2014). Puumala et al., 2016 examined implicit and explicit racial bias against Native American children among emergency department (ED) care providers and

its relationship with clinical care. The study design included the Race IAT and clinical vignettes to measure racial bias and clinical care decisions. The sample included 154 physicians and registered nurses. The study found most care providers had high levels of implicit and explicit pro-white bias in comparison to other studies. In addition, there were no associations found with racial implicit or explicit bias and clinical treatment (Puumala et al., 2016).

In addition to treatment decisions, two studies were designed to determine if there is an association or influence between racial implicit bias and clinical assessments among health care providers (Haider, Schneider, Sriram, Scot et al., 2015; Penner et al., 2016). For example, a study used a sample of 215 registered nurses to determine if implicit preferences are associated with clinical management of acute care surgical patients (Haider, Schneider, Sriram, Scot et al., 2015). Clinical vignettes were also used to determine treatment recommendations. The study findings suggested that mean IAT scores showed a preference towards Caucasians and upper class. However, there were no significant differences in treatment based on biases (Haider, Schneider, Sriram, Scot, et al., 2015). The other study had similar findings. Rojas, Walker-Descartes, and Laraque-Arena (2017) used clinical vignettes to determine whether racial implicit bias influences the suspicion of child abuse among pediatricians. There were no differences found in suspicion for abusive injuries based on race.

Moskowitz, Stone, and Childs (2012) designed a study to examine whether stereotypes unconsciously influence the thinking and behavior of physicians. An online survey was used to determine what diseases are implicitly associated with African

Americans. Then, a sample of 11 physicians viewed photographs of African American men at a fast speed. Word stimuli, including diseases from the survey, were incorporated while viewing the photographs. Reaction time was used to determine if implicit associations between specific diseases and African Americans existed. The findings resulted in implicit stereotyping of African American patients did exist among physician. Physicians linked certain conditions and social behaviors with no biological associations, such as obesity or drug abuse (Moskowitz et al., 2012) with African Americans. The study findings suggest that racial implicit bias among physicians may bias diagnosis or treatments decisions for African American patients. Therefore, a physician may not accurately diagnose or treat African American patients based on unconscious racial stereotyping. When healthcare treatment is ineffective, then patients may experience poor health outcomes, such as n poor disease control, which then contributes to healthcare disparities (Fiscella & Sanders, 2016).

Next, Hausmann et al. (2015) examined the racial implicit bias of spinal cord injury physicians and its association with functioning and wellbeing for individuals with spinal cord injury (SCI). Data were collected from patients with SCIs and their physicians at four different sites, which included provider racial implicit bias and functioning and wellbeing of the patients. The study design included a sample size of 14 physicians and 62 patients. The study found that physicians with racial implicit bias were associated with worse patient reported social integration, depression and life satisfaction (Hausmann et al., 2015).

Lastly, using a secondary data analysis design, Hymel et al. (2018) explored whether racial and ethnic disparities exist in evaluation and reporting of abusive head trauma among pediatric patients. Over three years, the authors reviewed 500 acute head injury-patient records. The study found more evaluations and reports for suspected child abuse among minority patients compared to Caucasians (86% versus 72%). This finding is significant because the patients were low risk for abuse. The study findings suggest that disparities exist in reporting child abuse (Hymel et al., 2018). Another study to consider includes Wakefield et al. (2018) who used qualitative methods to describe the racial bias experiences of youth with sickle cell disease. Using content analysis, the authors identified participants reported experiencing medical implicit racial bias as one of the major categories. Pain disregarded by health care provider and longer wait times at the emergency department were examples of medical implicit racial bias (Wakefield et al., 2018).

Although, some evidence does suggest that racial implicit bias does not impact the treatment decisions made by healthcare providers, more studies support the contrary. The studies discussed above suggest that racial implicit bias can negatively impact assessment and treatment decisions made by healthcare professionals. Additionally, the findings of the studies do support the disparities that exist in health outcomes among minority patients. Lastly, the study findings present an opportunity for nursing curricular to address essential areas such as, clinical assessment, decision-making, and healthcare disparities when caring for diverse patients.

Racial Implicit Bias and Healthcare Education

This review, included studies that specifically related to healthcare education. Two studies included faculty in medical schools (C. M. Gonzalez, Garba, et al., 2018; T. J. Johnson et al., 2017). For example, the T. J. Johnson et al. (2017) study identified levels of unconscious racial bias and perceived barriers to minority recruitment and retention among pediatric faculty leaders. Study results included; faculty had slight pro-white anti-black implicit bias. In addition, the findings of the study identified the following as perceived barriers: lack of minority mentors, poor recruitment efforts, and lack of qualified candidates. In the second study, C. M. Gonzalez, Garba, et al. (2018) explored faculty experiences related to facilitating discussion on racial and ethnic implicit bias recognition and management using qualitative interviews. Overall, there were three main findings. First, factors that influence the faculty's ability to teach about implicit bias included their background, past experiences, or identity. Next, the culture and values of the institution influences the instruction and how the students receive the curriculum. Lastly, faculty development programs are needed (C. M. Gonzalez, Garba, et al., 2018). The study findings begin to focus attention on racial implicit bias within an institution level versus among individuals. The findings of the two studies are significant, as they demonstrate how racial implicit bias can influence the views and decisions made within an institution which may result in curriculums that do effectively address racial implicit bias, faculty that do not address racial implicit bias, and lack of buy in from medical students.

Next, this review included studies related to healthcare education and racial implicit bias focused on medical students. The studies provide evidence that racial implicit bias also exists among medical students (Cormack et al., 2018; C. M. Gonzalez, Kim, & Marantz, 2014; Haider et al., 2011; R. Harris et al., 2018; Hernandez, Haidet, Gill, & Teal, 2013; Nazione & Silk, 2013; van Ryn et al., 2015). For example, two studies examined racial implicit bias among medical students in New Zealand. Both studies found that the medical students had implicit racial bias preference for New Zealand Europeans compared to Maori, the indigenous Polynesian people of New Zealand (Cormack et al., 2018; R. Harris et al., 2018).

Factors that influence racial implicit bias and how racial implicit bias can influence how decisions are made were also noted in the studies with medical students. van Ryn et al. (2015) studied the association between medical school experiences and changes in racial implicit bias within the first and fourth years among non-Black students. Experiences within the medical school training had significant associations with changes in implicit racial bias. Positive experiences such as favorable contact with African American faculty were associated with a decrease in racial implicit bias. Negative experiences such as unfavorable contact with African American faculty and exposure to negative role modeling were associated with an increase in racial implicit bias (van Ryn et al., 2015). In another study, C. M. Gonzalez et al. (2014) described an educational intervention and explored the attitudes of medical students regarding implicit bias and health disparities. The results of the study included 22% of the students disagreed or strongly disagreed that implicit bias might affect some of their clinical decisions or

behaviors. In addition, they also showed a preference towards people like themselves, and were more likely to believe that the IAT was not valid (C. M. Gonzalez et al., 2014).

Study findings also provided evidence that support racial implicit bias can influence one's view or perceptions. Nazione and Silk (2013) examined medical students' bias and helping intentions based on patient race and perceived patient responsibility, when patients are non-compliant with diet recommendations. The study found race to influence medical student bias. In addition, the medical students perceived the African American patient to have less favorable characteristics, compared to the Caucasian patient. Cormack et al. (2018) had similar findings in their study. In addition to their medical students showing a preference for New Zealand Europeans over Maori people, they also viewed the Maori patients' information as less reliable.

The remaining studies included one using occupational therapy students as participants and two that included nursing students. Steed (2014) evaluated the effect of an intervention with a measure of implicit bias using the Racial Argument Scale (RAS) among 22 Caucasian occupational therapy students enrolled in a class. The RAS is based on the concept of bias assimilation. The instructional intervention was implemented from week three through nine and included class discussions and videos. Findings included 25% of the students' RAS increased, showing increased bias towards African Americans. In addition, 25 % of the students' RAS decreased, showing a decrease in bias towards African Americans (Steed, 2014). This study also demonstrated factors, such as an educational intervention can positively influence one's racial implicit bias.

Next, Dunagan, Kimble, Gunby, and Andrews (2016) designed a qualitative study using a web survey describe the attitudes of prejudice reported by baccalaureate nursing students. The two main themes included prejudice against obese people and prejudice against someone of another race. Fear was associated with black and Hispanic men and participants described a lesser quality of care provided to obese people. The findings of this study shed light on the need to prepare nursing students to effectively address racial implicit bias and its connection to healthcare disparities before becoming registered nurses.

Next, Schultz and Baker (2017) used anonymous audience polling among 75 nursing graduate students to describe teaching strategies to increase acceptance and management of unconscious bias. The participants were directed to take an IAT of their choice that may influence practice or patient care. The anonymous audience response polling followed the IAT. Afterwards, activities, such as guided debriefing regarding the IAT, definition of unconscious bias, bias management strategies, and a perspective-taking exercise were implemented. The polling revealed 95% had positive results for an implicit bias, 51% did not feel concerned about the test result, and 74% had doubts regarding the validity of the test. Post class surveys revealed participants were likely to learn more about implicit bias, accept the impact on health disparities, and agreed on the importance of management strategies to address personal bias (Schultz & Baker, 2017). The results also suggest that an educational intervention may positively influence one's racial implicit bias. The high percentage of participants with implicit bias is consistent with other studies. However, the percentage of participants that doubted the validity of the

IAT is concerning. This supports the need for effective strategies to address and manage racial implicit bias among nursing students while they are learning to care for patients.

The racial implicit bias literature has consistently provided strong evidence to support that racial implicit bias exists among individuals and within institutions. Next, racial implicit bias can influence one's perception or how decisions are made on an individual or institutional level. This was noted during the patient-health care provider encounters. In addition, patients may perceive the patient healthcare provider encounter as negative, which may result in distrust and non-adherence. Lastly, there is also evidence that suggests factors can positively or negatively influence one's racial implicit bias. Similar findings were noted in studies with medical students. Another point of interest includes, many of the studies regarding racial implicit bias and healthcare, focused on physicians and medical students. There were only two studies that included nursing students, therefore not much is known about racial implicit bias in healthcare and nursing students.

Gaps and Opportunities

Research is needed to understand racial implicit bias and nursing students with the goal of developing strategies that effectively address and manage racial implicit bias. Effectively addressing racial implicit bias among nursing students will then produce nurses that will be prepared to join the nursing profession and provide equitable care, which can lead to better patient outcomes, and assist in eradicating health disparities.

Medical students have been studied in the racial implicit bias research for two main reasons. First, there is strong evidence that racial implicit bias among healthcare

providers negatively impacts the patient-healthcare provider encounter and negatively influenced the patient's perception of the medical encounter. As a result, the patient may not trust or adhere to treatment recommendations if the patient senses any behaviors of implicit bias from the provider, which then contributes to healthcare disparities. Therefore, research was directed towards medical students before they become healthcare providers. For example, C. M. Gonzalez et al. (2014) believed it was important to study medical students during their clinical education, early in their development. In addition, the authors also noted that medical students' views of ethical principles can negatively change during their clinical education experience (C. M. Gonzalez et al., 2014). For that same reason, nursing students need to be studied early in their development, during their clinical learning experiences. In addition to physicians, registered nurses also have racial implicit bias, which can negatively influence the nurse-patient relationship and negatively influence the view of the patient, resulting in distrust and non-adherence to health treatment (Haider, Schneider, Sriram, Scott, et al., 2015; Puumala et al., 2016; Tajeu et al., 2018). Therefore, it would be advantageous to study students before joining the nursing profession.

The second reason that medical students were included in racial implicit bias research includes the Institute of Medicine (2002) recommendation of education for current and future healthcare providers to address racial implicit bias and its role in healthcare disparities as a strategy to eradicate disparities. This led to the inclusion of medical students in racial implicit bias research. Several studies used medical students to examine the informal or "hidden" curriculum (R. Harris et al., 2018; Hernandez et al.,

2013; van Ryn et al., 2015). The informal curriculum includes experiences that were learned outside of the formal curriculum. The informal curriculum is conveyed through role modeling of faculty, and institutional culture (van Ryn et al., 2015). For example, van Ryn et al. (2015) explored if the socialization into medicine encourages or hinders any type of bias expressed by physicians. Therefore, the informal or "hidden" curriculum was explored to determine if it influences the medical students' racial implicit bias scores. The study results did demonstrate a significant association with negative role modeling by faculty and medical student race IAT scores that increased from the first year to the fourth year. This suggests that the medial students' socialization in medicine through the hidden curriculum may encourage racial implicit bias. Currently, few studies include nursing students regarding racial implicit bias. Therefore, there is a need to understand the experience of nursing students and racial implicit bias in healthcare as it may allow for insights to the "hidden" nursing curriculum.

Regarding racial implicit bias in healthcare, there is a need to study nursing students before they become registered nurses, which includes examining their clinical experiences and the informal nursing curriculum. In addition to the lack of nursing students in the racial implicit bias research literature, the inclusion of nursing students in research is also supported by the National League for Nursing (NLN). The NLN has also called for a response to address healthcare disparities. The NLN acknowledged that racial unconscious bias contributes to healthcare disparities. They also acknowledged that "micro-inequities", unconscious or unintentional messages that can set apart, disregard, or slight an individual based on characteristics such as gender, age or race, can become

patterns among nurses, faculty, and students. In addition, micro-inequities are barriers to diversity in nursing and nursing education, as it interferes with teaching students how to care for diverse populations (NLN, 2016). Therefore, the NLN has called for the creation of academic environments that allow students to be prepared to care for the health needs of all populations. This includes the willingness to effectively confront intentional and unintentional bias that promote micro-inequities. In addition to a call for action, several recommendations were made. Among those recommendations included research in nursing education regarding implicit bias and curricular that address care for diverse populations with attention to healthcare disparities (NLN, 2016).

Nursing Students

To date, there is a lack of studies that include nursing students in racial implicit bias research. Currently, there are studies that include nursing students to primarily make improvements to nursing programs or to ensure students are prepared to practice as registered nurses. For example, in order to improve gender diversity in nursing, there was a need to first examine the experience of a male nursing student (Gao, Cheng, Madani, & Zhang, 2019; Powers, Herron, Sheeler, & Sain, 2019). Through a qualitative descriptive approach, Gao, Cheng, & Zhang (2019) examined the male students' perception of their experience in a nursing program. The findings provided insight for needed cultural changes in nursing programs regarding recruitment and retention of male students, therefore addressing gender diversity in nursing.

McNally, Azzopardi, Hatcher, O'Reilly, and Keedle (2019) is another example of a research study with the inclusion of nursing students to make improvements to a

nursing program. An undergraduate baccalaureate program wanted to identify areas in the program to improve, such as student satisfaction and student engagement. Through qualitative focus groups, the experiences and perceptions of the students were explored. The study resulted in key findings and implemented changes in the curriculum, such as a need to support students with web-based technology.

Nursing students have also been included in research in order to ensure that they are adequately prepared to practice as a registered nurse. Studies were noted in areas such as incivility, spiritual care, and interprofessional collaborative practice (Ahn & Choi, 2019; Brown, Humphreys, Whorely, & Bridge, 2019; Walker, Cross, & Barnett, 2019). For example, in order to ensure nursing students are prepared for interprofessional collaborative practice, Walker et al. (2019) explored the clinical experiences of nursing students in order to gain a deeper understanding of their interprofessional education experience. Using focus groups, the study findings allowed for the needed changes in learning experiences for the enhancement of interprofessional education. Ahn and Choi (2019) also used qualitative methods to explore and describe the incivility that nursing students experienced during their clinical learning experiences. This type of inquiry provided a deeper understanding of how the students experienced incivility or how they respond to incivility. It also added to the body of knowledge that will enable the nursing discipline to effectively address this problem using strategies to empower students on how to respond to incivility during practice or the cultivation of positive learning practice environments (Ahn & Choi, 2019).

Therefore, for the same reasons as noted above, the inclusion of nursing students in the racial implicit bias research is needed so that the necessary changes can be made to nursing curricular and students are better equipped to effectively address racial implicit bias when practicing as registered nurses. Ultimately, this may help address racial implicit bias among healthcare professionals and its contribution to healthcare disparities.

CHAPTER III

METHODS

In the research literature, racial implicit bias is noted as a contributor to healthcare disparities. During the healthcare professional-patient interaction, racial implicit bias may manifest in several ways such as a lack of patient-centered care, waiting longer to be seen, or healthcare professionals dominating the conversation (W. J. Hall et al., 2015). When a minority patient experiences racial implicit bias during a medical encounter, they may perceive the encounter as discriminatory or negative. The negative patient experience may lead to a sequence of events. First, the negative patient experience influences mistrust of the provider or the institution. Next, the mistrust may lead to the patient not adhering to treatment recommendation, which then leads to negative health outcomes and contributes to healthcare disparities (Fischella & Sanders, 2016; The Institute of Medicine, 2002). In addition to the existence of racial implicit bias among healthcare professionals, and its contribution to race related health care disparities, evidence also supports that healthcare disparities continue to exist (Agency for Healthcare Quality Research, 2017a).

There has been numerous racial implicit bias, quantitative studies in healthcare and healthcare education over the past decade. Most participants in research studies have been physicians, residents, and medical students (Blair, Havranek, et al., 2013; Blair, Steiner, et al., 2013; Blair et al., 2014; Cooper et al., 2012; Cormack et al., 2018; C. M.

Gonzalez, Garba, et al., 2018; C. M. Gonzalez et al., 2014; Green et al., 2007; Hagiwara et al., 2013, 2017; Haider et al., 2014; Haider, Schneider, Sriram, Dossick, et al., 2015; Haider et al., 2011; R. Harris et al., 2018; Hausmann et al., 2015; Hernandez et al., 2013; Hirsh et al., 2015; T. J. Johnson et al., 2017; T. J. Johnson et al., 2016; R. L. Johnson et al., 2004; Moskowitz et al., 2012 ; Nazione & Silk, 2013; Oliver et al., 2014; Penner et al., 2016; Penner et al., 2009; Puumala et al., 2016; Rojas et al., 2017; Sabin & Greenwald, 2012; Sabin et al., 2009; Sabin et al., 2008; Tajeu et al., 2018; van Ryn et al., 2015). There were few studies that included nursing students (Dunagan, Kinmble, Gunby, & Andrewes, 2016; Schultz & Baker, 2017). Evidence also suggests that racial implicit bias may be conveyed to students from institutions during learning experiences (Fischella & Sanders, 2017; Murray, 2018; van Ryan et al., 2015). Therefore, the paucity of nursing students in the racial implicit bias research presented opportunity for the nurse scientist to use qualitative inquiry in order to critically examine the perspectives of nursing students regarding racial implicit bias among healthcare professionals, including nurses, and its impact on patient care during clinical learning experiences.

Qualitative inquiry allows the researcher to focus on the human experience, by deepening the understanding of racial implicit bias and its impact on patient care, and other potential dimensions that are interrelated. In addition, the in-depth knowledge of racial implicit bias and the inclusion of the nursing students will make a significant contribution to the state of the science. This study will make needed contributions towards addressing racial implicit bias and its contributions to healthcare disparities before the nurse generalist enters the nursing practice.

Study Aim

The aim of this study was to describe the perspectives of nursing students regarding racial implicit bias against minority patients and its impact on patient care.

Research Question

What are the perspectives of nursing students regarding racial implicit bias and its impact on patient care in healthcare settings?

Design

Qualitative descriptive was selected as the methodology to explore the perspectives of nursing students regarding racial implicit bias against minority patients. When attempting to answer questions such as a participant's thoughts, attitudes or feelings regarding a phenomenon, qualitative description is a desired method (Sandelowski, 2000). Neegaard, Olesen, Andersen, and Sondergaard (2009) noted a strength of qualitative descriptive is its usefulness in healthcare. Qualitative descriptive allows for gaining the perspective of the patient, family member, or health care professional regarding the patient-health professional interactions.

The purpose of qualitative descriptive is to simply describe the participant's experience regarding a phenomenon of interest (Neegaard et al., 2009; Sandelowski, 2000). Also, qualitative descriptive has been described as eclectic combination of suitable approaches to sampling, data collection, and analysis. In addition, qualitative descriptive does not obligate the researcher to a certain theory, framework, or philosophical underpinning in comparison to other methodologies such as phenomenology

(Sandelowski, 2000). Therefore, the phenomenon of interest can be studied in a natural state (Colorafi & Evans, 2016; Sandelowski, 2000).

In order to promote self-disclosure, focus groups were used to collect the data. Focus groups provide an environment that is relaxed, non-judgmental, and safe for self-disclosure of participants (Kreuger & Casey, 2000). In addition, focus groups help participants with similarities share ideas in a low-pressure environment and therefore provide rich data (Hawkins, Mitchell, Piatt, & Ellis, 2018). Other qualitative studies using focus groups to encourage disclosure were also noted. For example, in a study exploring the narratives of young women regarding the role alcohol plays during sexual interactions, the use of focus groups was successful in engaging participants with each other and responding to information offered by other participants (Carey et al., 2018).

In another study, the authors used focus groups to create a safe space for transgender men of color to discuss pre-exposure for prophylaxis for HIV (Rownaiak, Ong-Flahery, Selix, & Kowell, 2017). Focus groups are also suitable to determine the perceptions, emotions, or attitudes of participants regarding the phenomenon of interest (Kreuger & Casey, 2000). In addition, a focus group will remove some control from the moderator (Braun & Clarke, 2013; Kreuger & Casey, 2000). Therefore, focus groups may facilitate a more authentic discussion of the phenomenon of interest among participants versus individual interviews (Braun & Clarke, 2013; Streubert & Carpenter, 2011).

Qualitative descriptive does support the use of a theoretical or conceptual lens that guides a study regarding data collection and or analysis (Colorafi & Evans, 2016; Sandelowski, 2010). The Levels of Racism framework served as the conceptual lens for

this study. This framework guided the research question and semi-structured focus group questions for the study. This allowed for a critical lens, which facilitated a deeper analysis that included the relationships among the three levels. This approach was also congruent with the intent of the Levels of Racism framework (Jones, 2000).

Sample

Purposive sampling was used to recruit students from multiple pre-licensure nursing programs in the southeast of the United States. Inclusion criteria included students currently enrolled in a pre-licensure nursing program and completion of at least one semester of clinical experience in a hospital setting. Prior to recruiting participants, the institutional review board (IRB) at the University of North Carolina at Greensboro granted approval. Addition approval, such as IRB and letters of support were also obtained from the other nursing programs. Participants were recruited from two Historically Black College or Universities, one community college, and one state university.

Flyers with a brief a brief description of the study, an email, and phone number of the primary investigator for scheduling, was sent via email, learning management systems of the nursing program, and through word of mouth. In addition, the flyer was placed in in the student lounge area. To address potential social desirability, the participants were not told that the study is about racial implicit bias. Instead, the flyer presented the study as exploring nursing care experiences with minority patients. Once a participant contacted the primary investigator, a link was sent to sign up for a focus group using an online scheduling management system. Recruitment of participants continued

once the primary investigator reached saturation. This resulted in five focus groups with 25 participants in total. Each of the participants received a $25 gift card for their participation in the focus group interview.

Setting

To ensure privacy, the focus groups were held in a small conference rooms on their campus. The rooms consisted of a large table with chairs, access to a computer, a projector, and screen. The door remained closed during the focus group interviews. The participants were informed that the focus group would not exceed 90 minutes.

Protection of Human Subjects

In order to protect the rights of study participants, an application was submitted to the institutional review board at the University of North Carolina at Greensboro for approval to conduct the study. Once approval was received, recruitment of participants and data collection began. Participants were informed about the study with attention to purpose, benefits and risks that are associated with the study, their right to withdraw from the study, confidentiality, disclosure, and agreement to be contacted after the focus group if needed.

A potential challenge for this study included an issue with confidentiality and/or disclosure. Participants were asked not to discuss specific details or identify a specific person outside of the focus group. They were also informed that this study is part of the academic requirement of a Doctor of Philosophy nursing program and that a committee chair was supervising the study. Afterwards, an opportunity to ask questions was provided prior to the start of the focus group interview.

Data Collection

At the time of consent, a demographic data form was distributed to the participants to complete. Participant demographics and characteristics that were considered include race, age, gender, type of nursing program, and number of nursing school semesters completed. Afterwards, the participants watched a short video of a clinical vignette clip that depicted an example of a racial implicit bias from a nurse. A Caucasian nurse had two interactions, one with an African American post-partum patient and one with a Caucasian post-partum patient. The video depicted the nurse exhibiting implicit racial bias in verbal and non-verbal manners to the African American patient, versus providing appropriate care to the Caucasian patient (see Appendix C).

Vignettes are indirect prompts or tools used to stimulate discussion (Braun & Clark, 2013; Richards & Morse, 2013). Vignettes provide concrete examples of behaviors in which participants can comment on. The researcher can then facilitate a deeper discussion based on the participants' responses (Barter, & Renold, 2000). Using a vignette is also helpful when studying sensitive topics or if the participants do not have personal experience or knowledge of the topic of interest (Barter, & Renold, 2000; Braun & Clarke, 2013). For example, Barter and Renold (2000) used a vignette to study violence in a children's home. The vignette and use of semi-structured questions engaged a young population to participate in research, facilitated discussion of personal experiences of violence, included other types that may not have experienced, and discovered meanings and explanations that actors attributed to different situations (Barter & Renold, 2000). Studies of racial implicit bias also have used vignettes (Green et al.,

2007; Haider, Schneider, Sriram, Dossick, et al., 2015; Haider, Schneider, Sriram, Scott, et al., 2015; Puumala et al., 2016; Rojas et al., 2017; Sabin et al., 2008).

The viewing of the video was followed by semi-structured questions guided by the Levels of Racism framework to initiate discussion (see Appendix D). The questions included: What are your thoughts about the video you just saw? How would you describe this? Have you seen this in your practice? Has this ever happened to you? How do you feel about this? Why do you think the nurse responded that way? What do you think about the way the nurse responded? How do you think that made the patient feel? Have you ever reflected on the care diverse patients may be receiving by members of other racial groups? Are you familiar with racial implicit bias? How would you define racial implicit bias? Have you seen any efforts by hospitals to address racial implicit bias? These questions elicited responses of general views, the significance of vignette, and the context concerning implicit racial bias and patient care (Barter, & Renold, 2000). This method allowed the participants to discuss racial implicit bias and patient care whether they have or have not encountered this in their practice.

The focus group interviews were recorded using two digital recorders. In addition, field notes were taken during the interviews. The interview-recorded data were then transcribed verbatim by the researcher into a written word document. The researcher listen to the recordings more than once to ensure accuracy of the transcriptions. Afterwards, the recorded transcriptions were deleted and the focus group transcripts were stored in UNCG box, a secured content management system.

Data Analysis

Guided by the Levels of Racism framework, Braun and Clarke's (2006) thematic analysis approach was used to analyze the focus group data for this study. This this method is very flexible in qualitative research and results in organization and description of data in rich detail (Braun & Clarke, 2006). It also allows for reporting existing patterns or themes in the data (Braun & Clarke, 2006). A strength of thematic analysis is its flexibility. It does not require specific methods for data collection, theoretical or ontological frameworks. Therefore, it can be used with any question, sample size, and data collection method (Braun & Clarke, 2013).

Thematic analysis is also an appropriate approach for descriptive qualitative studies. It can answer questions such as what the participant's concerns regarding the phenomenon of interest is. It involves identifying, analyzing, and reporting patterns or themes within the data (Vaismoradi, Turunen, & Bondas, 2013). Additionally, Kim, Sefcik, and Bradway (2017) noted that thematic analysis was the second-most used analysis approach in a systematic review of characteristics of qualitative descriptive studies.

Analysis began with reading through the transcriptions of the recorded focus groups interview with the addition of field notes. In order to facilitate immersion with the data, the researcher read the transcripts multiple times. This enabled the researcher to identify anything significant such as meanings, patterns, points of interest, impressions, concepts or ideas regarding the data (Braun & Clarke, 2006). The next step included coding. Going through each line, one at a time, a feature of interest was identified and

assigned a code. This process continued through the entire data set. Next, the codes were sorted into categories. Then relationships between the codes with relevant data excerpts were analyzed, codes were combined and themes were developed (see Appendix E). The themes were then further reviewed to determine if they needed to be reined (Braun & Clarke, 2006).

For example, a theme may need to be broken up into two themes, or two themes may require combining to form one theme. Also, some themes may not be themes, due to lack of supportive data. In addition, the themes were reviewed to ensure a reflection of the data set. Additionally, analytic memos were taken during each step of the analysis process.

Trustworthiness, Credibility, and Bracketing

In order to ensure trustworthiness, the following steps were taken: a qualitative expert from the researcher's dissertation committee was provided with the data set and thematic map in order to determine too much or too little emphasis on a point, or if anything was missed by the researcher. This will improve the credibility and dependability of the study (Streubert & Carpenter, 2011; Janesick, 2007). An audit trail, which is the documentation of the research activities from the beginning through the reporting of the results, was used to ensure confirmability. The audit trail provides an illustration of the development of thoughts that led to the conclusion of the findings. It also provides confirmability (Streubert & Carpenter, 2011).

In addition to the audit trail, reflective journaling throughout the research process was also included to address bracketing. Journaling allowed the researcher to critically

reflect on the research process and personal assumptions and or biases. This reflective process enabled to researcher to set assumptions or biases aside so that they will not interfere with obtaining the purest description of the phenomenon (Braun & Clarke, 2006; Richards & Morse, 2013; Streubert & Carpenter, 2011).

CHAPTER IV

FINDINGS

Racial implicit bias exists among healthcare providers and is a known contributor to healthcare disparities (Fiscella & Sanders, 2016). Scholars have responded to the IOM's (2002) recommendation to address racial implicit bias with current and future healthcare providers in order to decrease health care disparities. Research has also pointed out the importance of studying students during their clinical education and designing interventions that effectively address racial implicit bias and health care disparities (C. M. Gonzalez et al., 2014). Nurses are considered front line healthcare providers, however not much is known about nursing students and racial implicit bias. Therefore, the purpose of this study was to describe nursing students' perspectives of racial implicit bias and patient care, based on their clinical experiences. A qualitative descriptive design guided by Jones' (2000) Levels of Racism framework was used to ask 11 semi-structured questions during focus group sessions. Prior to answering the questions, the participants watched a video of a clinical vignette that portrayed a Caucasian nurse caring for two patients, the first one was African American the second one was Caucasian. Both of the patients were first time mothers that had recently delivered a baby. They both complained of pain and had concerns about breastfeeding. The nurse exhibited racial bias in verbal and non-verbal behaviors to the African American patient, versus providing appropriate care to the Caucasian patient. This

chapter will describe the sample characteristics and the findings of the study with the themes and sub-themes that were discovered.

Sample Characteristics

The participants participated in five focus groups. The participants were nursing students that completed at least one semester of a clinical experience. Students were recruited from two Historically Black College or Universities (HBCU), a state university, and a community college. The number of participants in each focus group ranged from three to seven; with a total of 25 participants. The majority of the participants were female, there were only two males. The majority of the participants' ages ranged from 18 to 24 years old. The number of semesters already completed ranged from two to four (see Table 1). The focus groups were conducted face to face and the length of time ranged from 16.07 minutes to 47.14 minutes.

Table 1

Demographic Characteristics of the Sample (*N*=25)

Variable	Frequency	Percentage (%)
Age		
18-24	15	60.00
25-34	8	32.00
35-44	2	8.00
Race/Ethnicity		
Black/African-American	16	64.00
Caucasian	4	16.00
Asian	3	12.00
Hispanic/Latino/White	2	8.00

Table 1

Cont.

Variable	Frequency	Percentage (%)
Type of School		
State University	8	32.00
HBCU	11	44.00
Community College	6	24.00
Number of semesters completed in nursing school		
1	1	4.00
2	7	28.00
3	4	16.00
4	13	52.00

Data Analysis

Braun and Clarke's (2006) thematic analysis method was used for this study. First, the transcriptions of the focus group recordings were read multiple times. Then the investigator went through each transcript line by line, underlining a feature of interest that pertained to the phenomenon of interest. Next, the pertinent data excerpts were assigned a code. Once the entire data set was coded, then the codes were analyzed across the data set, using a thematic map. The codes were organized into similar categories for further analysis to combine or eliminate a code. Next using a thematic map, the codes were organized for potential themes and also were analyzed with consideration for the relationships between the codes and theme. As a result, the following themes were discovered: Theme 1: Some were not certain, but all certainly recognized discrimination, and were angered. This theme described how some of the participants were not familiar with or could not accurately define the term racial implicit bias, however all of the

participants were able to recognize various manifestations of discrimination after viewing the video of the clinical vignette and from their experiences during their clinical education In addition, this captures participants' responses to the discrimination. Theme 2 was: Reflection brings emotion and increased awareness of discrimination. This theme described how certain personal experiences of discrimination and reflecting on those experiences influenced emotional responses, heightened sensitivity to discrimination, and increased awareness of discrimination.

Themes

Theme 1: Some Were Not Certain, But All Certainly Recognized Discrimination, and Were Angered

It was not clear whether all of the participants understood the term racial implicit bias. Certainty versus uncertainty was manifested in a couple of ways. About half of the participants stated they were familiar with racial implicit bias. However, when asked to define racial implicit bias, the majority of the participants gave an incorrect definition. Some defined it as purposeful biased treatment, for example a female participant from a HBCU gave this definition: "I guess I know what racial bias is, implicit is throwing me off. I would define it as a purposeful racial bias. Being biased on purpose." A few of the participants did not know the term racial implicit bias. A female participant from a state university stated: "I would say no, just because I have to think about it when you say it. If I knew what it was, I would know already, I would understand it." Other responses included: "I got the racial bias part, not the implicit", "I feel like I heard of it before, but no not really", and "I guess I know what racial bias is, implicit is throwing me off." Some of the participants said they were not familiar, however still provided an accurate

definition. This can be seen in the definition provided by a female participant from a HBCU.

> I think racial implicit bias could have something to do with a person being born and raised in a certain environment where they were raised to be biased against other races and maybe they not know it themselves and then when they get into the healthcare field they still continue to act the same way but not know it.

Other participants did understand the term and also had insight on the role of institutions regarding racial implicit bias in healthcare. Two male participants from the focus group at the community college stated:

> I feel kind of ambivalent about it. People keep trying to solve problems in America by emphasizing the personal responsibility. This isn't about judging that one nurse for being whatever. It's a system issue. I don't really feel upset by the nurse, it's just something that came about insidiously, and something that can be fixed for the individual, but won't stop without broader change.
>
> So maybe we need teaching on the small things, like how we word things I guess. We're getting teaching on that but now it's a problem with the small stuff we don't notice when we are talking to the patients.

Although not all of the participants were able to define racial implicit bias, they all were able to identify the actions and behaviors of the nurse depicted in the video as discriminatory towards the minority patient. They were able to point them out and discuss them in depth. Additionally, they recognized deviations from the standard of care and identified negative patient outcomes that can result from less than quality of care.

The participants were also able to recognize the manifestations of racial implicit bias depicted in the clinical vignette video. All of the participants were able to recognize

the difference in how the nurse cared for both patients. A good illustration of this recognition is noted in several statements made by the participants:

> It was obvious that she treated the white patient differently than the African-American patient. My thoughts were there were definitely some discrepancies in how the black female was treated compared to the Caucasian.
>
> You can tell she was definitely a lot more brisk and didn't give time for the African American patient to respond or she wasn't as careful or sensitive with how she went through some of the procedures.
>
> It was obvious the nurse treated her patients differently when really they are both in the same situations. They are new moms, they just had babies, it hurts, they deserve to have their needs met compassionately no matter what.

Various comments were made about the nurse's interaction including, what the nurse said, the tone of voice used, her affect, how the assessment was performed, and certain actions that were omitted. A female participant from a focus group at a state university, illustrated the ability to recognize racial implicit bias with this observation of the nurse's nonverbal communication: "She was treating the first patient like she was some kind of fungus or dirty like she couldn't touch her." Another example of the nurse's interaction with the African American patient includes a discussion about patient centered care from a participant from a state university:

> When I think about it, I think of patient centered care, and that just wasn't. With the Caucasian lady that was definitely. We do our teaching, we assess, we have our resources. Whereas yes she gave the resource, but she didn't even, for the African American lady, she didn't even say this is what I can do until we get this resource for you. It totally was not patient centered care, it was I just want to do what I want to do for this patient.

Lastly, a state university participant's perception of how some nursing care was omitted during the interaction, provides another example of their ability to recognize manifestations of racial implicit bias:

> But I feel like with the African American woman she was just closed off and not really approachable and she did not. To me, I feel like that is part of nursing care, is to make sure that people feel like they can talk to you, be comfortable. Of course she just had a traumatic event, having a baby is traumatic, if you're not looking for how much bleeding, how much clotting, to me that is just negligent, so you are not doing your job.

It was also noted across the interview data, that the participants perceived the nurse's actions as a deviation from the standard of care. All the participants made a comment that described how the nurse was not following the standard of care. This is exemplified by a female participant from a focus group at a HBCU, as she discussed her perspective of quality care:

> She wasn't providing the quality of care. The quality of care was totally different. Because the black person was complaining about pain. What do we know about pain? Pain is whatever the patient says it is. You can't tell a patient to put your big girl panties on. I want to write her up.

Another comment by a female participant from a focus group at an HBCU included:

> There is a protocol that we all follow, right? I felt like she wasn't doing her job as a nurse. Because she is there to make sure all of her needs, all of the patients' needs were met. To answer any questions or concerns, to educate, she didn't do any of that. She just wanted to go in and get her job done and leave.

As the participants responded to the actions and behaviors of the nurse during the interaction with the African American patient, the majority of the participants identified

factors that are commonly associated with racial implicit bias. This can be seen by the multiple comments that were made by the participants describing the nurse or other person in a similar situation as not realizing how they were treating people and the impact of that treatment. For example, a female participant from a focus group at a community college stated, “I question whether the nurse is aware that she does it.” Another participant from a focus group at a state university said: “You may not notice it yourself, but then if you go back and look, I really did treat them completely different, even if you didn’t mean it but you are able to see that you did.”

Lastly a male participant from a focus group at the community college used the term insidious to describe the actions of the nurse in the video:

> It’s also insidious, that’s not a situation where the nurse did anything blatantly unprofessional, she is not necessarily going to realize or ever get called out on the fact that she is having trouble treating these patients equally. I don’t even believe that the nurse is clearly racist, she is just not treating them the same and I don’t know if anyone is going to notice.

A point of interest includes how often one focus group participants used the word “insidious.” It was used multiple times, by different participants in the focus group to describe the actions of the nurse while interacting with the African American patient in the video of the clinical vignette.

Some of the participants stated: “I don’t really feel upset by the nurse, it’s just something that came about insidiously, and something that can be fixed for the individual, but won’t stop without broader change.” “Again, that’s really insidious, an insidious way of doing it. So that probably made the patient feel completely, not only

uncared for but completely helpless in having any sort of recourse." Another participant said:

> We are getting a lot of education about providing equal care to everybody. But now we are running into issue of more of the smaller nuances of like being insidious like y'all were saying some of the small things you don't notice.

As noted earlier, some of the participants identified the nurse's lack of self-awareness as a factor influencing racial implicit bias. However, in contrast, other participants viewed the video with a different level of critique. They clearly identified discrimination or racism as the reason why the nurse responded to the African American patient differently. A female participant from a state university, demonstrated the use of critical lens in this statement: "Maybe they are not trying to be racist, but they are because they are not treating them the same." The participant still categorized this as racism even though the individual is not aware. Another female participant from a state university indicated: "Maybe it's really harsh to say, but I feel like some people are ignorant to the fact that they don't see their own racism."

Lastly, a female participant from a HBCU believed the nurse in the video did not want to give the African American patient pain medication because of the patient's race. The participant's belief is evident in this statement:

> She has medication prescribed, there is something there you can give her. You are choosing not to give it to her because you don't want to, not because she can't have it or its contraindicated or something. You are choosing because she is black not to give it to her.

This is insightful, because this was specifically identified from various other behaviors that the nurse displayed in the video during that interaction. The actions and behaviors could be described as subtle; however, the participant perceived the nurse making a decision to withhold pain medication because of the patient's race, which seems blatant.

Other factors associated with racial implicit bias that were identified by the participants, included stereotypes, cultural, and societal norms. A female participant from a state university identified societal norms as a factor. The participant stated: "I think she acted that way because of like, how the world is now. Or how the world has been against African Americans. Like the way we are seen, certain stereotypes: too loud, too this, too that." Another female participant from a state university, specified how societal and cultural norms of racism have shifted from actions that were explicit to now presenting as implicit:

> That's what you were taught. Even though I feel times are changing, the institution of racism or just that ideology has not changed. For now it's a lot more underlying. It's not as blatant as before but it is still there. That's what I think. It's how she grew up and I'm pretty sure she thinks it's right too. I don't think she thinks there is anything wrong.

In addition, a female participant from a state university recognized the correlation between stereotypes and racial implicit bias. This also demonstrates student nurses' ability to recognize.

> And I think that those stereotypes whether you know them or you don't, they play a huge impact on how you treat people. And this affects how you interact with them, speak with them everything changes when you have that mind set.

The participants acknowledged that the discriminatory actions by the nurse in the video as common and normalized. Various comments by different participants demonstrated this. A female participant from a state university noted, “Because this stuff happens all the time.” while discussing her initial thoughts regarding the video of the clinical vignette. Additionally, a female participant from a HBCU also recognized the normalization of racial implicit bias with this response: “It really wasn’t surprising to me. It’s numbing, it’s frustrating, yes because you know that’s wrong, but it’s not abnormal.” Lastly, a female participant from the community college focus group, discussed the role institutions and normalization play in recognizing racial implicit bias.

> I think there is racial implicit bias in all our systems in this country. And so because that is what we are used to, we have a hard time seeing. It’s really hard to see what is the norm, until you start picking it apart.

The participants were able to recognize how the care provided to the African American patient in the video can result in negative outcomes. All of the participants believed that as a result of the care that was provided the patient would likely respond negatively. They noted that this experience would impact the patient’s feelings, ability to trust, and result in a medical complication. Feelings of fear and neglect were noted most often. A female participant from a focus group at a state university discussed how the interaction with the nurse impacted the African American patient: “I think she was scared. She just had a baby, I’m pretty sure she thought is my baby going to be taken care as well as somebody else’s?” Another female participant from a HBCU identified the fear of a new mom struggling to breastfeed.

> She probably felt scared, but not of the nurse, but scared of the atmosphere because as far as the baby's feeding getting ready to come up. She was like . . . How am I going to feed you? This lady left out of here, she didn't offer any help and your next feeding is coming up. She is probably scared; she may feel like she has failed her child in this scenario because she can't feed her properly.

Another female participant from a HBCU noted that not only will the patient not trust the nurse, but also identified this as a current issue in health care.

> She broke the trust with the patient. It's something that gets perpetuated. There is already a thing where black people don't trust healthcare providers. So, you just fed into it and there is another person that does not trust the healthcare provider.

The participants were also concerned about the African American patient experiencing complications such as blood clots and bleeding due to the quality of care that the nurse provided in the video. A female participant from a HBCU said:

> African American women giving birth and having their needs neglected and not being cared for properly and then going home and they end up with some type of embolism, inability to breathe, have to come back to the hospital and then they find out they have blood clots and it's all because they weren't cared for properly to begin with.

In addition, another female participant from a state university stated:

> I saw the difference with the patient teaching. She was assessing her really quick, and it was like she wanted to go, get out of her room really quick. But then, just knowing a little background on situations like that, I know that actually happens to African American women. I don't know the statistics, but there is a statistic that African America women are more likely to have complications and stuff because they are not taken care of as well when they give deliveries as Caucasians or other races. And they are more likely to die from pregnancy. And things like that, deliveries.

In addition to the video, some of the participants shared the observations of what they perceived to be racial implicit bias during their clinical experiences. They described different interactions between minority patients and nurses in various settings such as neonatal intensive care unit, sickle cell unit, and pediatrics. One female participant from the focus group at a community college described how minority patients are treated differently compared to Caucasian patients by the nurses.

> I have definitely experienced behavioral changes, how one approaches one family versus another family. I've seen sometimes, I work with lower class families with newborns. The immediate nursing interaction is like "oh gosh drug baby." Which you don't even know yet, we haven't gotten report on this patient. They are immediately thinking 18-year-old . . ., drug baby. Looking at the baby that will say neurologically this baby looks jittery, they will say whatever assessments lead up to this assumption. Versus you get the same aged baby 20 whatever weeker, and I've seen the nurses talk differently multiple times, not the same situation every time, but every time there is a racial thing involved I've seen even the interaction with the parents, instead of explaining the process of "hey you can't come and see baby yet because we are doing a, b, and c . . . It's "now is not a good time." Blow you off.

Another female participant from a HBCU noted how African American parents are treated on a pediatric unit.

> I would say my experience in Pediatrics, definitely the nurses were, if it was a black patient and if the parent wasn't there all day, all night they would kind be like, and well your parents don't care about you, why wouldn't you be here with your kid in the hospital. It's just like they are not even thinking about that they have to time off work to be here and everybody doesn't have a job that they can just call off and not get fired for. I feel like that a little prejudiced against black people, that's just anti-black.

Other participants described experiences where they perceived the nurse to treat patients differently based on race instead of clinical presentation. A female participant

from a state university illustrated this point clearly when she described a clinical experience involving a minority patient that had difficulty breathing.

> We had two patients, one was African American the other was Caucasian and I feel like my nurse was biased. She would take longer. If that patient rang their call bell, she would say oh I'll get to them they're fine, they don't need anything. But I felt personally like that patient was more critical than the other patient, and I was concerned, so I would go and check on them. I'm worried, because I feel like they are calling out, like she had a really hard time breathing and I was just worried she wasn't getting the air she needed. The same case, if the Caucasian lady was like I can't breathe, I can't breathe, I felt like the nurse would have gotten to her a lot quicker than she did to this other patient.

Minority patients being treated differently based on race, was also illustrated by the statement made by another female participant from a state university.

> Do you remember when the patient's blood sugar who dropped down to 50 something and had to get orange juice real quick, you're nurse was saying, "he is always fluctuating up and down, up and down." But then the patient across from him was Caucasian, and he said he wasn't feeling well. She told the CNA to check the glucose, and I checked it twice, no three times, but she didn't have an attitude with it.

A final example includes two female participants from the community college focus group, discussing what they saw in their practice.

> Sometimes a Caucasian patient have a black nurse, and assume that they are not as qualified or don't have as much knowledge about the situation and its sort of the same thing but backwards. Yeah, I have seen that more probably than the other way around. Just questioning the nurse's judgment.

Lastly, all of the participants responded negatively about how the nurse treated the African American patient, compared to the Caucasian patient. Anger and frustration

were the most commonly used words to describe their emotions about the video. Some of the participants' anger was evident when they were defining racial implicit bias. The definitions provided appears to reflect their personal feelings of anger. A female participant from a HBCU, that shared a personal experience, provided this definition: "You're choosing to be racist. You're racist because you want to." Another participant said: "I think it's a purposeful racial bias and you're purposely acting and feeling this way based on those biases." Other feelings included "upsetting" and "disgusted". Negative comments were made about the nurse's character and actions while providing care to the African American patient. Some of the comments regarding the nurse's character included: "racist," "discriminatory," "unprofessional," "standoffish," and "negligent." Some of the participants were also concerned about the impact of the care that the African American patient received in the video. One participant described a part in the video that most impactful to her.

> The most important part of that video was that woman wanting to go home and that stuck with me. Because it made me think about wow, that made her feel like "I'm not comfortable here." Which can affect a lot of things further along.

Another participant described her concerns for the African American patient in the video.

> We are not taught to treat one patient this way and treat another, everyone is the same. We know black people or black women have complications more than whites. As a nurse, you should pay close attention. You don't want them to fall under that statistic.

Theme 2: Reflection Brings Emotion and Increased Awareness of Discrimination

Various types of personal experiences have formed the participants' level of awareness of discrimination and influenced them in several ways. Also, reflecting on these experiences stimulated different emotional responses. When the participants were asked "Has this ever happened to you?' after watching the video of the clinical vignette. About half of the participants responded yes and shared personal experiences that they perceived to be similar to the video that depicted racial implicit bias. All of the participants that shared a personal experience were minorities. The majority were African American, one was Asian, and the other Hispanic or Latino. The participants described experiences as a patient, a family member as the patient, or as a nursing student.

In terms of emotional responses from reflecting on past personal experiences, two African American participants shared their birth experiences, and described how they felt the nurse treated them differently because of their race. While the participants described their birth experiences, it appeared that they may still be affected by it. Watching the video, then reflecting and sharing their personal experiences of perceived discrimination, resulted in emotional responses. As they were describing their experience, the affect and tone of voice suggested they were re-living the experience. There appeared to be various emotions displayed by the participants such as fear, anger, and or frustration. One female participant from a HBCU displays all three emotions as she told her story to the group.

> My daughter was born in 2012 through an emergency C-Section. After I had my daughter I went into heart failure and wound up at the (blinded) Hospital. My baby was in the room with me. I had major swelling, I couldn't breathe well, my blood pressure was 180 over 110 and I thought I was going to die. I was asking the nurse questions and the nurse treated me like I couldn't understand what was

> going on. It wasn't until one of the other ladies that worked there, and who I used to work with, came into the room and told the nurse that I had worked in health care for a while. But it was just very obvious that she didn't want to take care of me. She didn't want to aid me. I was a first-time mother and I was horrified being there. The nurse didn't want to answer my questions and she treated me like I was a complete idiot. Those things are not always blatant, but when you're African-American you can tell when somebody doesn't want to deal with you because of your color.

Another female participant from a focus group at a HBCU expressed her frustrations about not being appropriately informed prior to a procedure during her birth experience. The participant also appeared to re-living the experience.

> Maybe I had an experience, I'm not sure if it was racial or just the end of the shift. But I did have an experience when I had to get a foley inserted and they had gave me the epidural, but it had not taken effect. And um I had some concerns because it was very uncomfortable, I didn't get a heads up, it was just like we are going to put this catheter in. I wasn't talked through the process. When I complained about it, it was just like, oh I barely touched you. And it's like it doesn't matter that you barely touched me, you still touched me and it was uncomfortable. But again, I was going through the pain and everything so I kind of brushed it aside, but it is something that I can recall from that experience.

A female participant from a state university was frustrated because she believed that she had longer wait time at a doctor's appointment due to her race. The participant explained:

> So, I go to the doctor quite frequently. I have aplastic anemia. So I go every month and to me . . . I don't know if it's just me but I have definitely seen where I can come in before another patient, and I don't know if its other assessments that they have to get done that day, and it's your just seeing the doctor and the doctor is not ready for you, but I have seen two or three other people go in front of me. But it's like I have been waiting everyone has to get their lab drawn and then go see the doctor, for I guess whatever assessments they have done for them. I just look at my mom and it's like we have been sitting there for 30 minutes, when are they going to call me. Then my mom would go up to the receptionist and ask do you know when are they going to call her? I feel like that would be the situation where something has happened to me.

Other emotional responses were also noted when other students described their experiences. A female participant from a HBCU expressed her disappointment as she recalled a personal experience as a nursing student.

> I remember one time at the women's hospital, my classmates and I were doing a rotation at the labor and delivery unit. There were no black nurses working that day. And we walked into the room where they get report, it was almost like we weren't there. They didn't acknowledge our presence. No one said anything. It wasn't until our instructor literally walked us over to the person that we were going to be shadowing for the day that they kind of started to deal with us, but even then they kind of just left us, like she said they would avoid us. They would try to handle everything then come back to us after the fact.

Another female participant from a HBCU, shared an experience as a nursing student. She described feeling like the nurses did not want to work with her during a clinical experience.

> But I kind of felt like they were "hot potatoing" me around. So, if my preceptor would say "hey go and shadow so and so". And I went to her and she was kind of like, oh I don't think what I am doing is that interesting, go to this person. So, I went to her and was like "hey can I watch your input assessment?" And she was like, "I don't have an input assessment. I don't know why your preceptor told you that." But like five minutes later another nurse is like "Hey do you want to come and see me do this assessment for so and so's patient? But she just told me she didn't have a patient. I was kind of like if you didn't want me around or with you, then just say that. Don't make me feel like the ugly duckling of the preceptorship. Just say what it is.

Some of the experiences of the participants appeared to be traumatizing, especially during one focus group in particular. This group was from a HBCU and they each shared a negative experience as nursing students during their clinical education.

Based on their responses, these experiences left them feeling insecure, and angry, and discouraged. One student discussed her insecurities of being a black new graduate nurse.

> It makes me nervous because we're about to be new grads. Kind of the first time working as nurses and we're going to need help. We're going to need white people to help us, nursing is mostly white. Someone has to help us whether we are black or white. I don't want to feel like the dumb black girl on the unit or the black girl that came from the HBCU and always needs help or is always asking questions. I want to feel like my questions are welcomed and I'm encouraged to ask as many questions and it doesn't make me stupid or less than anybody else.

Another participant from the HBCU focus group expressed her anger and discouragement, as she described reasons for wanting to work as an operating room nurse.

> I want to be an OR nurse, there I will have minimal interaction with other patients there and other coworkers in there. I'll get to slightly be in charge. That's what bedside nursing is, its competitiveness, cattiness between the nurses, male or female. It's about who wants to do the least amount of work. It makes me want to go into a different specialty and not even do bedside and deal with racist white ponytails and people who don't want to accept other people. They don't think you could be smart. They think that you have skirted by, you have affirmative action. No baby I went to a HBCU.

Other feelings that were expressed by the participants from an HBCU focus group, as a result of the personal experiences of discrimination, included feeling powerless and desensitized. One participant said, "I'm numb at this point, you don't even know how horrible you are acting right now. It's a normal day for them." Another participant from a HBCU, that also had a personal experience stated, "It really wasn't surprising to me. It's numbing, it's frustrating, yes because you know that's wrong, but it's not abnormal."

When other focus group participants described their experiences, they did not feel that anything can be done. They were even encouraged to accept it and was left feeling powerless. A female participant from a community college shared: “I think a lot of people tell you that’s just part of the world, you’re going to have to deal with it. That is just the field that you’re in.” Another participant from a state university recalled what an instructor told her.

> Just suck it up and keep it pushing. That is what my clinical instructor said, I am going to face that our entire healthcare career. We are always going to have do twice as much work than everybody else to prove ourselves. As a student, we can’t say nothing, you can but, you’re scared. You don’t want to step on anyone’s toes and you want to stay in role, stay your place.

While reflecting, it was noticed that the participants’ experiences of perceived discrimination influenced their level of awareness of discrimination in two ways. The participants appeared to have a heightened sensitivity to discrimination. This was noticed when the participants from this group elaborated about something in the video, they often would use themselves as the person being treated unfairly. It appeared as if their past experiences of perceived discrimination have created a heightened sensitivity to this topic. For example, a female participant was talking about minorities being stereotyped as having lower education levels and difficulty with comprehension. The participant said, “don’t dumb it down for me.” Another participant talked about how the patient may feel after the experience of discrimination, and said:

> It’s like I don’t have any family here, this nurse doesn’t want to care for me is going to be coming in and out of here trying to talk to me, making my confidence

> go down and feel worse and worse every time she comes in here so . . . she doesn't feel good at all.

This sensitivity was also noted when another participant described how the patient may have felt as a result of the care that was provided by the nurse.

> She was like . . . How am I going to feed you? This lady left out of here, she didn't offer any help, and your next feeding is coming up, she probably scared, she may feel like she has failed her child in this scenario because she can't feed her properly. She doesn't know if she's getting enough.

The participants' past experiences appeared to influence their level of awareness of being discriminated against. This was also noted when they answered questions during the focus groups. Compared to the participants that denied personal experiences, the participants that had personal experiences answered questions more comprehensively and tended to elaborate more, demonstrating an increased level of awareness. They also shared that they reflect on the care that minority patients receive from other healthcare providers of other races. A female participant from a state university shared: "yes because of the color of my skin and because of what we face daily in any situation and any circumstance and I know that falls into our level of care when we go inside of the hospital." Another female participant from a state university talked about reflecting after a clinical experience.

> I think that is mostly what I do with clinical, once I'm done with a day. I sit there and really think about what was kind of like the attitude. I feel a lot of it, reflecting on the care and the dynamic between the healthcare team and the patient and the healthcare team and me. Just kind of that whole situation. I feel a lot of it is subtle.

In contrast, a female participant from a HBCU, that denied any personal experiences, admits to not reflecting. The participant stated: “I never really thought about it until like just now honestly.” Another participant, from a state university admits to not reflecting.

> I feel like I am like most of the world, if it doesn’t happen directly to me, I don’t think about it as much. Which is horrible to say, but that is how it is. So if I had an experience where I felt I saw it directly on where someone was mistreated or I was mistreated, I’ll be like wow I’m upset about this, but I feel like it kind of takes a push for people to realize that this is a bigger problem than we think. People who are exposed to it more often understand, this is a huge problem. But for people who don’t see it as often or are afraid to speak or like any other reason, it’s just hard to get results.

Lastly, the participants’ increased awareness of discrimination was noted when they discussed the role of healthcare systems. When asked about efforts made by hospitals to address racial implicit bias, the majority of the participants denied seeing racial implicit bias addressed by health systems. Among those participants were the ones that had personal experiences. They appeared to have more insight on the role that healthcare institutions play with racial implicit bias due to their heightened sense of awareness of discrimination. A female participant from a community college described what she noticed.

> I think they attempt, by orientation, they have 45 minute blips about cultural disparities. I don’t know if those 45 minute compared to your whole entire career at a health care institute. I don’t know if that’s going to stick. I think it needs to get reinforced more. Like on each individual.

Another participant from a state university talked about hospitals addressing cultures but not racial implicit bias.

> I feel with the healthcare system, I feel that they don't make it a priority. I feel they just do the bare minimum by just mentioning it. By saying hey we are going to have classes and a little bit of education about cultures and cultural bias. We learned it over the summer, but it's very surface level, it's very basic. But it is not actually just delving into the actual statistics. Like hey this is a big deal and it changes health care. They say for the sake of looking good, of saying that we know that we've got cultures, but nobody actually really to make it priority to say that we need to make sure that our healthcare team is interacting with different cultures in an appropriate way.

In contrast, some participants that did not have any personal experiences, felt that the classes on culture and or diversity, were efforts that addressed racial implicit bias. One participant from a HBCU shared, "yes, classes on cultures, being culturally aware, diversity. They are really good on that now. I have seen more of that then I have ever seen before." Another participant from a HBCU mentioned a class that they have to take at one of their clinical sites. "We have to go through a culture class every year. And that is with everybody in the hospital, not just nurses, NAs and doctors."

Summary

This study provided an important description of the nursing students' perspectives of racial implicit bias and patient care from their clinical experiences. The findings of this study shed light on the different levels of insight that the nursing students had on discrimination such as racial implicit bias. Not all of the participants knew the definition of racial implicit bias, however they were able to identify the discriminatory behavior and consequences of racial implicit bias and had negative responses such as displeasure. This finding was described by the fist theme: Some were not certain, but all certainly recognized discrimination, and were angered. The second finding of this study includes past experiences of perceived discrimination which influenced the participants in several

ways. While reflecting on their past experiences, it triggered various emotions, heightened their sensitivity to, and increased their awareness of discrimination. This was described by the second theme: Reflection brings emotion and increased awareness of discrimination.

CHAPTER V

DISCUSSION

The aim of this study was to describe nursing students' perspectives of racial implicit bias and patient care, based on their clinical education experiences. The perspectives of the participants were attained through focus groups. Using semi-structured questions, a total of five focus groups, ranging from three to seven participants in each, were held. Two themes were discovered during the analysis process of the data. Theme 1: Some were not certain, but all certainly recognized discrimination, and were angered. Theme 2: Reflection brings emotion and increased awareness of discrimination. This chapter will discuss the themes within the context of the research literature and the Levels of Racism framework. Additionally, implications for nursing practice, nursing education, nursing research, and nursing theory will be discussed. Lastly study limitations are discussed in this chapter.

Themes

Theme 1: Some Were Not Certain, But All Certainly Recognized Discrimination, and Were Angered

This theme described the how only some of the participants were able to correctly define the term racial implicit bias. When the focus group participants were asked if they were familiar with racial implicit bias and asked to define racial implicit bias, one small focus group, responded that they were not aware of the term and could not define it. Other focus group participants responded with various combinations. Some participants

stated they were familiar with racial implicit bias, but defined it incorrectly. Others stated they were not familiar with the term, but defined it correctly. Some were familiar with racial implicit bias and defined it correctly. However, regardless of how they responded to being familiar and defining racial implicit bias, all of the focus group participants recognized and identified the behaviors of the nurse associated with racial implicit bias, factors that influence racial implicit bias, and the impact of those behaviors on patient care and were angry about it.

This study finding is both concerning and promising for a couple of reasons. Nursing students should be familiar with racial implicit bias and its connection with healthcare disparities, since the IOM (2002) and NLN (2013) have called for attention to education on discrimination and healthcare disparities for current and future healthcare professionals. This study finding is also promising due to the knowledge that some of the participants had. Some were able to correctly define racial implicit bias in addition to speaking the role that institutions and or systems have concerning racial implicit bias. Perhaps somewhere in their nursing program, they have received a formal or informal educational intervention on discrimination such as racial implicit bias and healthcare disparities. One focus group acknowledged that their clinical instructor took them to a lecture on racial healthcare disparities which may have influenced their level of knowledge.

This finding supports the efforts that should to be directed towards nursing education curricular. Attention is needed to ensure that the nurse generalist's preparation includes the nurse's role in caring for minority patients through effective interventions

that effectively address and manage racial bias, which will then assist with decreasing healthcare disparities. Currently there are no studies that specifically measure nursing students' knowledge of or ability to recognize discrimination such as racial implicit bias, however there are studies that support specific teaching interventions that yield positive learning outcomes of addressing and managing implicit bias in nursing programs (Schultz & Baker, 2017). In addition, there is evidence that supports the need for nursing curricular change (Dunagan et al., 2016).

Despite the ability or inability to define the term racial implicit bias, the participants were able to detect actions or behaviors of the nurse towards minority patients that were racially biased. They consistently pinpointed those behaviors after watching the clinical vignette video. The behaviors and interactions of the nurse which were recognized by the participants were manifestations of racial implicit bias. The participants identified behaviors which included discrimination, poor communication, deviations from the standard of care, and less patient centered care.

After watching the clinical vignette video, the participants pointed out the differences in nursing care that the African American patient received compared to Caucasian patient. They recognized that both patients had the same need, yet their care was different. They described the nurse's affect and tone of voice during the interaction with the African American patient as insensitive, and not caring. The participants also described the nurse's interaction as brisk and she appeared to want to leave the patient's room quickly. One participant compared the interaction between the nurse and the

African American patient to how she treats the manikin during simulation, which is no connection.

In addition, the participants described the nurse as neglecting the patient's pain, questions, general concerns and needs. Multiple participants believed the nurse withheld pain medication from the patient and others felt that she did not offer anything else to address the pain. Some of the participants also identified the actions of the nurse in the video as a deviation from the standard of care.

The focus group participants' ability to acknowledge factors that are commonly associated with racial implicit bias was also noted. During the focus group discussions, the participants were asked why they thought the nurse responded that way in the clinical vignette video. The participants noted various reasons such as a lack of self-awareness, discrimination, and stereotypes. Additionally, the participants also recognized that the behaviors of the nurse in the clinical vignette video as common and occurs frequently due to societal, cultural, and institutional norms. A point that was made during a focus group discussion included the difficulty with noticing discrimination due to it being normalized. This point is also supported by the Levels of Racism framework. It is captured in the Jones's (2000) level, institutional racism. Jones (2000) described it as a racial inequality with access to resources, opportunities, and services of society such as healthcare, education, or employment. Additionally, due to the structural foundation of institutions, such as health systems, hospitals function based on structural racism being routine practice. Therefore, it is normalized and there is a lack of response when action is needed (Jones, 2000).

After viewing the clinical vignette video, the participants were able to articulate how the interaction of the nurse and the African American patient, may result in negative patient outcomes. All of the focus group participants noted that the patient's experience was negative and influenced her to wanting to leave the hospital. The participants also noted that the interaction will impact the patient's ability to trust the nurse, and felt as if her needs and the needs of the newborn will not be met. Many of the participants were also concerned about the nurse missing early signs of a postpartum complications such as bleeding or a deep vein thrombosis.

Not only did the participants recognize discrimination depicted in the video of the clinical vignette, some of the participants were able to recall clinical education experiences in which they perceived to be similar to the video. The participants described several situations in which they observed interactions between the nurse and minority patients, in which the patient was treated differently due to their race and not clinical presentation. These interactions took place in a variety of clinical settings such as pediatrics, a sickle cell impatient unit, a medical inpatient unit, and a neonatal intensive care.

Lastly, all of the participants' reactions to both the discriminatory behaviors that were depicted in the video and the clinical experiences in the practice were negative. The responses ranged from feelings of anger and disgust to critiquing the nurse as unprofessional, negligent, and discriminatory when asked how they felt about the video. Some of the participants also showed their anger while responding to other questions by displaying their personal feelings in their responses. In addition to expressing their

discontent with nursing care of the African American patient in the video, they were also concerned about the potential negative patient outcomes that may result. Other participants shared similar concerns about the experiences in their clinical practice in which they witnessed patients receiving care that was different based on race. There are studies that document emotional responses after witnessing discrimination (Hahn, van Dyk, & Ahn, 2020; Schmader, Croft, Scarnier, Licket, & Mendes, 2012; Norris, McGuire, & Stolz, 2018). However, there are no studies that specifically examines recognizing discrimination. This is the first study to document a nursing student's ability to recognize discriminatory behaviors of the nurse.

As previously stated above, the students' ability to recognize discriminatory behaviors of the nurse is also both promising and concerning. The students immediately recognized that care was racially biased and described this type of care as deviations from the standard of nursing practice. It is evident that their nursing curriculum is based on professional standards of practice. For example, the American Nurses Association (ANA) code of ethics speaks to practicing compassionately and respectfully of every person, the primary commitment is to the patient, and promoting and advocating for the rights, health, and safety of the patient in provisions one, two and three (ANA, n.d.). This was clearly demonstrated based on the participants' ability to recognize deviations in care.

However, in addition to the students responding negatively with anger to the care depicted in the video, this study finding sheds light on the role modeling of racially biased care that the students were exposed to during their clinical education. Similar to van Ryn et al.'s (2015) study that examined medical school experiences of medical

students and the association of racial implicit bias, medical students were exposed to negative role modeling during their clinical experiences. This finding may suggest an incongruence with the standard of care taught in the formal nursing curriculum and the deviation in standards of care, such as racially biased care that is role modeled in the informal curriculum. The informal or hidden curriculum is the clinical experience in which learning occurs outside of the academic environment. This type of negative role modeling was noted in other healthcare education studies that examined the informal or hidden curriculum (R. Harris et al., 2018; Hernandez et al., 2013; van Ryn et al., 2015).

This finding also points out that students may have witnessed acts of racial discrimination towards minority patients during their clinical learning experiences. The students were upset about the way some minority patients were treated during their clinical experiences. This was consistent with other study findings that noted witnessing discrimination can cause stress and or emotional responses (Hahn et al., 2020; Schmader et al., 2012; Norris et al., 2018). It is not clear if the participants of this study were debriefed or what type of follow-up occurred regarding the experiences that they described in the current study; however, efforts are needed by administrators of nursing practice and education to address these types of negative clinical education experiences.

Theme 2: Reflection Brings Emotion and Increased Awareness of Discrimination

The second theme was characterized by the emotional responses of the participants when they reflected about their own perceived experiences of discrimination. Also, the different personal experiences influenced their awareness of discrimination in certain ways. When the focus group participants were asked “Has this ever happened to

you?" all of the participants that responded yes, were minorities. They described the personal experiences in which they believed they were treated differently due to their race and included mostly experiences as a patient and as a nursing student.

During the focus groups, different emotional responses were noticed as the participants described their experiences of perceived discrimination. Several of the participants that shared their personal experiences as a patient displayed several emotions such as fear, anger and frustration through their facial expressions and tone of voice. This finding was comparable with other studies that found an association with experiences of discrimination and resulting traumatic stress symptoms such as anger or emotional upset (Flores, Tschann, Dimas, Pasch, & de Groat, 2010; Loyd et al., 2019; Motz & Currie, 2019).

One participant shared her experience as a patient after giving birth and experiencing complications. She described the nurse neglecting to fully explain things to her. She also described feeling scared and thinking death was imminent. Furthermore, due to her anger and frustration of this experience, she explained no longer seeking care at that healthcare facility, as she scheduled her daughter's surgery at a different health system. She was willing to wait longer for a surgery date and driving an hour in order to avoid dealing with the hospital where she gave birth to her daughter. The feeling of fear, anger, frustration, and distrust that results from perceived discriminatory experiences was also noted in a similar study that described patient perspectives on racial implicit bias clinical encounters (C. M. Gonzalez, Deno, et al., 2018).

What appeared to be the most impactful for participants in one of the focus groups, was their personal experiences as nursing students. All of the participants in this focus group commented on the negative experiences of perceived discrimination that was endured as African American nursing students during their clinical experiences. This finding is also noted in other studies (Metzger, Dowling, Guinn, & Wilson, 2020; Sedgwick, Oosterbroek, & Ponomar, 2014). The participants described different situations during their clinical education, in which they perceived they were treated differently due to their race. These experiences included nurses not wanting to work with the student, having to work harder to prove competence, and not being acknowledged by nursing staff. This finding was similar to the results of Sedgwick et al.'s (2014) study that identified reasons that influence minority nursing students' sense of belong during clinical experiences. All of the participants from this focus group expressed various feelings such as disappointment, excluded, angry, discouraged, and insecure about their future careers. Similar findings were also noted in Motz and Currie's (2019) study that examined students that experienced racially motivated housing discrimination.

Other participants that shared personal experiences of discrimination as nursing students, described feeling desensitized and powerless. These feelings were attributed to the normalization of discrimination. White, Mentag, and Kaunda (2020) had similar findings in which minority nursing students did not believe they should report the inequities they experienced. Several participants acknowledged that experiences of discrimination, such as racial implicit bias, among minorities are common. Other students recalled being told accept these types of experiences as just a part of healthcare or were

encouraged to work twice as hard to prove competence. This was similar to another study that examined how Black students from a university respond to race related stressors. Griffith, Hurd, and Hussain (2019) found that students that experienced discrimination were advised by mentors to continue working hard despite the stressors of discrimination. This finding is also supported by the Levels of Racism framework. Internalized racism, which can manifest as one belonging to the stigmatized race, accepts negative messages or limitations and is signified by encouragement to accept their experiences as a part of the job (Jones, 2000).

It was also noted that these participants appeared to have an increased sensitivity to discrimination based on how they responded during the focus group discussion. It seems as if their past experiences of discrimination have created a heightened sensitivity for this topic. This was noticed in a couple of ways. First, when elaborating on something in the video or in practice, the participants automatically used themselves as the person being treated unfairly. This finding was similar in other studies, which suggested that prior experiences of discrimination can cause one to become more sensitive or have an increased perception of discrimination (C. M. Gonzalez, Deno, et al., 2018; Huynh, Huynh, & Stein, 2017). Pearson, Derlega, Henson, Ferrer, and Harrison (2014) also found an association with perceived racism and a heightened psychological reaction such as increased negative affect, thought disturbance about the racist experience, or resentment for the perpetrator.

The personal experiences have also heighted their sense of awareness. Participants that experienced personal discrimination provided responses to questions that

were rich, reflected on racial bias, and reflected on the care that minority patients receive from other races, compared to participants that did not have personal experiences of discrimination. Additionally, they had insight on the role of healthcare systems and racial bias. They critiqued hospitals for not effectively addressing discrimination such as racial implicit bias. These findings are also supported in other studies. Griffith et al. (2019) examined the racial discrimination experiences of black university students and found that their experiences may cause a heightened awareness of racial stereotypes. C. M. Gonzalez, Deno, et al. (2018) also found that minorities who have perceived to experience discrimination, may be more aware of non-verbal behaviors and perceive then as biased.

Implications for Nursing Practice

The findings of this study raise questions about the current standards of nursing practice and have a number of important implications for future practice. First, nursing students are observing nurses provide care that is incongruent with standards of care (ANA, n.d.). The students provided specific examples such as neglecting to address patient needs, not advocating, ineffective pain management, and omitting patient education due to race. Also, evidence has pointed out that this type of role modeling in clinical education negatively influences students into adapting those type of behaviors in their own practice (van Ryn et al., 2015). Lastly, not only has racial implicit bias affected the minority patients, but also minority students. The study findings suggest, that minority nursing students are being treated differently by staff and patients based on their

race. This leaves the student with feelings of mistrust and skepticism with the nursing profession and medical institutions with regards to their future nursing career.

Nurse administrators of teaching hospitals should incorporate the use of surveys with the learning institutions that use the hospitals for clinical training. Surveys should ask students specific questions about the quality of care observed with the inclusion of specific questions to address discrimination such as racial implicit bias. This will allow for the opportunity to uncover some of the issues that students may observe or experience during their clinical education. In addition, surveys that ask specific questions about discrimination such as racial implicit bias should be sent to the patients. A common survey used by hospitals is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a national survey commonly used by hospitals to obtain the perspectives of patients regarding hospital care (Centers for Medicaid & Medicare Services, 2020). The survey does not include any items about discrimination or racial bias.

Specific training for hospital staff is also recommended. Similar to educational institutions, the culture of the institution should be supportive of racial implicit bias recognition and management education, and specific training for the staff. Currently the Association of American Medical Colleges (AAMC) have a four-day workshop to train leaders in healthcare to integrate unconscious bias into their organizations (AAMC, 2020). Other scholars have developed frameworks that focus on areas of racial implicit bias such as provider communication or the patient's perspective (C. M. Gonzalez, Deno, et al., 2018; Haiwara, 2019). The IOM (2002) and NLN (2015) have both made

recommendations in response to racial implicit bias and its contribution to health care disparities. Therefore, there is a call to action for administrators of nursing practice to create environments that enables students to be prepared to care for the needs of all populations (NLN 2015).

Implications for Nursing Education

This study has found that, not all of the nursing student participants could accurately define the term racial implicit bias. Some of the participants mentioned what they learned in school regarding bias and diversity. One focus group mentioned that their clinical instructor took them to a lecture on health disparities and minorities. Evidence has proposed that positive experiences are associated with decreased racial implicit bias (van Ryn et al., 2015). Additionally, all nursing students should have a clear understanding of racial implicit bias and its relationship with healthcare disparities. Therefore, this points out the needed nursing curricular changes.

In order to successfully develop and implement curricular changes to effectively address and manage racial implicit bias, there must be a culture that supports the instruction of implicit bias within the educational institution and faculty should be qualified to teach this topic (Gonzalez, Garba, et al., 2018). Evidence suggested that curricular changes are dependent upon the climate of the educational institution and the competency level of faculty topic (Gonzalez, Garba, et al., 2018). Gonzalez, Garba, et al. (2018) also noted the need for comprehensive faculty development in order to ensure competence in teaching how to address and manage implicit bias. In addition to competence, Sukhera (2018) noted that faculty should embody certain characteristics

such as approachable, inclusive, open-minded, and encouraging in order to create a safe learning environment. This type of training can empower nursing faculty to effectively address and problem solve issues such as when a student encounters or witnesses a minority patient experiencing discrimination such as racial implicit bias during clinical learning experiences.

Evidence also suggests that racial discrimination experienced by minority students can negatively impact student success (Motz & Currie, 2019). Therefore, it is imperative for nursing programs to ensure that the appropriate resources are in place to address the needs of all students. Mentoring has been noted in the literature as effective in supporting and fostering inclusiveness with minority undergraduate students that have experienced discrimination (Griffith et al., 2019; T. M. Johnson et al., 2020). Nursing programs would benefit in developing a similar program to address the issues of discrimination that minority students face during their education.

Lastly, nursing curricula revisions to include implicit bias instruction are needed. Gatewood, Broholm, Herman, and Yingling (2019) designed and implemented an implicit bias learning activity with learning objectives such as summarizing how implicit bias impacts healthcare and identifying a resource for self-assessment of implicit bias. Another strategy for curriculum design includes using a framework as a guide. Sukhera (2018) proposed a six key feature framework to integrate implicit bias recognition and management in healthcare professional education. Creating a safe learning environment, knowledge of the science of implicit bias, and the impact of implicit bias on behaviors and patient outcomes are some of the key features of this framework. Sukehera (2018)

also suggested how hidden curriculum influences may interfere with implementation of the revised curriculum. Nursing education is responsible for generating front line healthcare providers, therefore there is a call to action for administrators of nursing education to revise nursing education programs to address racial implicit bias which would assist with improving healthcare disparities.

Implications for Nursing Research

Currently, most of the studies of racial implicit bias in healthcare students are only focused on medical students. There is evidence that supports the need to study students early in the clinical education, that racial implicit bias may exist in the "informal curriculum", and the informal curriculum is implemented by examples of poor role modeling and institutional culture (R. Harris et al., 2018; Hernandez et al., 2013; van Ryn et al., 2015). Additionally, there are few studies that include nursing students (Dunagan et al., 2016; Schultz & Baker, 2017).

The focus group participants in this study varied in their knowledge of racial implicit bias, but they all recognized when minority patients were treated unfairly and received subpar care due to race. Also, some minority participants personally experienced racial implicit bias and suffered from those experiences. However, it is not clear if all of the participants clearly understand what racial implicit bias is, how it impacts patient care outcomes, and the importance of the role that institutions play in healthcare disparities.

These study findings have added to the racial implicit bias and healthcare education research. These findings also further support the need for more research on this topic. In order to make the needed changes to nursing curricular, student perspectives

should be studied, therefore this study should be replicated in other areas of the country. In addition, intervention studies are needed. Programs need to be developed in which students are introduced to racial implicit bias and its connection to health care disparities. Programs also should provide opportunities to reflect and support to students that are faced with various types of racial implicit biased experiences during their education. These recommendations for research will allow the nursing profession to answer the IOM and NLN's call to affectively address racial implicit bias and healthcare disparities (IOM, 2002; NLN, 2015).

Implications for Theory

The Levels of Racism framework was used by the researcher to guide this study. Jones's (2000) framework allows for an understanding of racism on three levels: institutionalized, personally mediated, and internalized racism. The examples of discriminatory actions by the nurse represented The Levels of Racism framework constructs of being personally mediated, institutionalized, and internalized.

The 11 focus group guided questions used to gather data were guided by the three levels of this framework. This allowed for getting the perspectives of the participants on a deeper level. Over the past two decades, the racial implicit bias research has focused mostly on the behaviors of individuals. Scholars have pointed out that health care inequities exist due to structural racism (Delgado & Stefoncic, 2017; Ford & Airhihenbuwa, 2010; Freeman et al., 2017; Jones, 2000; Saetermore et al., 2017). In addition, scholars are called to focus on the structural issues versus continuing to focus on the issues of individuals. Jones's (2000) framework does allow for this deeper view.

Therefore, it was imperative to gain the perspectives of the participants using this framework.

In addition to gaining a deeper understanding of racism, Jones's (2000) framework also allows for the development of new hypothesis for racial differences in health outcomes and to develop interventions to eliminate racial differences. This is exemplified in the work undertaken by Medlock and colleagues' (2017) didactic curriculum for psychiatric residents. It can be suggested that utilizing the Levels of Racism framework to create or revise using nursing curricular would be beneficial in effectively addressing racial implicit bias and healthcare disparities.

Limitations

A limitation to this study includes response bias. The recruitment flyers and consent forms described the study as exploring nursing care experiences with minority patients instead of using the term racial implicit bias. This was done as an attempt to address social desirability. However, the focus groups still may have been biased with their responses, due to the race of the researcher. Also, the findings of this study is not generalizable due to the small sample size of five focus groups from a southeastern state in the United States.

Conclusion

Racial implicit bias continues to be a contributing factor to healthcare disparities and there has been a call to address this issue with healthcare providers (Fiscella & Sanders, 2016; IOM, 2000; NLN, 2013). Since nurses are frontline healthcare providers, the nursing discipline needs to respond to this call. Evidence suggests that intervening at

the beginning of students' clinical education can yield positive outcomes (C. M. Gonzalez et al., 2014; Hernandez et al., 2013). Therefore, the purpose of this study was to describe the perspectives of nursing students about racial implicit bias and patient care, based on their clinical learning experiences.

The perspectives of nursing students regarding racial implicit bias and patient care were examined and resulted in different levels of knowledge in understanding the term racial implicit bias, however all were still able to recognize discrimination against minority patients and were angered by it. In addition, minority students personally experienced discrimination, some as patients, but most as nursing students. One focus group best represented this finding. Talking about these experiences can cause negative emotional responses. These experiences may also have influenced a sensitivity to discrimination and a heightened awareness in identifying discrimination.

These findings present various issues that need to be addressed. The participants in this study are witnessing discrimination and are being role modeled by hospital staff towards nursing care that is a deviation from the standards of practice during their clinical education. In addition, the minority participants are dealing with personal experiences of discrimination. This qualitative descriptive study, with the use of the Levels of Racism framework, has touched on the various levels of racial implicit bias and how they collectively contribute to healthcare disparities. Therefore, the discipline of nursing, using the same critical lens, need to effectively address these issues in nursing education and practice that have surfaced from the findings of this study.

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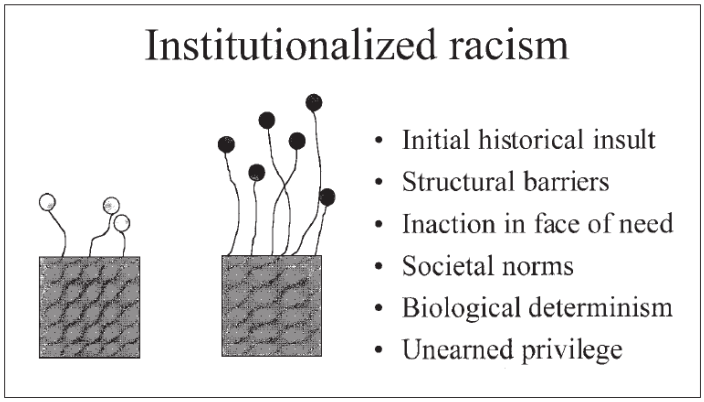
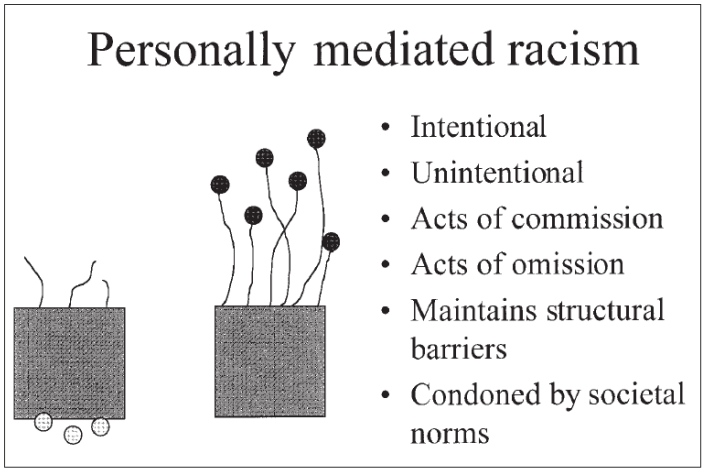
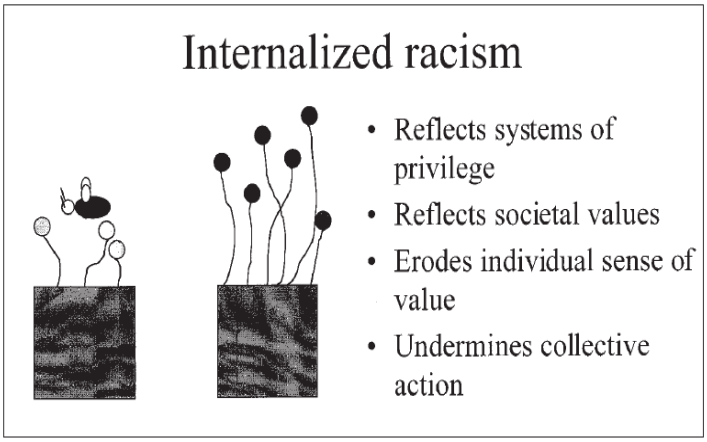
APPENDIX A

LEVELS OF RACISM FRAMEWORK







APPENDIX B

QUESTIONS GUIDED BY LEVELS OF RACISM

Questions	Levels of Racism Concept
What are your thoughts about the video you just saw?	Personally mediated racism
How would you describe this?	Personally mediated racism
Have you seen this in your practice?	Personally mediated racism
Has this ever happened to you?	Personally mediated racism
How do you feel about this?	Internalized racism
Why do you think the nurse responded that way?	Institutionalized racism
What do you think about the way the nurse responded?	Personally mediated Institutionalized racism
How do you think that made the patient feel?	Personally mediated
Have you ever reflected on the care diverse patients may be receiving by members of other racial groups?	Internalized racism
Are you familiar with racial implicit bias?	Institutionalized racism
How would you define racial implicit bias?	Personally mediated
Have you seen any efforts by hospitals to address racial implicit bias?	Institutionalized racism

APPENDIX C

CLINICAL VIGNETTES

Vignette #1

Nurse

Caucasian mom

The **nurse** is working in a mother baby unit. She goes to see her first patient. A **Caucasian woman** that has just had her first baby. When the nurse walks in she goes out of her way to be kind to the patient. “Good morning, congratulations on your baby Mrs Spell. I am going to do a quick assessment (fundus, lochia, breast, edema, pain does teaching/explaining for each assessment). Asks patient if she is breast feeding then go into breastfeeding support, offer breast pump, and ongoing support for after discharge. Also lets the patient know if she gets uncomfortable, she has prn medications ordered and to call her for some.

Vignette #2

Nurse

African American mom

The nurse, then goes into second patient’s room, an AA woman that has just had her first baby. The nurse (using a different affect, less friendly) quickly introduces herself as the nurse. Begins assessment (fundus, lochia, breast, edema, pain does not provide same teaching). The patient complains of extreme soreness of perineal area. The nurse encourages the patient to use the ice packs, and encourages her to put her “big girl pants on, having a baby hurts.”

APPENDIX D

FOCUS GROUP GUIDE

We are interested in your point of view based on your clinical learning experiences, so there no right or wrong answers. I want to encourage everyone to participate. Since this is a focus group, there may be a risk maintaining confidentiality. Therefore, we do ask that you do not share or discuss any of the details of this session with others.

1. What are your thoughts about the video you just saw (Personally mediated racism)?
2. How would you describe this?
3. Have you seen this in your practice?
4. Has this ever happened to you?
5. How do you feel about this?
6. Why do you think the nurse responded that way?
7. What do you think about the way the nurse responded?
8. How do you think that made the patient feel?
9. Have you ever reflected on the care diverse patients may be receiving by members of other racial groups?
10. Are you familiar with racial implicit bias?
11. How would you define racial implicit bias?
12. Have you seen any efforts by hospitals to address racial implicit bias?

APPENDIX E

CODES AND THEMES

Theme: 1 Some were not certain, but all certainly recognize discrimination, and were angered.	
Codes	**Data Excerpt**
Negative actions/behavior	Tone of voice was different, body language was different, word choice and obviously action, what she chose to do. How helpful she chose to be
Negative characteristic	It was unprofessional because I thought she was violating scopes and standards of practice
Negative student response/emotional response	It makes me angry
Inequity	It was obvious that she treated the white patients different than the African-American patients.
Standard of care	She wasn't providing the quality of care. The quality of care was totally different. Because the black person was complaining about pain. What do we know about pain? Pain is whatever the patient says it is. You can't tell a patient to put your big girl panties on. I want to write her up.
Negative outcomes	She can't trust the nurse. She had to call somebody and say something was not right
Lack of self-awareness	it's also insidious, that's not a situation where the nurse did anything blatantly unprofessional, she is not necessarily going to realize or ever get called out on the fact that she is having trouble treating these patients equally
Negative assumption/stereotype	I think there is an assumption sometimes that minorities are not as well educated as others
Normalized	Racial bias is a part of the daily life
Cultural/societal norms	I think she acted that way because of like, how the world is now. Or how the world has been against African Americans
Certainty of RIB	It's not this blatant racism of throwing around offensive slurs or anything like that. It's just this sort of I'm indirectly letting you know that I feel some type of way about you being a different color.
Uncertainty of RIB	I feel like I heard of it before, but no not really
Clinical experience	we had two patients, one was African American the other was Caucasian and I feel like my nurse was biased
Not reflected	I feel like I am like most of the world, if it doesn't happen directly to me, I don't think about it as much

Theme 2: Reflection brings emotion and increased awareness of discrimination.	
Codes	**Data Excerpts**
Role of the institution	I think they attempt, by orientation, they have 45 min blips about cultural disparities
Emotional responses	It makes me nervous because we're about to be new grads.
Personal Experiences	Sometimes when I'm a student nurse on the floor, it's hard to tell if the nurses don't want to be with me because I'm as student or they don't want to have a black student.
Not welcomed/feeling excluded	I have also experienced where you feel like they don't want to take you on
Powerless	Just suck it up and keep it pushing. That is what my clinical instructor said, I am going to face that our entire healthcare career. We are always going to have do twice as much work than everybody else to prove ourselves