

ENHANCING NURSING FACULTY AWARENESS OF IMPLICIT RACIAL BIAS, IN AN
ONLINE TEACHING ENVIRONMENT, AS AN ANTIRACISM STRATEGY TOWARD THE
ELIMINATION OF HEALTH DISPARITY FOR THE BLACK, HISPANIC, AND
AMERICAN INDIAN POPULATIONS

A Disquisition presented to the faculty of the Graduate School of
Western Carolina University in partial fulfillment of the
requirements for the degree of Doctor of Education.

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To my husband, Wesley, who kept asking “when will you be finished “ and honestly did not believe this day would ever come.

I am humbled by the gift that God has given me to be in this place at this time in my life. I pray that this work will help raise awareness of the existence, and negative impact, of implicit bias on health disparity, support change in the way we interact with our patients, and ultimately improve the health status of the Black, Hispanic, and American Indian populations.

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Thank you to my Disquisition Committee. You have been of great support from my proposal defense to completion. I am blessed that you agreed to be part of this (longer than expected)

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ABSTRACT

Enhancing Nursing Faculty Awareness of Implicit Racial Bias, in an Online Teaching Environment, as an Antiracism Strategy Toward the Elimination of Health Disparity for the Black, Hispanic and American Indian Population

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Chair: Dr. Yancey Gulley

There is a long history of health disparity between the Black, Hispanic, and American Indian, and the White population even though the United States of America has the highest per capital health care expenditures than any modernized country in the world. This healthcare divide is perpetuated by system which focuses on the majority population and does not adapt to the needs of the minority population. Healthcare providers do not intentionally provide a lesser standard of care for their “not White” patients; however, the caregiver’s unconscious (implicit) bias may have a negative effect on access to care, treatment choices, and health outcomes. I believe that nurses have the great opportunity to change this environment of inequity and the best opportunity to raise awareness of implicit bias will be in the nursing education experience.

Eight faculty members representing our undergraduate, graduate, and doctoral programs participated in a six-week series of facilitated sessions each lasting between one and two hours in an online environment. The sessions were designed to provide various types of learning experiences intended to increase awareness of implicit bias. The quantitative measures did not demonstrate appreciable change in the level of bias. Qualitative feedback from the faculty participants indicated a level of increased awareness and affirmed that implicit bias awareness activities must continue with faculty and students.

The Disquisition

The EdD was first offered at Harvard University in 1921 to prepare school leaders with the knowledge and skills to solve problems. Structurally the PhD and the EdD were very similar in curriculum and both included a research-based dissertation. The greatest distinction between the PhD and EdD is the intent for the research. The rigor is the same and there are similarities in structure, however, the PhD is more theoretical and the EdD focus is problem solving.

The process to develop leaders is very different than the process to prepare researchers (Lomotey, 2018). The Executive Doctor of Education (EdD) program in Educational Leadership at Western Carolina University is focused on the development of scholar practitioners who are prepared to use research to inform solutions to a problem that has been identified in the educational setting. WCU has been a member institution since 2014 within the Carnegie Project on the Education Doctorate (CPED). Participation in this consortium has been instrumental in support of the dramatic changes in the WCU EdD program design, focus, and outcomes. The Disquisition was adopted as the capstone for the EdD program: it is unique in that it is a “formal, problem-based discourse or treatise in which a problem of practice is identified, described, analyzed and addressed in depth, including methods and strategies used to bring about change and to assess whether the change is an improvement” (Lomotey, 2018, p. 4). The term disquisition was chosen for this new model of scholarly writing in order to make a clear separation from the dissertation model. The disquisition encourages the focus on a problem of practice to support development of the ability to identify, assess, and solve problems from the practitioner’s experience in daily work life. This focus on problem solving in the disquisition model is supported by the use of improvement science to provide process and meaning for research (Bryk et. al, 2015). “As a methodology, the problem-focused, user-centered approach that characterizes the science of improvement naturally lends itself to the daily problems faced in

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situ by educators (Crow, Hinnant-Crawford, & Spaulding, 2019).” The use of an experimental intervention to test a theory for improvement, collect data, and continue with iterative cycles of tests of change promotes true improvement and not merely an episode that is soon forgotten and the improvement opportunity is lost. The greatest value for the disquisition model at WCU is that the process of disquisition development begins early in the program when you identify a problem of practice. The activities of learning throughout the curriculum are used to engage the student in the application of the concepts as they develop the sections of disquisition. The disquisition is research in practice used by scholar practitioners to solve real problems in the education setting.

Introduction

There is evidence of broad differences in health status between the Black, Hispanic, American Indian and White populations living in the United States of America (USA). This is true across every indicator of health and wellness despite multiple funding and programmatic initiatives over the last 30 years aimed at closing the gap (Artiga, et.al, 2016). Health is defined by the World Health Organization (WHO) as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (1948, p.1). By default, using this definition, anything less than wellbeing, not just the absence of disease/infirmity, is undesirable. Health status, the level of health, may be informed by many factors such as: socioeconomic status, race, ethnicity, education, personal behavior, access to quality health care, and other environmental factors. The wide range of health status between various groups of people is known as health disparity. Health disparity is defined by the Centers for Disease Control (CDC) “as preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations” (2008, para 1). To reduce health disparity between racialized populations in the United States of America (USA) we must clearly understand disparity, investigate causes for the differences in health status, and evaluate methods to ameliorate the causes and support health equity. Health inequity generally exists because of unequal access to healthy living conditions and resources; therefore, we need to explore the nuance of these factors as well as the opportunities that exist or need to be created to counter them.

There have been many initiatives which attempted to improve outcomes for all patients by standardizing care processes with the premise that if you ensure all patients receive the same care then all patients would have the same positive outcomes. Providing equality-based care to persons living in inequitable realities does not improve results. Improvement initiatives designed

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to reduce health disparity have been disappointing due in part to broad-brush strategies that ignore socio-cultural and socio-political realities which create the disconnect between dominant and non-dominant racial/ethnic groups in the USA.

A major driver for “quality improvement” activities in health care systems since 2006, has been to achieve high scores on established quality measures in order to maximize reimbursement from government and insurance payors. There are two components of healthcare quality metrics (meeting expected length of stay and outcomes of care for the diagnosis) and the patient’s perception of the quality of care. Public posting of quality scores has been an effective motivator for health care staff in healthcare organizations resulting in overall improvement in outcomes and satisfaction. However, we have not seen appreciable improvement in care and outcomes for the Black, Hispanic and American Indian populations. The quality scores are aggregated for internal and public reporting. The perception of care data is collected after hospital discharge via a telephone survey. The data does not break out the percentage of Black, Hispanic and American Indian patients who are contacted for post discharge surveys shared as part of the report. Posting quality scores by racial/ethnic populations may be a strategy that would highlight differences in quality of care, outcomes, and inspire quality improvement strategies specifically focused on patient focused care, and subsequently reduce health disparity. Unfortunately, health systems, payors, and government agencies have not incorporated metrics of quality of care by racial/ethnic population into their quality reports. This one change has the potential to drive healthcare entities to actively work toward the reduction of disparity in health care quality and patient outcomes for minority populations.

My experience in healthcare leadership is that health disparity has become accepted as inevitable norm. This acceptance coupled with a feeling of being helpless to affect change perpetuates an unconscious, at best, intentionally negligent at worst, sanction of a lower quality

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of care for minority populations. I recall a personal experience with unconscious complicity to disparity through my acceptance of a lower quality of care for the Hispanic population while I was a Chief Nursing Officer at a hospital. Many years ago as a member of hospital leadership in a rural hospital, we began to see an increasing number of Spanish speaking patients at our rural hospital. We did not have translation services readily available for the patients with little or no knowledge of the English language who were entering our Emergency Department and Labor and Delivery units for care. There was one physician and one kitchen employee who spoke Spanish and we drafted them into service when possible, however more often we relied on family members or crude drawings to communicate. Contract services for face-to-face Spanish/English translators were not available at that time and telephone translation services were quite expensive. The executive leadership team decided it was too costly to supply the level of translation services required to ensure access for our growing Hispanic population. I always considered myself as a champion for high quality care and hated the situation, however, I accepted this “no” answer to equitable quality care for our Hispanic patients as “the best we could do with what we had”. I did not take a firm stand to refuse to allow this unacceptable standard of care. My complacency perpetuated a terrifying hospital experience and substandard care for our Hispanic patients during two of the most stressful hospital encounters, mothers in labor and emergency care. It is but one example of how a “caring” White healthcare provider can be desensitized to accept chronic inequity for anyone who is not a White English-speaking insured person. A systemic pattern of substandard care for non-White populations and inadequate provider education regarding bias in the delivery of health care continues to contribute to patient hesitance to seek care (translated as fear) from the health care system and perpetuates poor outcomes and health disparity.

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Unfortunately, more than 20 years later, this scenario is still experienced every day in healthcare facilities across America. Diagnosis and treatment decisions should be based on data and physical assessment, however, for the Black, Hispanic, and American Indian populations the care and treatment decisions are often based on provider perceptions and bias. One example of this is found in many hospital Emergency Departments (ED). Decisions regarding patient treatment may be jaded by the provider's own racial bias or from a learned bias about patients who are perceived to misuse services in the ED; the bias is that they should see their primary care provider instead of taking time from patients who need emergency care. Other patients are labeled "frequent fliers" which is slang for patients who come to the Emergency Department (ED) frequently because they are noncompliant with their treatment regimen, seeking drugs, or refuse to use the appropriate care provider. Often patient complaints and symptoms are minimized until the patient finally returns to the ED in critical condition. The patient is then blamed for creating their medical condition through their noncompliance.

I will share the experience of two of three friends who received substandard care in different EDs and a third friend who had a very different experience as an example of the inequity in care. The first is the story of a Black friend who has a serious chronic condition which causes episodes of severe pain. This friend presented to an ED with a complaint of severe pain. There had been several prior visits to this facility for this well documented illness. On this night a cursory assessment was performed by the doctor, however, appropriate pain management was not provided. Even though she was obviously in extreme pain no treatment options were provided. My friend sensed that they had labeled her as a drug seeker and therefore disregarded the complaint of pain. She was ultimately admitted and continued to receive minimal medical care. After several days this well-educated, articulate Black person was discharged, essentially untreated. The very clear message was that the standard of care was compromised because of

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the caregiver's perception that Black/Hispanic/American Indian, (i.e., not White) persons chronically abused the healthcare system seeking drugs to support their narcotic addiction. The anger about this experience was still present several months after the episode and unfortunately, feeling personally diminished by the experience she is terrified of needing care in the future.

I have a White friend who went to the same ED with chest pain, no history of heart disease. The physical exam and test results indicated that the pain was not cardiac and yet the provider insisted that she take a bottle of 16 oxycodone pills home in case the pain returned, although she voiced her adamant objection to taking narcotics. She has a history of drug abuse and shared that she had been clean for 25 years. The provider still pushed the bottle of pills into her hand. She brought them to me and I took them to a disposal station. These are just a few examples of how implicit, and at times conscious, bias is producing a dual standard of care. Black, Hispanic, and American Indian patients must be able to convince care providers of the integrity of their complaints and still may not receive appropriate care. White people do not face that challenge! The power of implicit bias cannot be allowed to continue to perpetuate disparity in health and healthcare between the Black, Hispanic, and American Indian populations and the White population.

My third example is a colleague who is a Native American. She has a child with a chronic illness. Over the years of treatment, the mother has become quite proficient in her understanding of nuances of the disease as well as effective treatment and care options for her child. They receive extraordinary respectful care at their community hospital and yet when they go to a "White" hospital for specialty care the physicians speak very slowly using simple language as though they assume she knows nothing about her daughter's disease or current situation. She often interrupts and shares her child's history in a fluent manner and they act shocked that she could communicate and understand this complex illness. This has happened so

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many times that she now opens the conversation with new physicians by bringing them up to speed on her knowledge of the disease and management of her daughter's care.

Now, as a nursing faculty member, I have an opportunity to support improvement in the quality of healthcare provided to Black, Hispanic, and American Indian populations. This improvement can begin with raised faculty awareness of implicit bias and its negative affect on patient's health and wellbeing. The choice to use the phrase "enhancing nursing faculty awareness" was not a casual choice. Enhance is defined by Oxford Languages Dictionary as to "intensify, increase, or further improve the quality, value, or extent of". In this case the goal of this research to "intensify, increase, or further improve the quality, value, or extent of" care provided to minority population through awareness of the effect of implicit bias. We can build on the innate desire of nurses to provide comfort, promote healing, and improve health and wellbeing. Raising faculty awareness of the effect of implicit bias will encourage modifications to curricular activities for our students at every level. We can disrupt the pattern of health disparity in the Black, Hispanic, and American Indian populations through a generation of nurses who recognize the effect of their bias in the provision of care, can raise awareness of inequity in the workplace, and improve the quality of care for minority populations.

The purpose for this improvement initiative was to raise faculty awareness of the presence of implicit racial/ethnic bias. The process included various experiential learning techniques intended to stimulate self-reflection regarding implicit bias and thus increase nursing faculty capacity to realize the impact of bias on disadvantaged populations. My research question was: Do experiential education activities promote self-awareness of implicit racial/ethnic bias and its impact on health disparity? My goal is that this improvement research will stimulate an ongoing discourse in the school of nursing which will inspire antiracism and result in curricular changes which raise awareness of the presence and impact of implicit, and conscious,

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racial/ethnic bias and the power of nurses to positively impact health disparity. The cycle of poor care and the perpetuation of health disparity due to provider bias must be broken if we expect to see improvement in health status for the Black, Hispanic and American Indian populations.

The Problem of Practice

The United States of America (USA) has a long history of variation in health status between the Black, Hispanic, and American Indian population when compared to the better overall health status of the White population. Dame Margaret Whitehead, head of the World Health Organization (WHO) Collaborating Centre for Policy Research on the Social Determinants of Health, defines health disparity as “differences in health which are not only unnecessary and avoidable but, in addition, are unfair and unjust” (as cited in Carter-Pokras & Bauquet, 2002, p. 427). She further contends that health disparity is unethical and unacceptable. Dr. Whitehead’s position is that everyone should be able to live at their full health potential and that disadvantages to the achievement of that potential must be eliminated to the extent possible. Disparity and inequity are often used interchangeably, however, they have vastly different meanings. Disparity merely states that there is a difference. Inequity has a moral and ethical tone with a message of injustice, unfairness and unnecessary pain, discomfort, and poor outcomes (Meghani & Gallagher, 2008). There is no evidence that health disparity has its foundation in a genetic predisposition that would contribute to the variance in health status for these populations. There is, however, evidence that health disparity is influenced by socioeconomic status, culture, health system processes, English language skills, and the relationship between a patient and their care provider. There has been some improvement in a few indicators of health disparity between the Black, Hispanic, and American Indian populations and the White population, however, overall improvement has been negligible in spite of substantial funding initiatives and hundreds of failed programs.

The Department of Health and Human Services (DHHS) launched a comprehensive agenda for health promotion in the document Healthy People 2000 in 1990, with an update in

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2000, followed with ongoing reports every ten years with the goal to eliminate health disparities (Carter-Pokras & Baquet, 2002). DHHS proposed sweeping recommendations for disease prevention and health promotion which were well received. However, debates ensued regarding definitions of health disparity versus health inequality, personal responsibility, varying approaches to the measurement of diversity, and decisions regarding what is avoidable and affordable. The inability to gain consensus and the influence of political agendas diminished the effectiveness of the Healthy People agenda's ability to achieve the goal of health equity. The Healthy People 2030 (2020) agenda continues the effort with goals to diminish the impact of social determinants of health. Health Disparity has been widely discussed, position papers presented, and programs have been developed for more than thirty years and yet the ratio of health disparity between the White population and Black, Hispanic and American Indian populations has not appreciably improved.

The National Institutes of Health (NIH) 2021-2025 Strategic Plan states that previous efforts to improve health disparity failed because the issue of minority health is too complex. The current strategic plan separates the work plan for NIH research into two components, the science of minority health and the science of health disparity. The separation of the two disciplines for the NIH 2021-Strategic Plan resulted in the following revision to their definition of minority health; “minority health refers to the distinctive health characteristics and attributes of racial/ethnic minority groups... that can be disadvantaged due in part to being subject to potential discriminatory acts” (NIH, 2021, p. 6). The Minority Health Division will focus on measurement and description of the health status of minority communities to develop consistent definitions and measurement methods for specific aspects of health in minority racial/ethnic groups which can then be more effectively targeted. NIH has defined Minority Health Research as “the scientific investigation of distinctive health characteristics and attributes of minority

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racial/ethnic groups who are usually underrepresented in biomedical research to understand health outcomes in these populations” (2021, March 31, p. 6). The Health Disparity Division will take a deep dive into the differences between specific disadvantaged groups and the White reference population in order to better identify cause and provide clearer focus for intervention. NIH defines “health disparity populations as racial/ethnic minority populations.... less privileged socioeconomic status (SES) populations, underserved rural populations, sexual and gender minorities (SGM), and any subpopulations that can be characterized by two or more of these descriptions” (2021, March 31, p. 6). Both disciplines, minority health and health disparity, acknowledge the wide range of difference in health status between the Black, American Indian, Hispanic, and White populations.

The problem identified by the NIH, the inability to address the needs of minority populations due to the scope and magnitude of the issue and inadequate representation of pertinent data, has also been an issue in nursing education. There is an opportunity to raise faculty awareness of the impact of health provider implicit bias on the quality of patient care and subsequent variation in health outcomes and work together to find novel ways to incorporate ongoing awareness raising activities into the curriculum.

The American Association of Colleges of Nursing (AACN), recognized as the national voice for academic programs, provides guidance for accreditation for nursing programs regarding the development of curriculum and through rigorous quality standards for nursing education. The Essentials for Baccalaureate Nursing (Essentials), 2011 revision, include the following 10 domains of nursing practice.

Domain 1: Knowledge for Nursing Practice

Descriptor: Integration, translation, and application of established and evolving disciplinary nursing knowledge and ways of knowing, as well as knowledge from

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other disciplines, including a foundation in liberal arts and natural and social a scientific body of knowledge that guides nursing practice regardless of specialty or functional area.

Domain 2: Person Centered Care

Descriptor: Person centered care focuses on the individual within multiple complicated contexts, including family and/or important others. Person centered care is holistic, individualized, just, respectful, compassionate, coordinated, evidence-based, and developmentally appropriate. Person centered care builds on a scientific body of knowledge that guides nursing practice regardless of specialty or functional area.

Domain 3: Population Health

Descriptor: Population health spans the healthcare delivery continuum from public health prevention to disease management of populations and describes collaborative activities with both traditional and non-traditional partnerships from affected communities, public health, industry, academia, health care, local government entities, and others for the improvement of equitable population health outcomes.

Domain 4: Scholarship for Nursing Practice

Descriptor: The generation, synthesis, translation, application, and dissemination of nursing knowledge to improve health and transform health care.

Domain 5: Quality and Safety

Descriptor: Employment of established and emerging principles of safety and improvement science. Quality and safety, as core values of nursing practice, enhance quality and minimize risk of harm to patients and providers through both system effectiveness and individual performance.

Domain 6: Interprofessional Partnerships

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Descriptor: Intentional collaboration across professions and with care team members, patients, families, communities, and other stakeholders to optimize care, enhance the healthcare experience and strengthen outcomes.

Domain 7: Systems-Based Practice

Descriptor: Responding to and leading within complex systems of health care. Nurses effectively and proactively coordinate resources to provide safe, quality, equitable care to diverse populations.

Domain 8: Information and Healthcare Technologies

Descriptor: Information and communication technologies and informatics processes are used to provide care, gather data, form information to drive decision making, and support professionals as they expand knowledge and wisdom for practice. Informatics processes and technologies are used to manage and improve the delivery of safe, high quality, and efficient healthcare services in accordance with best practice and professional and regulatory standards.

Domain 9: Professionalism

Descriptor: Formation and cultivation of a sustainable professional nursing identity, accountability, perspective, collaborative disposition, and comportment that reflects nursing's characteristics and values.

Domain 10: Personal, Professional, and Leadership Development

Descriptor: Participation in activities and self-reflection that foster personal health, resilience, and well-being, lifelong learning, and support the acquisition of nursing expertise and assertion of leadership (AACN Essentials, 2011, p. 11-12).

Many words in the domain descriptions point toward provision of equitable care as well as self-awareness of bias and awareness of system/structural bias. This awareness can support

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improvement in patient care and reduction of health disparity; however, the words do not explicitly call out the power of implicit bias to negatively impact health care and health for these populations. The AACN Essentials 2021 revision maintain similar standards as the 2011 version, however they are defined by Domain, Competency, and Sub-competencies and are organized developmentally as Entry Level Nursing Education and Advanced Level Nursing Education. The competencies in the AACN Essentials 2021 that are most closely related to this research are listed below:

- Establish mutual respect with the individual and family.
- Demonstrate relationship-centered care.
- Consider individual beliefs, values, and personalized information in communication.
- Apply nursing knowledge to gain a holistic perspective of the person, family, community, and population.
- Engage the individual and the team in plan development.
- Address the individual's experiences and perspectives in designing plans of care.
- Assist the individual to engage in self-care management.
- Employ individualized educational strategies based on learning theories, methodologies, and health literacy.
- Respect individuals' and families' self-determination in their healthcare decisions (pp. 27-28).

The Essentials are framed in such broad language that it is left to educators (and nurses) to interpret the application of the standards. I noticed that there is not a direct reference to nursing bias, the effect of bias on patient care, or the assessment of nurse bias on patient outcomes. It is implied through the elements of involvement in decision making and relationship-based care. Without faculty recognition of the existence of bias and the impact

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of bias in the provision of care as an important causative factor of health disparity it may not be specifically addressed in the curriculum. It would be more powerful if the document included stronger language with explicit recognition of the impact of caregiver and healthcare system bias presenting a challenge for educators to ensure that nurses, the largest and most influential healthcare workforce who spend the most time with patients, become a driving force for improvement in health care disparity and inequity.

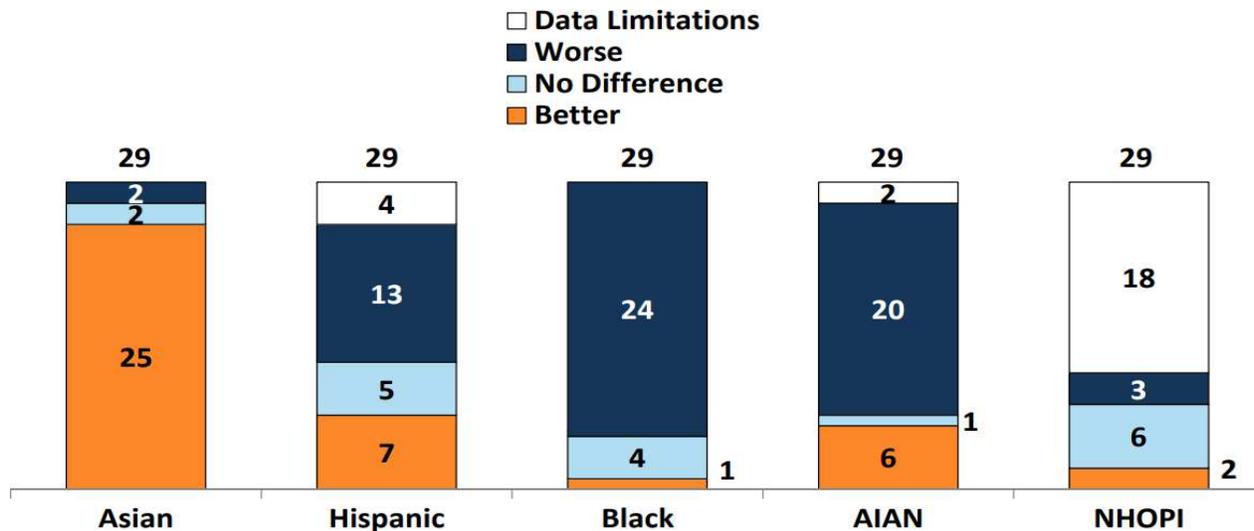
This is a call to action for me as an educator and for our school of nursing! My goal was that this research would provide evidence that competent, caring faculty have implicit bias and that there are experiential activities which can support the recognition of that unconscious bias. These activities can inform a very visible intentional plan to continue this awareness raising process with all faculty members and subsequently implement curricular changes to ensure all graduates of programs in the School of Nursing have the opportunity to learn about the presence of implicit bias and its effect on health status for the Black, Hispanic, and American Indian populations.

Significance of the Problem

There is a wealth of data demonstrating the existence of persistent health disparity between minority populations and the White population in the USA. As we review some of the data that measures health disparity, I must reaffirm the previously stated position that there is no biological/genetic rationale for health disparity between the Black, Hispanic, and American Indian populations as compared to the White population. Artiga, Foutz, Cornachione, and Garfield (2016) evaluated the level of health for the five most prevalent racial/ethnic minority groups in the USA: Asian, Hispanic, Black, American Indian and Alaskan Natives, and Native Hawaiians and Other Pacific Islanders. Each group was ranked using 58 common measures of health status in the following categories: demographics, health access and utilization, health status and outcomes, and health coverage by race and ethnicity. The findings are displayed in bar graphs, in Table 1 below, and indicate the levels of variance when compared to the health rankings for the White population.

Table 1

Health status and outcome measures where groups fared better, the same or worse as compared to White.



AIAN refers to American Indians and Alaskan Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders (Artiga, et. al, 2016, p. 10).

The dark blue bars indicate the number of measures with scores that were worse than the White population and demonstrate the magnitude of health disparity between the Black, Hispanic, and American Indian populations. It is noted that the reliability of the health metrics for the Hispanic population may be understated due to limited availability of interpreter services, transportation issues and a general fear and distrust of the system.

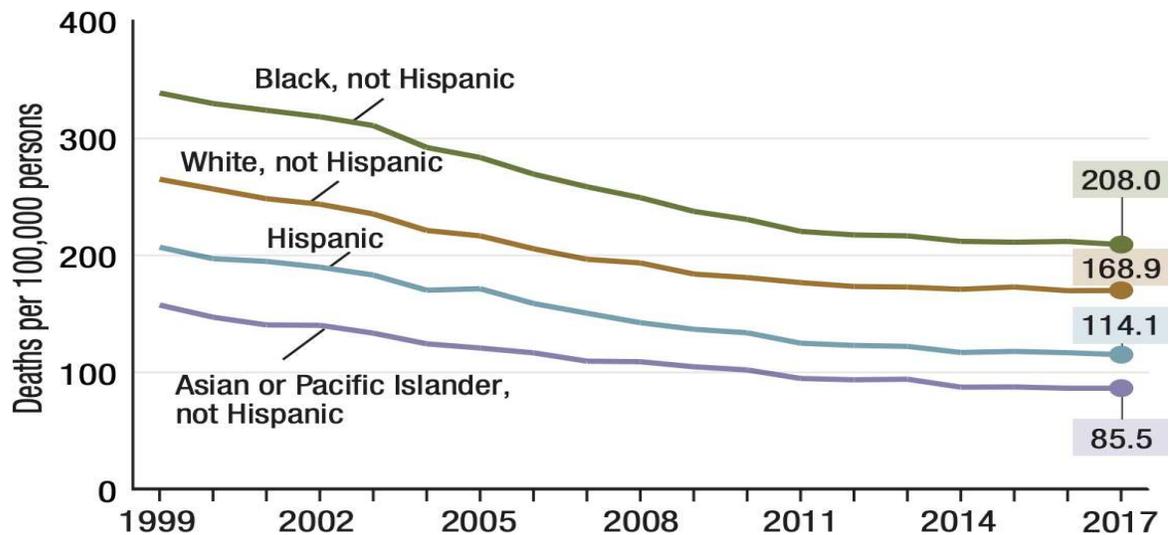
Overall life expectancy in the USA in 2017 was 78.6 years, a decrease from 78.7 in 2016. Life expectancy for the Black population was 75.3 years, Hispanic at 81.8 years, American Indian at 76 years, and White at 78.5 years (National Vital Statistics Reports, 2019, June 24). One cause for the variance in death rate for the Black population is the higher death rate from heart disease compared to other populations, as noted in Figure 1below.

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The graph indicates some improvement in health status with a reduction in overall deaths from 1999 to 2017, however the variance in the disparity rate remains constant between populations.

Figure 1

Age-adjusted death rates for heart disease, by race and Hispanic origin: 1999-2017



National Center for Health Statistics (2019, April)

Another example of persistent health disparity is that Black, Hispanic, and American Indian mothers experience a higher rate of complications of pregnancy than White mothers. These complications include a higher incidence of low birthweight babies and infant death (Oberg, Colianni, & King-Schultz, 2016). The infant mortality rate in the USA is at least 50% higher than other comparable countries and yet the USA spends substantially more in healthcare dollars per capita than any other country. In 2013, the overall infant mortality rate dropped below the national target of 6 per 100 live births to 5.96; the Hispanic rate was 5.1 (the same as White infants); however, the Black infant mortality rate was 11.2, almost double the target! By 2017, the overall infant mortality rate had improved to 5.79, evidenced by the White results at 4.57 and Hispanic results at 5.1; however, the variance persisted with the Black mortality rate per 1000 at

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10.97 in spite of nationwide initiatives to improve maternal and infant health (Peterson-KFF, 2020, October 18).

The percentage of infants with lower-than-average birth weight is a corollary measure related to the health and wellbeing of the mother. The percentage of low birth weight infants in the USA increased from 7.0% in 1990 to 8.3% in 2006 and remained stable for about 10 years. (Oberg, Colianni, & King-Schultz, 2016). The low birth rate percentage for Black infants in 2013 was 13.1%, Hispanic infants at 7.15%, and White infants at 7%. In 2018, the low-birth-weight rate in the USA improved to 8.3% overall with 14.1% Black, 7.4% Hispanic and 6.9% White. The most recent March of Dimes Report Card (2018) indicated continued inequity in the premature birth rates for Black women at 49% higher than all other women. There is an opportunity to improve the health and wellbeing of families through evaluation of the impact of racial/ethnic bias, explicit and implicit, on health status for Black and Hispanic children.

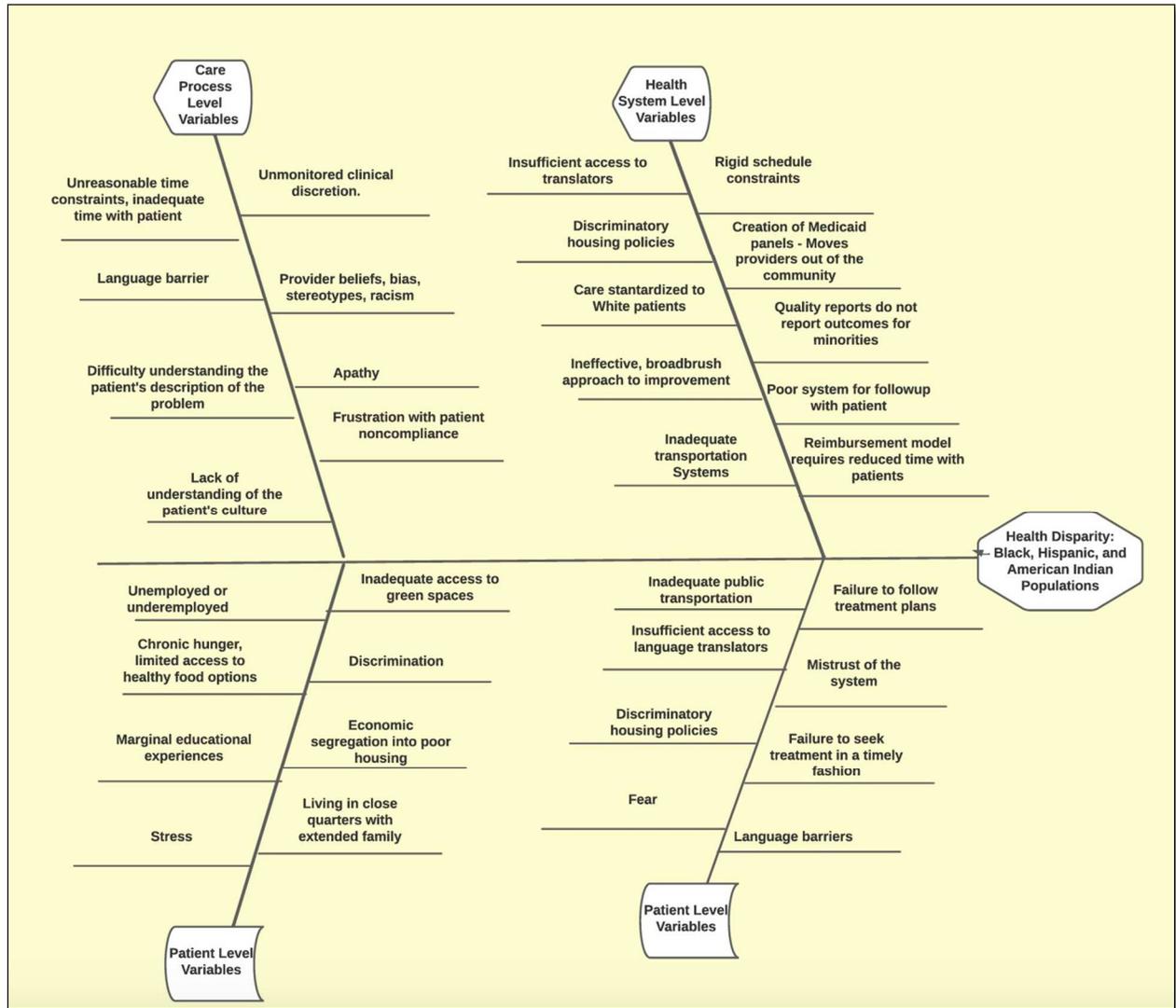
Causes of Health Disparity

The Institute of Medicine (IOM) Report, *Unequal Treatment* (2003), grouped the causes of health disparity into three categories: Patient-Level Variables, Healthcare Systems-Level Factors, and Care Process Level variables which includes the influence of bias, stereotyping, and uncertainty. Socioeconomic factors were noted to be a significant variable contributing to the variance in care. However, most of the research demonstrated that racial/ethnic disparities in care and outcomes remained even after controlling for socioeconomic status. Some of the causative variables which have been found to affect health disparity are presented below in an Ishikawa Fishbone Diagram named Causal Factors Contributing to Health Disparity. The purpose of the fishbone, noted below, is to identify potential causes of the problem and then to assist with determination of the key causes that will be the focus of the improvement process.

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Figure 2

Causal Factors Contributing to Health Disparity



The problem is stated in a box on the right-side center of the diagram. The broad categories of causes: System Barriers, Healthcare Provider Variables, Social and Economic Factors and Patient Level Variables, are stated in boxes at the peripheral ends of the slanted “bones” of the diagram. Causes for each category are placed on either side of the bone toward the spine in the center.

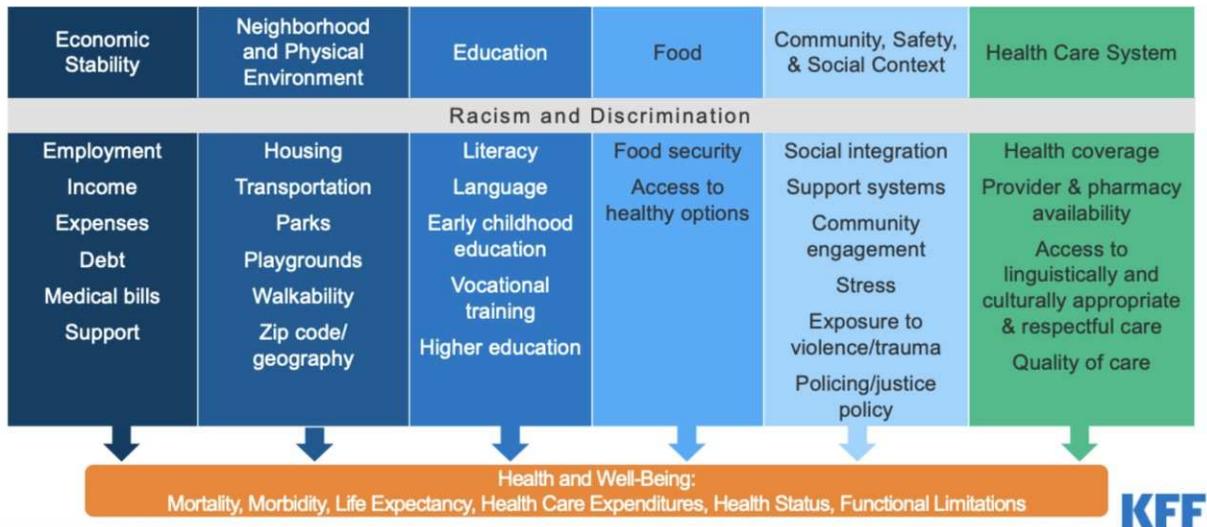
Patient Level Variables

Patient-level variables which impact health disparity were found to include: personal preferences, treatment refusal, the clinical appropriateness of care, failure to follow treatment plans, and failure to seek out treatment in a timely manner. There is a long history of mistrust by the non-White population of the predominantly White health care providers, resulting from trauma from previous negative experiences, poor understanding of care instructions and a general lack of understanding related to using healthcare resources. Overuse of healthcare services by the White population was identified as one factor affecting the range of disparity. However, the impact of overutilization diminished when the data was evaluated based on clinical need and established standards of medical practice. The greatest variance was found in provider decisions related to discretionary treatment and procedures.

Suboptimal socioeconomic factors have a negative influence on health and well-being. The data demonstrates lower overall health status in Black, Hispanic, and American Indian populations who tend to also have a lower income level, live in unhealthy housing, have marginal educational experiences, decreased access to healthy food due to cost, limited access to quality healthcare and inequity in the delivery of health-related services (WHO, 2018). Figure 3, below, groups various components of key socioeconomic factors around six categories which, if inadequate, negatively affect health and health outcomes. The design for this organization of components is intended to provide better focus and support collaboration between organizations and agencies to improve effectiveness of interventions and support

Figure 3

Health Disparities are Driven by Social and Economic Inequities



(Ndugga & Artiga, 2021, May11).

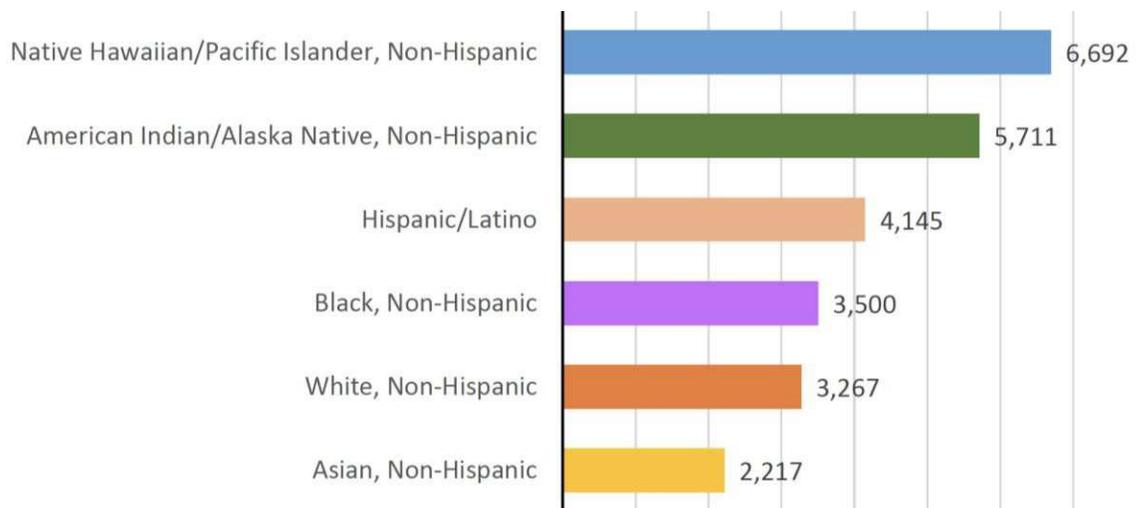
Unhealthy living conditions have been identified as a contributor to health disparity and is believed to be a major driver for the high rates of COVID-19 infection in the Black, Hispanic, and American Indian populations (Walsh, 2020). Black and Hispanic populations are placed at particular risk for chronic and acute medical and mental health problems due to economically induced segregation into housing situations which do not support optimum health, for example: exposure to environmental hazards, living in close quarters with multiple extended family members, a lack of access to green space, and limited access to a healthy diet. The American Indian population has historically chosen to live together with their extended families as part of the cultural heritage of the family unit caring and nurturing elders and young ones. The higher incidence of chronic diseases coupled with living in close proximity to multiple generation has contributed to the higher rate of COVID-19 infection and death in the Black, Hispanic and American Indian populations (Smith 2020, May13; Walsh, 2020). The COVID-19 outbreak

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dramatically demonstrated class and race related vulnerabilities as evidenced by a higher rate of infection and death in the Black, Hispanic, and American Indian communities. The following graph demonstrates an example of the disparity in health outcomes for the Black, Hispanic, and American Indian populations.

Figure 4

Provisional COVID-19 Age-Adjusted Death Rates per 100,000 persons by Race and Ethnicity, Reported through March 6, 2021



Note: While only 53 percent of reported cases had known race and/or ethnicity, the denominators used for calculating these rates are based on national census data. Therefore, these age-adjusted case rates likely underestimate true rates, and the degree of underestimation might vary across the race/ethnicity groups. These age-standardized distributions show what disparities would look like if the age distribution were the same across all race and ethnic groups.

(Simmons, et. al, 2021, March, p 3)

In the early phase of the COVID -19 pandemic, the CDC reported that of the 58 hospitalized COVID-19 patients with recorded race/ethnicity data, approximately 45% (26) were White, 33% (19) were Black, and 8% (5) were Hispanic” (as cited in Walsh, 2020, p.1) indicating a disproportionate percent of the Black population were affected. It was estimated that 200 Black people per day died from COVID-19 who would not have died if they had the same health experience as the White population (Walsh, 2020, p. 1).

Health Care System Level Variables

There are healthcare system-level variables which impact health disparity. These factors include the failure to provide adequate translation services, changes in reimbursement that reward physicians for reduced time with patients, Medicaid conversion to defined treatment panels which often move patients away from a community provider who is more attuned to their needs and understands their values, increases access challenges due to the lack of adequate transportation. An additional negative result of the cost reduction strategies, coupled with the increasing complexity of medical care, has eliminated the opportunity for providers to devote extended time to make sure the patient understands the benefit of treatment and the result of noncompliance. These elements contribute to patient distrust of the system, noncompliance with a treatment regimen and poor health status.

It is natural to assume that disparity in health status might be a result of inadequate funding for health-related services, however, health disparity in the USA between the Black, Hispanic, and American Indian populations and the White population has persisted despite enormous financial investment and multiple health improvement initiatives. Per capita health related spending in the USA is two times higher than other wealthy countries and 28% higher than Switzerland, the country with the next highest investment (Sawyer & Cox, 2018). In 2018, almost 17% of the gross domestic product in the USA, about \$3.7 trillion, was spent on health-related goods and services as compared about an average of 10% for most European countries (USAFACTS, n.d.; Mijulic, 2020). And yet, compared to the 10 wealthiest nations, the USA has the lowest life expectancy rate and the highest suicide rate (Tikkanen & Abrams, 2020). The USA has the highest percentage of adults with multiple chronic health conditions, the highest obesity rate, and has one of the highest hospitalization rates for preventable causes. The definition of health access is having “the timely use of personal health services to achieve the

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best health outcomes” (Millman, 1993). Much of the work to improve health disparity over the last twenty years has been focused on improved access to health care services. The U.S. Census Bureau (2019) reported that 8.5% of the U.S. population did not have health insurance in 2018, up from 7.9% in 2017, when about 574,000 non-citizens were reported as uninsured. In 2013, prior to the implementation of the Affordable care Act, 13.3% were not covered by insurance. About 92% of the population in the USA were covered by some form of public or private health insurance in 2018 and yet there was no improvement in the overall health rankings between the USA and other wealthy countries or the rate of health disparity between the Black, Hispanic and American Indian populations and the White population in the USA (USFACTS, n.d.). It is estimated that there is a \$230 billion (about \$710 per person) savings potential in the USA if excess cost due to health disparity was eliminated.

Care Process Level Variables

Care process level variables are driven by the provider’s inability to develop a healing relationship with the patient. Health disparities may be perpetuated, in part, by bias, discrimination, and stereotype by health care providers (Holland, 2011). Black, Hispanic and American Indians often experience a lower quality of care because of conscious or unconscious discrimination from the medical staff, nursing staff or other caregivers (Fitzgerald & Hurst, 2017). This discrimination may be manifested in overt or covert behaviors such as: discounting patient description of symptoms, withholding or providing very limited patient education due to an assumption that the patient will not comply or will not understand, inadequate communication, dismissive tone of voice, eye rolling, poor eye contact, or physical distancing. Black, Hispanic and Native American patients are often intimidated by members of the medical profession and have been socialized not to complain. Provider behavior during patient interactions is rarely witnessed by other caregivers and may even have become normalized,

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therefore variances in care can be difficult to recognize, measure, report, or correct and is far more prevalent than we imagine.

The quality of the patient's interactions with healthcare providers has an impact on health outcomes (Blair, Steiner, & Havranek, 2011). Overt prejudice, provider discomfort/uncertainty with patient interactions, difficulty understanding the patient's description of symptoms, frustrations about patient noncompliance, and conscious or unconscious personal beliefs or stereotypes negatively affect the provider patient relationship, impact the quality of assessment, education, and treatment, and thereby contribute to health disparity. Often the provider demonstrates these feelings and beliefs through nonverbal communication, however, there has been evidence of overt expressions of bias communicated to the patient. Care process level variables is the least researched of the three factors and may have the greatest impact on health disparity. Smedley, Stith and Nelson (2003) describe clinical discretion as a form of institutional racism. Patients present to care providers with a particular concern or need. Decisions regarding testing, treatment options, and plan of care are influenced by the provider's training, experience, learned societal norms, perception of the patient, as well as legal and cultural constraints, payor, insurance requirements, office culture and organizational pressure to meet productivity and cost containment goals. Prejudice, discrimination, or antagonism directed against a person, or population, on the basis of membership of a particular racial/ethnic group, whether conscious or unconscious, negatively impacts the effectiveness of health services, patient compliance with treatment regimens and meaningful communication between patients and providers. Hundreds of years of inequity and repression in the USA has informed a level of disadvantage for the Black, Hispanic and American Indian population that perpetuates health disparity (Ober, et. al, 2016).

The USA has a 37% higher hospital admission rate than is reported in other comparable countries (Sawyer & McDermott, 2019). The avoidable hospital admission rate is a data element

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that can be used to demonstrate health disparity between populations. A potentially avoidable hospital admission is one which could have reasonably been prevented with appropriate, timely intervention in the community setting. Avoidable hospitalizations are often related to exacerbation of a health problem due to noncompliance with the disease or disorder treatment regimen, for example, taking medications as prescribed, symptom monitoring and reporting, adherence to a special diet and/or level of physical activity (Horne et al., 2013). Black and Hispanic populations were found to be more likely to be noncompliant with treatment plans and experienced a higher avoidable admission rate. Noncompliance is more complicated than merely choosing not to comply with instructions. It is often related to the patient's difficulty understanding the disease process and the expected effect of the treatment regimen, lack of financial resources which impact the ability to get medicines or testing supplies, access to transportation and cost. Other barriers include a perception that previous treatment did not make a difference, the patient experienced an unexpected unpleasant side effect from treatment, and a lack of social and medical support at home (Horne et al., 2013). Many hospital readmissions might have been prevented if the patient, family members, and/or social support system had received effective education regarding the problem, treatment regimen, early warning signs for complications or infection, had regular monitoring and support from a healthcare provider, and adequate access to other outpatient services (Figueroa et al., 2020).

Some people believe that the major cause of health disparity (the differences found in the health status of Black, Hispanic, and American Indian populations when compared to the health status of the White population) is not based on bias toward the Black, Hispanic, and American Indian populations, it is the result of White privilege provided to White people from other White people (DiTomaso, 2015). Privilege is defined as a right, favor or immunity specifically granted to an individual, group or class and withheld from certain others. White privilege is a spectrum

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of benefits and advantages shared solely based on being White. This favoritism exists at every level of society; however, it is generally invisible to the White population. The outcome of White privilege behavior includes sequestering upper-level jobs for people in a certain category, (also called opportunity hoarding or restricted hiring). An example of this privilege, outside of the healthcare environment, is the historical establishment of a monopoly in the landscape gardening business in New York. It did not occur by excluding Blacks, it was reinforced by Italians using influence to ensure that jobs were provided only to Italian Americans (DiTomaso, 2015). White privilege favoritism is reinforced by seeing it as good to help family or friends succeed, it makes people feel good about themselves. It is perpetuated because it reinforces positive relationships, it is not illegal, and is often celebrated within the social network. Opportunity hoarding continues to occur within social groups through advantages earned through connections made at work, educational systems, church, and professional settings. White Privilege is also unconsciously reinforced through the concept of maintaining high standards. For example, the admission criteria for most colleges and universities. Black, Hispanic and American Indian students may not be able to meet the required grade point average or success in college preparatory high school courses because of decreased access to quality schools, extracurricular educational activities, or an expectation from their family that college is a possibility for them. In the college/university example White privilege favoritism is respected as maintaining high standards, ensuring a marketable education and degree.

How can this level of health disparity continue to persist between the Black, Hispanic, and American Indian populations, and the White population? We have seen health care facilities develop cultural sensitivity programs, the USA government has dedicated billions of dollars to the creation of community education initiatives and programs intended to increase access to care, multiple research studies and white papers demonstrating the issues. Why has there been so little

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improvement? The summary document from an IOM workshop in 2012 “How far have we come in reducing health disparities?” stated that the lack of improvement results from the failure to specifically address the causes of health disparity described above: patient level variables, healthcare systems level factors and the role of bias, stereotyping, and uncertainty. The wide gap in health status demonstrated by the disparity data begs the question, why have we been unsuccessful in the elimination of health disparity for the Black, Hispanic and American Indian population in the USA? The landmark report, *Unequal Treatment* (Smedley, Stith, & Nelson, 2002), included a powerful Goethe quote that, in my opinion, summed up healthcare’s failure to address health disparity “Knowing is not enough; we must apply. Willing is not enough; we must do” (p. iii). What do we need to do? Facing the issue of bias in the healthcare system has never been a major focus for health care improvement strategies. Unless we raise awareness and acknowledge the impact of implicit and conscious bias on health disparity there is little hope for equitable delivery of health care and a reduction in health disparity.

Conscious and Unconscious (Implicit) Bias

There is a long history of health disparity in almost every disease and health category between members of Black, Hispanic, and American Indian communities in relation to White populations in the USA. Although many funding and healthcare initiatives have been implemented to address health inequity, we have seen very little improvement. Health disparity may be caused, in part, by the demonstration of conscious and unconscious (implicit) bias by nurses, physicians, and other health care providers toward their minority patients (Marcelin, et. al, 2019; Holland, 2011). The impact of provider bias, particularly implicit bias, has been largely ignored. Empowering healthcare providers with the knowledge of the negative impact of conscious and unconscious bias on health and healthcare is a strategy to improve care and support health equity for minority populations. Nurses are in the unique position, as the largest body of healthcare providers, to be a force for change in the quality and effectiveness of care to benefit our Black, Hispanic, and American Indian patients. We make a formal public commitment to unbiased, patient focused care when we commit to a nursing pledge at nursing school graduation based on the original version crafted by Florence Nightingale. Over time the pledge has been updated to more modern language. The following is a sample of the updated nursing pledge which affirms the commitment by the nurse to “do no harm” caring for patients without prejudice or bias.

Pledge for Professional Nursing

In full knowledge of the obligations I am undertaking, I promise to care for the sick with all the skill and the understanding I possess, without regard to race, creed, color, politics, or social status, sparing no effort to preserve quality of life, alleviate suffering, and to promote health, as affirmed by the person. I will respect at all times the dignity

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and beliefs of the patients under my care, holding in confidence all personal information entrusted to me and refraining from any action which may endanger life or health. I will endeavor to keep my professional knowledge and skill at the highest level, and to give loyal support and cooperation to all members of the health care team. I will do my utmost to honor the International Code of Ethics applied to nursing and uphold the integrity of the profession. (University of Texas at Tyler School of Nursing Pinning Information, n.d., para.7).

Nurses have the duty and opportunity to raise awareness of the negative effect of conscious and unconscious bias on the quality of health care minority populations, take responsibility for addressing personal biases, and take appropriate action to mitigate bias when observed as declared in the nursing pledge.

Bias is developed over time through social interactions and reinforcement by personal experience and media messaging. Over a hundred years ago Sigmond Freud proposed that the preconscious, or unconscious, mind was the power behind most human behavior (McLeod, 2018). However, we still do not acknowledge the role of the unconscious mind on our behavior and therefore take no action to prevent negative effects when we act on those unconscious biases. Explicit racial/ethnic bias is the conscious and intentional expression of negative attitudes toward a group. These biases are often based on group-based stereotypes which are founded on assumptions about one's perceived racialized identity and not on personal experience. Implicit bias is a reflexive action often contrary to the person's expressed beliefs and values. McLeod (2018) explains the impact of implicit biases by explaining that they include the same assumptions and negative stereotypes with the same negative (or positive effect) without personal ownership of the outcome.

Bias, explicit or implicit, can negatively influence the quality of patient-caregiver

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interactions, the way data is collected from the patient, and how provision of care decisions are made (Smedley et al., 2003). Findings from a physical evaluation and laboratory tests which are outside the normal range may be dismissed as acceptable for a Black, Hispanic, or American Indian where for the White patient treatment may be prescribed. At times the provider may merely choose not to act upon the test results due to the provider's bias about a patient's potential non-compliance with a treatment plan based on their race. Controlled studies using hypothetical patients found significant differences in the treatment plans recommended by providers between White and Black patients with identical symptoms (Zescott, Blair, & Stone, 2016). Biased delivery of health care is contrary to the purpose of healthcare which is to "enhance the quality of life by enhancing health" (Berry, 2018, para 2). However, providers may not be aware of making decisions based on race, they are acting on their implicit bias. Implicit bias is evaluated through two parameters. A person can consciously have nonprejudiced thoughts about a member of a marginalized group while simultaneously making unconscious associations with negative stereotypical traits and then act based on the stereotype. The second parameter is that a person can have bias and knowledge of stereotypes and yet not act on them (Holroyd, Scalfe, & Stafford, 2017). Whether it is implicit or conscious, bias has a negative impact on health care and health status for the Black, Hispanic, and American Indian populations.

Zescott, Blair, and Stone (2016) completed a review of relevant research regarding healthcare providers' implicit and explicit biases toward Black and Hispanic patients. Early in the report, they shared one of the most extreme examples of medical provider racial bias, the Tuskegee study of untreated syphilis in the Negro male which ran from 1932 until 1972. Black men were infected with Syphilis and then monitored to document the progression of the disease. The men did not receive treatment (although treatment was available) and were not aware that they were research subjects. This event has contributed to mistrust by the Black population of the

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medical profession. Another example of the demonstration of provider implicit bias was that many providers shared their belief that Black and Hispanic patients are not likely to be compliant with the prescribed treatment plan, that Black patients are more likely to be drug abusers and are generally found to be less cooperative in the health care setting (Zescott et al., 2016). Although the providers stated this belief as fact, they were not able to share specific examples supporting these beliefs based on their own personal experience.

In summary, evidence documenting the impact of provider bias on health disparity can be stratified in four categories. First, differences in health status and outcomes between Black patients and White patients continue even when factors such as access, education, and financial status were accounted for. Second, provider perceptions of their Black patients were more negative than their perception of their White patients. Third, controlled experimental studies revealed inequity in the treatment plans for the White and Black patients even though their symptoms and diagnoses were the same. Finally, racial/ethnic minority patients reported dissatisfaction with the care and communication from their White care providers. All healthcare providers involved in the reviewed studies had participated in cultural competence education. The researchers concluded that the cultural competence education provided in preservice education and clinical practice was inadequate to support high quality equitable care for minority populations because it did not include activities designed to raise awareness of the existence of personal bias, implicit and explicit, and the negative impact of bias on patient care and outcomes.

Samuel, et al. (1998) recognized a pattern of bias in the misdiagnosis of Black children who presented with symptoms representative of attention-deficit/hyperactivity disorder (ADHD). Their literature review revealed the scarcity of research related to ADHD diagnosis and treatment for Black children. However, it was noted that thousands of White children were diagnosed and treated for ADHD and only seventeen Black children with the same symptoms

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received the ADHD diagnosis and appropriate treatment. The symptoms of ADHD include excessive hyperactivity beyond what is expected for the developmental level, impulsivity, and difficulty with focus and attention (Samuel, et al., 1997). More than ten years after the Samuel, et al. study Miller, Nigg, and Miller (2008) found that since 1997 more Black children were being identified as having symptoms of ADHD and yet were less often diagnosed with ADHD than White children. A Mental Health Family Nurse Practitioner colleague shared the experience that Black children are very often misdiagnosed with mood disorders or behavioral problems instead of ADHD. Unfortunately, this means that their treatment includes medications which have serious side effects rather than the safer, and more appropriate, medications recommended for a diagnosis of ADHD. It is disconcerting that providers disregard evidence-based guidelines for diagnosis and treatment so detrimental to the patient that it could be seen as malpractice (A.T. personal communication, March 15, 2021).

One strategy to raise implicit bias awareness is to provoke self-reflection using assessment tools. One of the most well-known tools is the Harvard Implicit Association Test (IAT). Introduced in 1998, “the IAT is now the most validated measure of implicit bias” (Xu, et al., 2014, para 1). It is an online test that provides feedback about beliefs that a person may be unaware of and therefore cannot report or is not willing to report. The Project Implicit website, which administers the IAT, describes the IAT as a test which measures “the strength of associations between concepts (e.g. black people, gay people) and evaluations (e.g., good, bad) or stereotypes (e.g., athletic, clumsy)” (Project Implicit, n.d.). A question posted in the IAT Frequently Asked Questions section was whether the test results might be skewed by a person’s familiarity with the items (White faces, Black faces, etc.) in the test. The answer given was that it is possible that familiarity may have a role in liking the categories and possibly implicit bias might lead to unfamiliarity and not liking a category. It was also noted that about 30% of Black

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participants show a preference to White people perhaps suggesting a learned bias from a culture that regards White people more highly than Black people. The value of the IAT is to raise awareness of implicit bias and provoke introspection and conversation.

The Implicit Association Test assessment process asks participants to quickly match pictures to words that attach a value or category. The system then evaluates the response time to indicate the strength of the association between the concept, for example White people, and a value or assessment word such as good/bad. Findings are expressed as having a slight, moderate, or strong implicit preference toward one group or the other. The IAT website includes the following statements regarding the link between implicit bias and behavior; “The link between implicit bias and behavior is fairly small on average but can vary quite greatly... The IAT does predict behavior in areas such as discrimination in hiring and promotion, medical treatment, and decision related to criminal justice” (IAT Frequently Asked Questions, 2021, July 6). The IAT provides value to support a heightened awareness of implicit bias in order to become alert to behaviors and decisions which may be influenced by bias.

To improve health status and health care equity for the Black, Hispanic, and American Indian populations nursing educators have an opportunity, in fact a duty, to disrupt the pattern of bias and inequity through raised awareness of the effect of caregiver unconscious (implicit) bias on the provision of care. This requires raised awareness of implicit bias in the faculty and curricular changes to include intentional strategies to increase the student’s awareness of their internalized understandings of race. I believe that the best time to affect change in awareness of bias in the nursing environment is to address the existence and effect of healthcare provider bias during the preservice nursing education. Faculty must be able to build the knowledge, skills, and personal awareness needed to facilitate student learning which must include understanding of self (Funge, 2011). Students must gain an understanding of how to integrate social justice into

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their practice which includes the recognition of the negative effect of implicit bias on the provision of care and the health status of Black, Hispanic, and American Indian populations.

Nursing Education - The Local Setting

The setting for this improvement research is a well-respected school of nursing in a regional comprehensive state supported university in rural southeast United States. The school of nursing was formed in the mid 1960's with a Baccalaureate Nursing program and has grown to include four programs which award the Bachelor of Science in Nursing (BSN), two Master of Nursing (MSN) degrees, and three Doctor of Nursing Practice (DNP) degrees. The school of nursing has an excellent reputation as an education provider and has also been an integral part of the community as a health care partner, community service provider, and collaborator in health improvement activities in our region. Where we have been less successful is in recruitment and retention of a diverse faculty and student population.

In 2016, the leadership of our university identified increased diversity as a priority for the organization and created an Office of Equal Opportunity and Diversity Programs to help prepare students for success in a culturally and racially diverse society. The office, staffed with one employee in the newly created role of Chief Diversity Officer, was tasked with providing leadership for cross-divisional diversity initiatives. The office was commissioned to develop and implement programs and policies to promote diversity. The programs and policies are guided by the following strategies:

- Strengthening the university's ability to create a learning environment needed to develop the extraordinary leaders who will succeed in an increasingly culturally diverse and globalized society.
- Focusing on the university's goal of providing the highest quality educational experience that is fully representative of the diversity of human difference in our state.
- Serving as a resource to our campus community by providing policy information and development, referrals, advocacy, coordination, and support for diversity-related events,

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initiatives, and discussions (Office of Equal Opportunity and Diversity Programs, n.d., para 5).

Establishment of these strategies and the new department represent an important step to support increased diversity in our organization, however, a one-person department with goals this lofty cannot be expected to achieve substantive improvement for the university. It will require collaboration across the university. Recruitment activity intended to increase diversity will not be successful unless we understand the impact of implicit and structural bias on recruitment efforts and also work with faculty, staff, and students to raise awareness of the impact of implicit bias on retention.

The University's core values, and guiding principles include cultural diversity and equal opportunity. The 2020 Strategic Plan Strategic Direction 3: Inclusive Excellence includes Priority Action Statements declaring a commitment to diversity and inclusion by recruiting, retaining, and developing a diverse community. The action statements include language committing to non-discrimination, equal employment opportunity, building a more diverse and inclusive student, staff, and faculty community to ensure academic and professional success, professional development for faculty and staff, and ensuring that diversity, equity, and inclusion are foundational aspects of educational offerings. However, operationalizing these goals have not been effectively internalized as goals on meeting agendas at the college, department, or at the program level. Recruitment and retention efforts to increase employee and student diversity will not be successful without prioritizing intentional ongoing work with faculty, staff, and students to raise awareness of the impact of implicit bias on recruitment, retention, curriculum, and teaching.

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The official position of our university is shared on our University Diversity web site “Diversity at Western Carolina University is all-inclusive and recognizes everyone and every group as part of the diversity that should be valued. It includes race, ethnicity, gender, gender identity, age, national origin, geography, religion, disability, sexual orientation, socioeconomic status, education, marital status, language and linguistic differences, and physical appearance”. Unfortunately, recently there have been several very visible incidents where videos were posted showing students making racial slurs and other disgusting messages against students of color. The students were identified and expelled from the University due to their racially hostile behavior. It is difficult to measure the extent of racial bias in the faculty or student body because it may not be overt and seldom reported. The existence and effect of implicit bias has not been openly discussed at the university or school of nursing level.

The school of nursing faculty and student body has been predominantly White since inception of the program. We are located in a rural, majority White region. There is currently no racial diversity within the fulltime faculty of our school of nursing and there is less than 5% diversity in our nursing student population. This is a challenge when trying to include the voice of diversity in classroom and faculty discussions. Table 2 demonstrates the level of diversity in the university, our school of nursing, and the region.

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Table 2

University and Region: Percent of Population by Race/Ethnicity 2019

	Percent by Race/Ethnicity				
	BSN Graduates	Faculty	Overall University, Students	Overall University, Faculty	Region Surrounding the University
Asian	1		1.08	1.88	
Black or African American	1.5		5.5	2.03	4.4
Hispanic or Latino	4.2		7.16	0	5.9
White	88.6	100	80	92.06	89.9
American Indian			0.847		1.5
Other races	4.7		3.64	4.03	

(Data USA, 2019; College Factual, 2019)

The School of Nursing has experienced very little faculty turnover during the last 10 years, however recent vacancies have opened several faculty positions which provide an opportunity to increase the diversity in our currently 100% White fulltime faculty group. It has been challenging to recruit a more diverse faculty due the very low diversity in the population of our region (specifically as related to race and ethnicity). If we can increase the diversity of our faculty, provide a safe space for difficult conversations, and raise faculty awareness of implicit racial bias we may be able to identify and improve areas of structural bias in our hiring and admission processes, raise awareness about the effect of implicit and explicit racial bias in our curriculum. This will improve the education for nursing students who will be better prepared to provide appropriate, high-quality care for our Black, Hispanic, and American Indian populations.

Nursing is known as a caring profession. Nurses proudly state their commitment to treat all patients the same regardless of race, or other differences. However, nurses may not have a

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clear vision (awareness) of their racial biases and prejudices nor a working definition of social justice, equity and inclusion that could impact their interactions with a diverse patient population. Nursing educators have not addressed the existence nor the negative effect of implicit bias on care provided to minority populations, therefore the disparity continues. Nurses learn bias-based behaviors not only from peers in the practice of nursing but subliminally during the education they receive in preparation for the profession. It isn't just what they hear, it is what they do not hear.

Nursing licensure and healthcare accreditation organizations have included language in their standards to promote a commitment to the provision of high-quality care for all patients without consideration of race, social status, politics, or preferred language with the intent to promote care equity. The reality is that the statements support the concept of equity in the provision of care, however, it is difficult to assess care equity at the patient level in healthcare organizations. The regulatory boards have also been unable to effectively relate poor healthcare outcomes to the effect of bias or prejudice except in cases of overt misconduct (Bekemeier & Butterfield, 2005).

Several national nurses' organizations have approached equitable care for all persons by advocating for patient centered care. The American Nurses Association (ANA, 2015) and the American Association of Colleges of Nursing (AACN, 2017) promote patient centered care as the optimal methodology to support consistent high-quality patient care and positive health outcomes for a diverse population of patients. Patient centered care requires that the nurse engage with every patient as an individual who has their own unique characteristics, needs, and desires and then collaborates with the patient to guide the delivery of care. Patient centered care means that the patient and family are engaged as partners in the promotion of health as well as in the diagnosis, treatment, and rehabilitation after an illness. All of the healthcare disciplines

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involved in care of the patient should be engaged to collaborate to meet the patient's outcome goals. Where patient centered care has been adopted nurses are more satisfied with their work and outcomes are improved. The goals of patient centered care support equitable care based on the needs of the patient without the influence of bias or prejudice. This holistic care concept represents the core values of nursing, and yet unfortunately, this is often more of an ideal than a reality (Hughes, 2011). In order to achieve this level of quality care, the concept of patient centered care must be understood by all providers and there must be an awareness of personal, system, or process barriers to equitable care. One element that is not specifically identified in this concept is the effect of caregiver implicit bias on the ability to provide patient centered care.

Our Bachelor Science in Nursing (BSN) program uses Jean Watson's Theory of Caring (Sitzman & Watson, 2014) to support the nurses' ability to deliver patient centered care. The word "Caritas" is Latin and is translated as "to cherish, appreciate, and give special or loving attention with charity, compassion, and generosity of spirit" (Sitzman & Watson, 2014, p. 21). These 10 Caritas processes are used to guide the nurse toward development of a supportive relationship with the patient.

1. Embrace (Loving-Kindness) - Sustaining humanistic–altruistic values by practice of loving kindness, compassion, and equanimity with self/others.
2. Inspire (Faith-Hope) - Being authentically present, enabling faith/hope/belief system; honoring subjective inner, lifeworld of self/others.
3. Trust (Transpersonal) - Being sensitive to self and others by cultivating own spiritual practices; beyond ego-self to transpersonal presence.
4. Nurture (Relationships) - Developing and sustaining loving, trusting–caring relationships.
5. Forgive (All) - Allowing for expression of positive and negative feelings -

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authentically listening to another person's story.

6. Deepen (Creative Self) - Creatively problem-solving-“solution-seeking” through caring process; full use of self and artistry of caring–healing practices via use of all ways of knowing/being/doing/becoming.
7. Balance (Learning) - Engaging in transpersonal teaching and learning within context of caring relationship; staying within other's frame of reference-shift toward a coaching model for expanded health/wellness.
8. Co-create (Caritas Field) - Creating a healing environment at all levels; subtle environment for energetic authentic caring presence.
9. Minister (Humanity) - Reverentially assisting with basic needs as sacred acts, touching mind/body/spirit of other; sustaining human dignity.
10. Open (Infinity) - Opening to spiritual, mystery, unknowns, allowing for miracles
(Sitzman & Watson, 2014, p. 21-22)

The Caritas processes provide guidance for effective patient-nurse interactions, particularly the second process, honoring subjective inner, life-world of self and others, and the third process, being sensitive to self and others. These processes support self-reflection, however, without intentional focused strategies specifically designed to raise awareness of implicit bias, self-reflection is generally not effective. For nurses to provide care that meets the intent of the Caritas standards the nursing curriculum must include educational experiences that are designed to raise awareness of implicit bias, demonstrate the impact of bias on the care relationship between the nurse and patient, and support understanding that nurse bias may perpetuate health disparity experienced by Black, Hispanic and American Indian population groups. Currently, this is not explicit in the curriculum for most nursing programs, including the programs at the school of nursing where this improvement research opportunity was implemented.

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Compinha-Bacote (2007) posited that cultural competence is a perpetually developing skill set necessary to provide patient centered care. Cultural competence education encourages nurses to learn about the patient's culture, beliefs, and values to improve development of, and compliance with, a specialized patient specific care plan. Provision Eight of the American Nurses Association Code of Ethics for Nurses (2015) acknowledges the impact of nurse bias on patient care with a statement that the nurse will set aside any bias or prejudice and focus on the promotion of health and wellness in collaboration with the patient. This philosophy is shared with students during their nursing education. The cultural competence approach has been implemented by creating a record of the patient's religious, dietary, and other cultural preferences. It is imperative that nursing educators not only teach students to assess the patient's culture and preferences for care but also include conversations about how to recognize the nurse's potential internal conflicts with other cultural norms and that impact on patient care. This will not be possible without recognition of the impact of educator implicit, and explicit bias, on student and faculty recruitment, curriculum development and delivery, and the care of Black, Hispanic, and American Indian patients.

Research regarding efforts to facilitate the exploration of conscious and implicit bias has typically occurred in a classroom setting or a with small groups in a face-to-face environment. Our post-licensure Bachelor of Science in Nursing (BSN) and non-clinical master's programs have been completely online for many years. It is important that the conversations with faculty and students regarding implicit bias are not limited to the programs with face-to-face classroom experiences. Facilitating crucial conversations regarding implicit bias in an online format may pose challenges, but we will not be able to engage all of our students unless we are able to include the use of this medium in our awareness raising strategies.

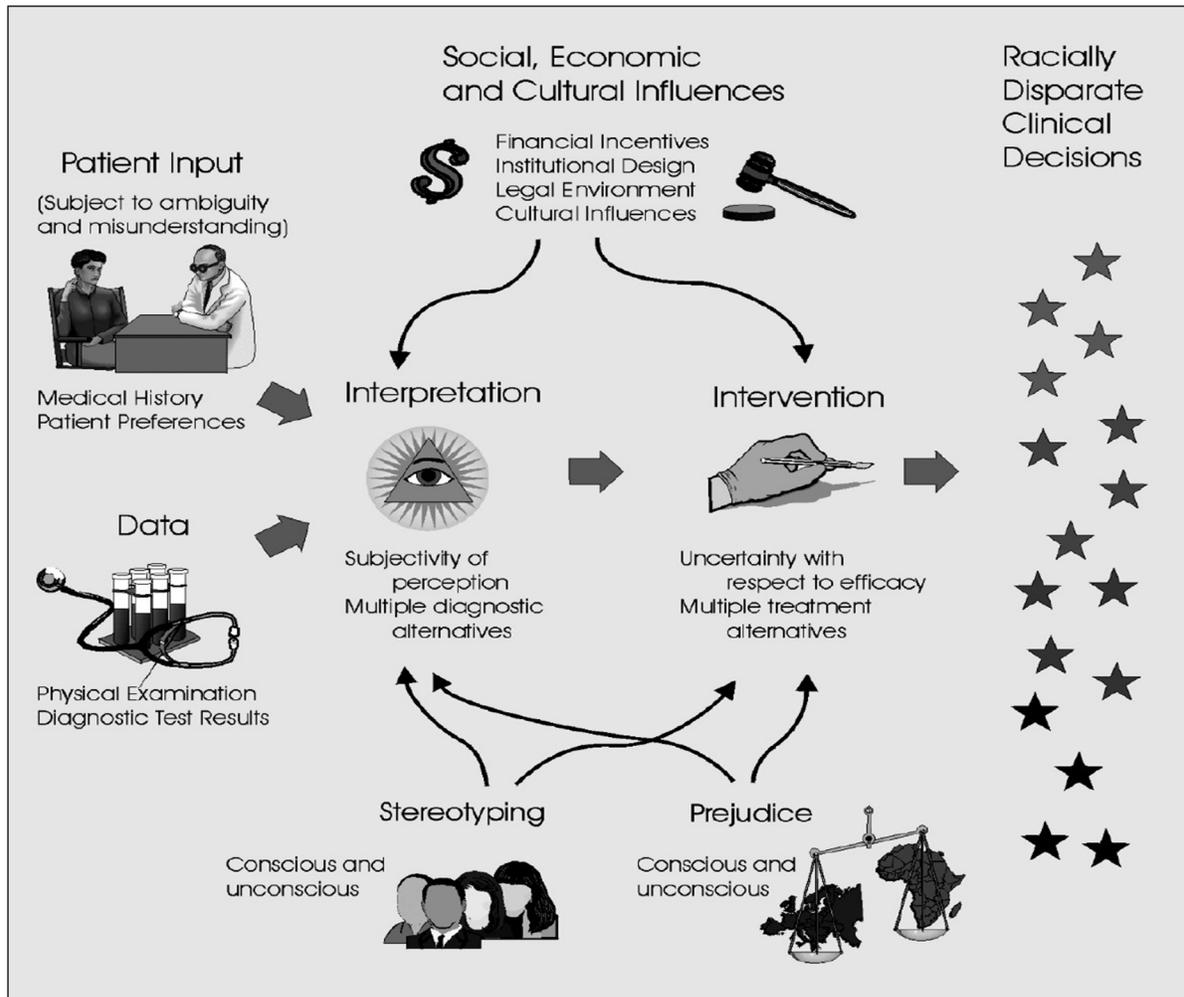
Review of Literature

In previous sections I have shared pertinent literature to help define the problem of practice, highlight the major causes of health disparity, and describe the negative impact of healthcare provider implicit bias on the quality of health and healthcare for the Black, Hispanic, and American Indian population. This section builds on that foundation with relevant literature that informs this improvement research intervention. The elements identified for inclusion in this review of literature were selected to demonstrate the scope of previous efforts to improve health inequity, to further explore the major causes of health disparity, the impact of bias on the delivery of care, and review the effect of interventions intended to address implicit and explicit bias in health care.

The Institute of Medicine (IHI) report, *Unequal Treatment* (Smedley et al., 2003) demonstrated that racial minorities were less likely to receive the quality of preventive and treatment care that White people received regardless of social status, income, or health insurance status. The multiple influences which contribute to health disparity are represented in Figure 5 below.

Figure 5

An Integrated Model of Contributors to Healthcare Disparity



(IOM, 2003, p 127)

Smedley et al. (IOM, 2003) reported the outcomes of multiple studies about the effect of health care provider bias on the provision of care and health outcomes for minority patients. For example, data from a survey in 2000 with 781 Black and 1,003 White cardiac patients found that black patients were four times more likely to convey distrust of the healthcare system and a perception of racial/ethnic discrimination in physician offices. This is only one of the many studies in this report which confirm a long-standing belief by the Black and Hispanic population

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that racism is a major factor in the care they receive and therefore they are always concerned that they would be treated unfairly due to their race. One outcome of their experience with discrimination was a tendency to avoid going to a healthcare provider until the problem is intensified to a level that they could no longer delay care. This lack of trust in the system also contributes to the high rate of refusal for surgical or other invasive interventions. This report, and many others, demonstrate a causal relationship between health disparity for minority populations and health care provide/institution bias (Smedley et al., 2003; Chin, Walters, Cook & Huang, 2007, October):

The Department of Health and Human Services (DHHS) launched a comprehensive agenda for health promotion in the document Healthy People 2000 with an update report in 2010 and 2020. Each report included current data and proposed broad strategies to eliminate health disparities. The recommendations for disease prevention and health promotion were well received. Subsequent debates regarding the definition of health disparity versus health inequality, implications regarding personal responsibility, varying approaches to the measurement of diversity, conflict regarding what is avoidable and affordable, and the influence of party politics have diminished the ability to implement strategies intended to support the goal of health equity. For more than twenty years this information has been widely discussed, position papers have been presented, and programs developed and yet health disparity has not appreciably improved. Unfortunately, getting in the weeds about the minutia of an issue is often a tactic for not having to do the more difficult work of addressing bias as a root cause for health disparity for the Black, Hispanic, and American Indian populations.

Carter-Pokras and Bauquet (2002) assert that a major factor impeding progress toward health equity are the multiple definitions of health, health disparity, and health equity which can prevent focused intervention. They suggested that health disparity “should be viewed as a chain

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of events signified by a difference in: (1) environment, (2) access to, utilization of, and quality of care, (3) health status, or (4) a particular health outcome that deserves scrutiny” (Carter-Pokras & Bauquet, 2002, p.427). The focus for improvement in health disparity must therefore include an evaluation and elimination of the specific differences in the chain of events which lead to disparity. In the context of inequity and inequality “what is unequal is not necessarily inequitable” (Carter-Pokras & Bauquet, 2002, p. 427). The distinction between equitable and equal is significant. Equitable means fair and impartial, equal means being the same in quantity, size, degree, or value. The difficulty with the provision of equitable care is that the decisions about what is fair are made based on the provider’s definition of what is avoidable, and what is appropriate. Treatment decisions are impacted by the interpretation of the provider who is making the decision which are influenced by their education experience, personal bias, and previous interactions with patients. To be effective, providers must be able to interact with patients in a way that care can be adapted to meet the individual needs of the person. This distinction is key to the evaluation of causes for health disparity between the Black, Hispanic, American Indian, and White populations.

Health disparity is impacted by access issues such as, inadequate transportation and ability to pay for services, however, the quality of the interaction between the patient and healthcare provider may be a stronger factor leading to health disparity (Balsa & McGuire, 2001). Black, Hispanic, and American Indian patients are often treated differently than White patients regardless of education level, compliance with appointment schedules, or ability to pay. Balsa and McGuire (2001) identified three ways that physician bias (also applicable to nurses), whether known or unconscious, may be demonstrated through prejudice, uncertainty, and stereotypes. Prejudice may be demonstrated by an unwillingness to treat minority patients, communicating low regard or disdain of minority patients, overt disregard of symptoms or

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concerns voiced by the patient, ineffective communication with minority patients and variation in diagnosis and/or treatment plans based on the population group rather than patient needs and preferences. Provider uncertainty is the discomfort felt by the physician when facing a situation that the provider does not feel prepared for or does not feel in control. This discomfort often occurs when the provider does not know how to effectively relate or communicate with a patient who does not speak English fluently or has a different racial/ethnic identity. Uncertainty can be expressed as impatience and frustration which may contribute to provider misunderstanding of the patient's description of symptoms, discounting complaints or concerns voiced by the patient, increased patient anxiety, and patient hesitancy to ask clarifying questions. Provider uncertainty may result in misdiagnosis, an ineffective treatment plan, and patient noncompliance with a plan they do not understand or cannot afford.

Another factor which minimizes quality of care is profit focused business models which require the provider to maximize the number of patients seen each day by limiting their time with a patient. It is natural for a provider to revert to making decisions based on previous experience and stereotypes when under the pressure of 15-to-20-minute appointment times. Providers must quickly identify the reason for the visit and quickly assess the patient. There is not time to build a relationship with the patient or listen to a long description of the patient's concerns or symptoms. They may resort to making decisions about care based on stereotypes. For example, a provider may not be as likely to take the time to order the recommended treatment for a Black patient with alcoholism because of a perception that Black people are more likely to be alcoholics, are often noncompliant with treatment plans, and will most likely refuse inpatient rehabilitation. Therefore, the Black patient is seen as a "self-fulfilling prophecy" and health disparity continues between the Black population and the "more compliant" White population. The focus is on the symptom, the cause is not addressed therefore poor health continues and the

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systemic problem of the effect of bias on health care and health status remains unchallenged.

Healthcare provider education, including nursing, incorporates learning associations as part of the education process. Learning associations develop a connection between multiple elements in our brains to facilitate faster decision making. Learning associations support quick assessment by focusing on the most prevalent findings for a specific population. This technique can be useful to expedite treatment, for example, a child who is seen frequently with respiratory infections would be evaluated for cystic fibrosis (Marcelin, Siraj, Kotadia, & Maldonado, 2019). However, this tendency to evaluate an individual through a group lens also contributes to biased care. Black, Hispanic, American Indian, and other marginalized populations often experience this phenomenon due to stereotypes about their culture, lifestyle, and communication ability. Bias is described as a preferential opinion about one group over another based on a stereotype, a strongly held belief/value or generalization about a group and may be positive or negative.

Oberg, Colianni, and King-Schultz (2016) state that racism is, in large part, to blame for variances in health outcomes. They propose that there are three levels of racism: Structural or Institutional, Personally Motivated (by those in power or influence), and Internalized. The first level of racism, Structural or Institutional, is described as “the normalization of an array of historical, cultural, institutional, and interpersonal dynamics that routinely favor White people while producing cumulative and chronic adverse outcomes for people of color” (Oberg, Colianni, & King-Schultz, 2016, p. 291). This type of racism is imposed by people in power and internalized by those who are discriminated against. Structural racism is so ingrained in American society that it is a strong factor in all indicators of health and personal success. This type of racism is sustained when policy and regulations are implemented without consideration of the impact on existing inequities and health disparities. It is manifested both in access to power and material conditions, such as access to quality education, a healthy physical

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environment, and convenient access to health care. The second level is Personalized Mediated racism otherwise known as prejudice and discrimination. Prejudice is making assumptions about a person's abilities, intentions or motives based on their race. Discrimination is taking action, or inaction, based on those assumptions (Jones, 2000). Prejudice may be intentional (explicit) or unintentional (implicit). The third level is Internalized Racism which is defined as "acceptance by the stigmatized races of negative messages about their own abilities and intrinsic worth... characterized by their not believing in others who look like them and not believing in themselves" (Jones, 2000, p. 1213). At this level, the stigmatized race accepts the assumptions of limitation to their right to self-determine and even their ability to dream for a better life. There may also be "embracing whiteness" actions such as straightening hair, efforts to lighten skin tone, self-deprecation, departing from ancestral culture and loss of ambition. Jones (2000) describes features of the levels of racism as:

Structural racism	Initial historical insult
	Structural barriers
	Inaction in face of need
	Societal norms
	Biological determination
	Unearned privilege
Personally Mediated racism	Intentional
	Unintentional
	Acts of commission
	Acts of omission
Maintains structural barriers	Condoned by societal norms
	Internalized racism

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Reflects systems of privilege

Reflects societal values

Erodes individual sense of value

Undermines collective action (p.1213-1214).

In summary, Structural, or Institutional, racism promotes, or allows inequity to continue unchallenged. Personally Mediated racism may be conscious or unconscious and includes action and inaction, Internalized racism may be conscious or unconscious and reflects acceptance of the historical hierarchy of White privilege. McIntosh (1988) reinforces this concept from a White perspective in her experience, “I was taught to see racism only in individual acts of meanness, not in invisible systems conferring dominance on my group” (p.3). Over time the effect of racism progresses to a point that it becomes internalized by the victim, and the dominant group, and is accepted as status quo.

Explicit bias is conscious and intentional, often based on group-based stereotypes and not personal experience. Prejudice is a term often used to project the negative expression of bias. Implicit bias is an unintentional, unconscious demonstration of bias with the same negative or positive effect. Implicit bias is a reflexive action often contrary to the person’s expressed beliefs and values. Bias can influence the way data is collected, analyzed and decisions are made. Biased delivery of health care is contrary to the stated goals of healthcare which include the promotion of health and the prevention of disease. While overt discrimination in healthcare has become less visible; implicit bias/discrimination continues to influence provider behavior in unexamined ways.

Giddings (2005) used a cross-cultural life history methodology to study social injustice in a healthcare environment between nurses of various races and nationalities, and White nurses. Paulo Freire’s pedagogy of empowerment informed the study’s design. Empowerment in this

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context is the formation of critical consciousness, the ability to recognize and evaluate systems which support inequity and inequality and taking responsibility to take action to change those systems. The study method included facilitated interviews with 26 minority nurses where they shared historical, and current, social conditions, such as oppression and power, that influenced their interactions with the White nurses. The participants identified as one of the following: African American, European, Hispanic, Asian, Pakeha, or Maori.

The participant nurses' stories were recorded and analyzed revealing a meta theme of not fitting in based only on the fact that they were not White. The evaluation of the experience of the minority nurses in the White dominated nursing workforce demonstrated the same discrimination and bias that patients often experience. The organization required cultural competence education for all nursing staff to encourage better understanding of cultural differences, reduce bias and improve care. Culture was defined as the unique elements specific to a person's culture or nationality, however, it was noted that within the cultural competence education patients were described as White or "other". This exclusionary othering was clearly felt by the minority nurses in their work relationship with the White nurses.

Nurses were asked to tell stories about experience with racial/ethnic bias. One nurse shared feelings of unfair treatment generated by rejection for admission to a predominantly White school of nursing despite an excellent academic history. Another nurse shared the huge feeling of accomplishment she felt when she was accepted into a reputable nursing school only to have that pride crushed when she found she was the only Black student in an all-White nursing class. Despite her excellent academic record, she suddenly felt like she was admitted as the "token" Black student. One nurse told her story about a guidance counselor at a high school who directed her to apply to a diploma nursing program rather than the baccalaureate program because it was "more appropriate" and a better fit for her. That student is now a PhD

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graduate. She stated that she was only able to accomplish her goals because she was determined to overcome the multiple access barriers placed in her path. She achieved success “in a system that says I can’t” through her own resiliency. However, she resented the fact that she had to fight to overcome the resistance based on her color. She felt that it should not be incumbent on the student from the non-dominant culture to overcome the unequal and inequitable behavior of the dominant culture (Giddings, 2005, p. 5). One goal of the study was to determine ways to change the White staff’s orientation away from the focus on “others” (not White) as outside the norm, a mindset that negatively impacted the relationship between the minority nurses and the White nursing staff as well as the minority patients. The study concluded that there are biases within nursing that benefit the privileged White nurse and diminishes others. The impact of these biases is also experienced by minority population patients.

The use of the term other, or othering, was first introduced into nursing literature by Canales in 2000 to describe a framework for engagement with persons different from oneself describing inclusionary and exclusionary practices. Inclusionary othering is focused on coalition building as an approach to better understand differences and collaborative interaction with those different from oneself. Exclusionary othering represents power relationships to dominate and subordinate. Within the last several years the term othering has been used to describe exclusion of an “out” group (lesser than) by an “in” group (preferred) influencing the way that people are treated and perceived. Othering can be based on a single or multiple attribute which may include age, sexual orientation, race, religion, ethnicity, nationality, gender identity, skin color, and/or political affiliation. The one constant is that the term other is used to describe difference and refers to a “person or group oppressed, marginalized, or discredited within society” (Canales, 2010, p. 28). These biases are not based on personal experience with a person or group but are learned unconsciously over time. The negative effect of othering is significant in the evaluation

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of factors contributing to health disparity.

A study in 2021 (Kula, et.al) suggested that one way to address implicit bias could be by expanding the cultural competence of nurses through education. Their research provided an “online culturally informed intervention” for 72 undergraduate nursing students. Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes. Cultural competence education in preservice nursing education, reinforced with continuing education classes provided by healthcare organizations, generally includes the assessment of a patient’s culture, nationality, customs regarding food, family, and religion. They found that the online intervention integrated into the curriculum improved basic understanding of cultural content. They recommend further investigation into methodologies designed to promote deeper levels of understanding.

Cultural competence education has become a common intervention intended to reduce health disparity in healthcare. Kumas-Tan, et. al(2007) studied the validity of cultural competence measurement instruments used in the medical field. Their search identified 54 instruments. They selected the 10 instruments used most often in the literature to discover the common elements which define provider culture and cultural competence. Instrument design was based on White healthcare practitioners as the norm, therefore, the study of cultural diversity using these instruments was, by default, about the culture of the “other than White” (Kumas-Tan, et. al., 2007, p. 551). Ethnocentrism and racism were not addressed in most of the instruments except in a few assessment questions where disadvantages for the minority group was implied, however, none mentioned advantage from membership in the dominant (White) group. The study reinforced a perception that when White nurses care for Black, Hispanic, or American Indian

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people they perceive normal to be the White experience and difference means different from “us”. Cultural competence is not only about learning characteristics of a racial/ethnic identity or measuring equity or access, but also about attempting to understand how to develop a caring relationship between people from multiple “racial, ethnic, cultural, religious and socioeconomic background, various disabilities and other groups” (U.S. Department of Justice, 2015, July 29, p. 1). To improve health outcomes, healthcare organizations must improve the quality of the patient-provider relationships and develop the expectation, and provide appropriate education, that supports patient centered (equitable) care.

Healthcare accreditation organizations require that patient care is provided in a culturally sensitive manner. While the requirement is well intended, the activity to address this standard for most organizations has been diminished to taking a class about cultural sensitivity and completion of checkboxes during the admission data collection process. The nurse records the patient’s religion, ethnicity, dietary preferences, and perhaps any customs related to health and healing. Recording this information in the patient’s medical record was intended to ensure that the staff would have the information they needed to better engage with the patient. Armed with this information it was hoped that caregivers would provide care sensitive to patient preferences, more appropriately create collaborative treatment plans, and support a therapeutic caregiver-patient relationship. Unfortunately, this minimized implementation of the requirement has not resulted in improved care for most patients. To document compliance with the accreditation standard, healthcare organizations require their staff to complete cultural competence education. When well designed and delivered in an interactive modality one-to-two-hour education offerings have been proven to improve provider cultural awareness, however, without ongoing reinforcement the result of the education event was a short-term effect on the care providers’ approach to patient care, generally lasting about 24 hours (Devine, et. al, 2012). Documenting a

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patient's religion, dietary preferences, and health related cultural beliefs will not necessarily change the provider's approach to patient care, improve the patient-provider relationship, or reduce the negative impact of caregiver implicit, or explicit, bias.

Despite inclusion in most organizational position statements and periodic attendance in cultural diversity training most nurses have little understanding, or even awareness, of the healthcare access barriers for Black, Hispanic, and American Indian patients and are unconscious of how caregiver attitudes and behavior may impact quality of care and thus the patient's health status (Thurman & Pfitzinger-Lippe, 2017). Nurses may observe the effect of inequities of the health system, and acknowledge system failures, yet may feel powerless to change the system and may even be unaware of how their own practices support the systematic inequities they may notice. Nursing education is very focused on the assessment and treatment of physical and mental illness often without attention to the larger concern about social marginalization and care inequity issues which may contribute to the presenting illness (Thurman & Pfitzinger-Lippe, 2017). There is some evidence that a health care provider's communication can reflect and reinforce societal messages of deservingness, value, and ability for self-care which may negatively impact health outcomes for minority populations (van Ryn & Fu, 2003). Thurman and Pfitzinger-Lippe (2017) recommend a fresh look at educating the current and future nursing workforce, addressing the structural barriers, social injustice, and provider bias that sustain health inequity in the United States.

Nursing literature is replete with advocacy for social justice and equitable care for all, however, the reality is that social justice and equitable care are terms used in high level discussions of health disparity but are not effectively addressed at a person level in nursing education or in the practicing nurse's daily clinical care (Kirkham & Browne, 2006; Anderson, et al., 2009). Social justice is described as fair and equitable treatment of people (Ruger, 2004). The

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nursing profession is based on a philosophy of caring. Although nurses may genuinely believe that they are providing consistent high-quality care, disciplined inquiry into the care of each individual patient is almost non-existent in health care, therefore inconsistencies in care management based on bias are not identified. Even when there is a serious negative outcome for a patient the impact of bias as a contributor to an error is not evaluated.

Healthcare providers often accept that the level of chronic illness with patients from the minority populations is a norm and therefore do not treat the concern as aggressively as with their White patients. Historically, certain populations were noted to have a higher incidence of diabetes, heart disease, and other chronic conditions than other populations which led care providers to an incorrect assumption that these illnesses are genetically predetermined due to race or ethnicity. This belief coupled with a perceived history of noncompliance with treatment plans can result in a tendency to become complacent about supporting active intervention due to the assumption that the Black, Hispanic, or American Indian patient cannot or will not assume responsibility for their health. A nurse's implicit bias can contribute to inadequate care of the patient through not taking time to gather a complete patient history and assessment, providing inadequate treatment, spending less time with the patient, inadequate discharge education and planning, and inadequate post discharge follow-up (Narayan, 2019). The nurse may default to a focus on the minimum requirements for care during the episode with little (or no) attention toward prevention and improvement of health status.

In 2003, the Institute of Medicine of the National Academies presented a groundbreaking report, *Unequal treatment: Confronting racial and ethnic disparities in health care* (Smedley, Stith, & Nelson, Eds). This massive 781page document is the result of a Congressional request to complete an intensive evaluation of the differences in the delivery of healthcare to the dominant and minority populations in the USA and also provides recommendations for strategies to reduce

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health disparity. The report presents a broad range of research including the effect of health care provider bias on the care and health outcomes for minority patients. For example, data from a study in 2000 with 781 Black and 1,003 White cardiac patients revealed that Black patients were four times more likely to convey distrust of the healthcare system and a perception of racial/ethnic discrimination in physician offices. This is only one of the many studies shared in this report which confirm a long-standing belief by minority populations that racism is a major factor in the care they receive and therefore they are always concerned that they would be treated unfairly due to their race. One outcome of their experience with discrimination is a tendency to avoid going to a healthcare provider until the problem is intensified to a level that they could no longer delay care. This lack of trust in the system also contributes to the high rate of refusal for surgical or other invasive interventions by Black, Hispanic, and American Indian populations. This report, and many others, demonstrate a causal relationship between health disparity for minority populations and health care provider/institutional bias (Smedley et. al, 2003; Chin, et. al, 2007, October).

Healthcare professionals endeavor to provide excellent patient centered care, however, prejudicial beliefs/stereotypes that people absorb unwittingly from their environment and experience can negatively impact the effectiveness of the healthcare experience (McDowell, et. al, 2020). Implicit bias has been demonstrated to diminish the effectiveness of patient-provider interaction, affect diagnosis and treatment decisions as well as impact the patient's perception care and the value of the treatment plans. This disruption in the patient-provider relationship has a direct effect on the health and well-being of the patient.

McDowell, et al. (2020) used the results of a literature review to inform training sessions which used patient/provider communication scenarios to prompt discussion and identify areas for improvement Not finding substantial research on implicit bias related to their chosen population

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group, sexual and gender minority people, they were able to find relevant information from research related to racial/ethnic groups. They also used results from the Implicit Attitudes Test (IAT) to evaluate the presence of implicit bias in the research participants. As noted earlier the IAT is a validated computerized tool which reflects the presence of implicit bias through measurement of the participant's response time to visual stimuli when asked to attach a negative or positive response to a population group. McDowell, et al. (2020) recommended the following strategies to raise awareness of healthcare provider implicit bias. Building self-awareness was identified as the first step, becoming alert to one's own preferences, beliefs, and behaviors.

Discussion about implicit bias with colleagues or friends is helpful not only to support raised awareness but to engage colleagues as partners who will communicate their observations of provider language and behavior that demonstrate a level of bias. Organizations must recognize the impact of structural bias on the healthcare experience. An essential strategy is to provide ongoing education/training in culturally affirming care at all levels of the organization. A contributing factor to the persistence of implicit bias in healthcare is that it is not effectively addressed during preservice education for healthcare providers. It is essential that educators, nurse leaders, and professional organizations provide experiential and didactic opportunities for both preservice and practicing healthcare providers to raise implicit bias awareness, identify areas of systemic and structural bias, and make appropriate changes to reduce the power of implicit bias to negatively impact health outcomes.

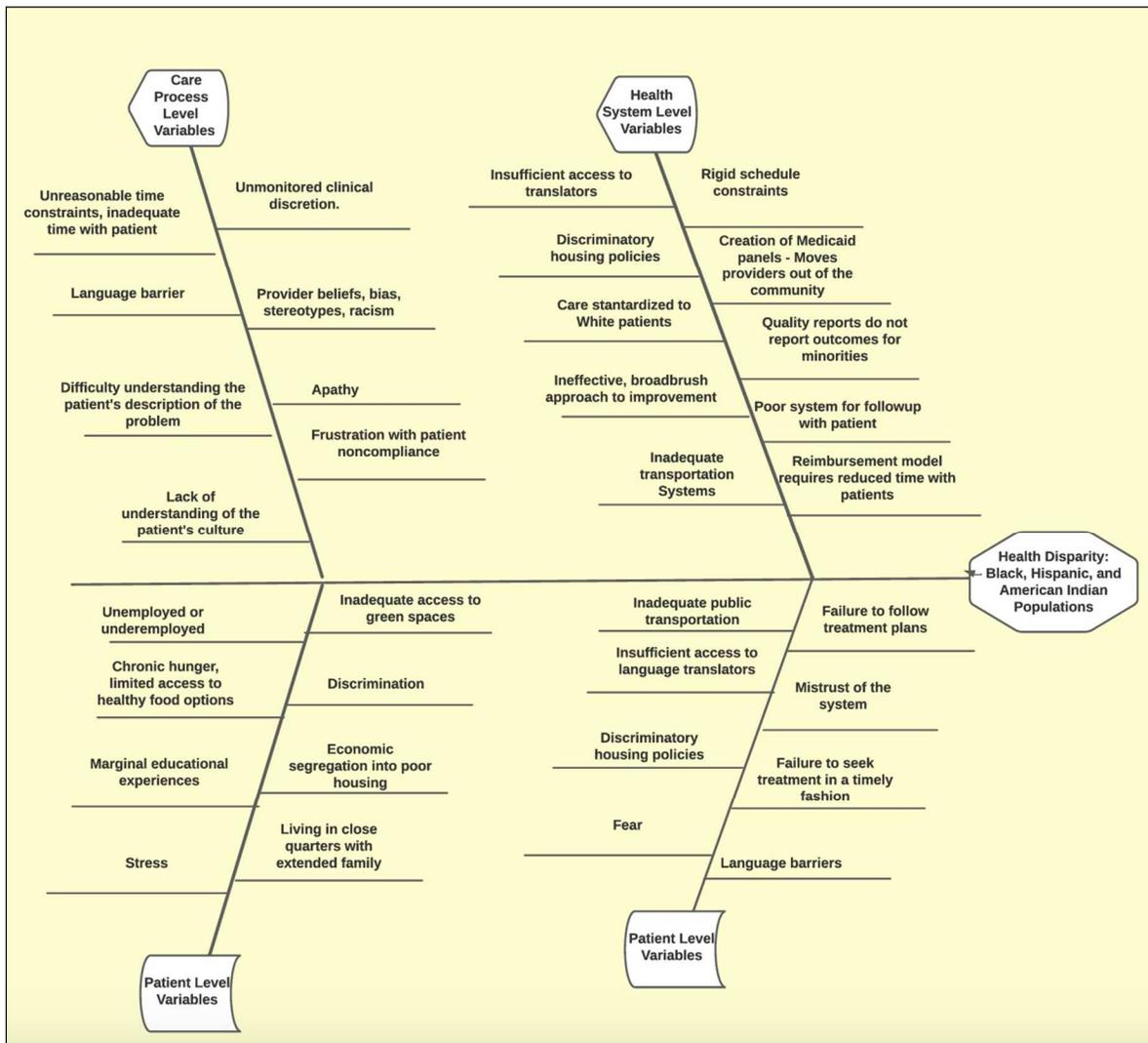
Improvement Methodology

Nurses are in an ideal position to improve health care delivery and reduce health disparity for the Black, Hispanic and American Indian populations by becoming aware of the presence and negative impact of implicit (and explicit) racial/ethnic bias on the quality of patient care. One way to support nursing awareness is to incorporate activities throughout preservice education. School of Nursing faculty can influence a new generation of nurses, and thereby improve future equitable care, through open discussion about the existence and effect of bias. However, to effectively implement strategies in the nursing curriculum designed to raise awareness of racial/ethnic bias and care inequity we must first raise awareness within our faculty.

The purpose for this improvement initiative was to raise faculty awareness of the presence of implicit racial/ethnic bias. I selected various experiential learning techniques to stimulate self-reflection regarding implicit bias racial/ethnic bias. My desire is that this initiative provides data which demonstrates the presence of implicit bias and that sharing this information will expand nursing faculty capacity to become aware of their implicit bias and realize the impact of bias on disadvantaged populations. The first step in research design using the improvement research model was to define the problem of practice. A Cause-and-Effect diagram, also called a Fishbone or Ishikawa diagram, (see Figure 6 below) was selected to create a visual representation of the possible causes of health disparity which would inform this improvement research.

Figure 6

Causal Factors Contributing to Health Disparity



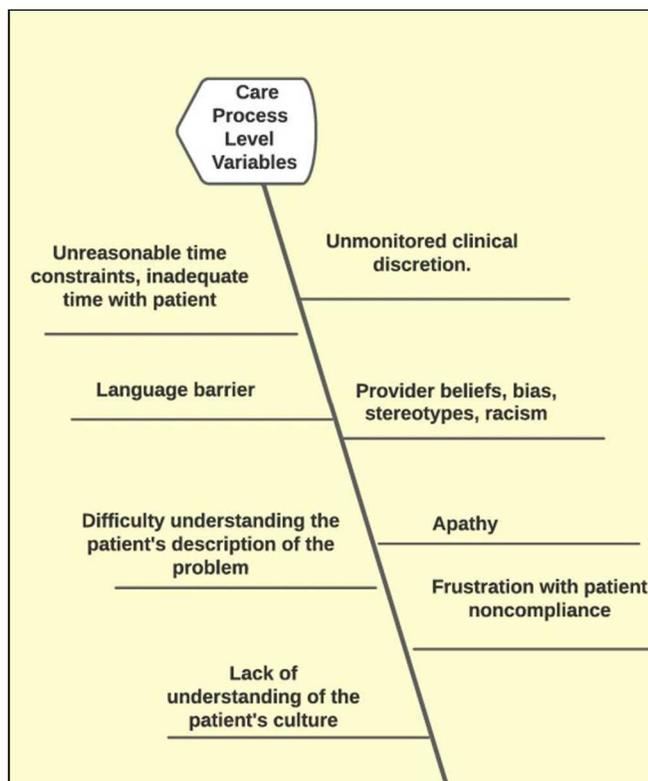
The Cause-and-Effect diagram uses a brainstorming process to reduce a broad problem into contributing factors by the identification of root causes for the defined problem.

This Cause-and-Effect diagram, titled Causal Factors Contributing to Health Disparity, is a visual demonstration of the four major categories of causal variable which contribute to the effect or outcome, Health disparity in the Black, Hispanic and American Indian populations, as noted on the right side, or the head, of the fishbone diagram. Causal categories which impact

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health disparity are set up as branches off a central horizontal line. Contributing factors are then added to the causal category branches. Health System Level Variables, Care Process Level Variables, and Patient Level Variables are identified as primary causal categories. Each causal category in the Cause-and-Effect diagram represents an important area which can have a negative impact on health status for the Black, Hispanic, and American Indian populations. Factors which contribute to health disparity were identified and added to the appropriate causal category. Finally, each causal category and contributing factor was reviewed to determine an area where a time limited improvement initiative to raise awareness of implicit racial bias in the school of nursing faculty might be most meaningful. The Care Process Level Variables causal category was selected for this improvement initiative with specific focus on the contributing factor: Provider Beliefs, Bias, Stereotypes, and Racism (see Figure 7 below).

Figure 7
Causal Factors Contributing to Health Disparity: Care Process Level Variables



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The Care Process Level Variables causal category, and particularly the contributing factors Provider Beliefs, Bias, Stereotypes, and Racism, was selected for this improvement initiative because this is an area where nurses can have the most influence on the quality of care. The term provider is used here in a broad sense to include every care provider at every level of the provision of care. My focus will be on the nurse provider. The interactions between the patient and the nurse can be compromised by the impact of racial/ethnic bias and have a negative effect on the quality of nursing care, patient outcomes and health status. Patient care can be improved dramatically if nurses are made aware of the existence and impact of their personal beliefs, biases, stereotypes, and implicit racism on the way they manage the care relationship with the patient. A secondary benefit of this improvement initiative for our graduates would be an opportunity to support raised awareness of the existence and effect of personal beliefs, bias, stereotypes, and racism bias with the nursing assistants and other care providers in the work place. It is reasonable that the school of nursing faculty can positively influence improvement in patient care and outcomes by including activities to raise awareness of the presence and impact of healthcare provider beliefs, bias (explicit and implicit), stereotypes, and racism into the nursing curriculum.

The expression of patient related explicit bias in the healthcare arena has been actively suppressed by peer pressure and administrative oversight. However, there is evidence that implicit racial bias is present in members of the healthcare team. Not only does implicit bias negatively impact the quality of direct patient care but the impact of implicit bias can cause a failure to develop a trusting patient-provider relationship which often results in the patient's reluctance to follow a treatment regimen and avoid accessing the health-related services required to maintain their health. Raising awareness of a nurse's implicit bias has the potential to improve

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quality of care and reduce health disparity. One way to raise awareness is to make it an integrated part of the curriculum during the education for nurses at all levels. However, for students to learn about the topic, the faculty must first be oriented to the concepts of implicit bias and engage in their own reflective activities to explore their biases. An interactive intervention with a group of school of nursing faculty to support raised awareness of implicit bias may result in the recognition of implicit bias by the participating faculty. The inclusion of similar activities with the rest of the faculty and integrated into the nursing curriculum intended to promote implicit bias awareness may support improved quality of care for Black, Hispanic and American Indian populations.

Theoretical Model for Improvement

My theory of improvement holds that intentional engagement in experiential learning techniques that stimulate self-reflection regarding implicit racial bias will increase nursing faculty's self-awareness of implicit bias. This improvement initiative has the capacity to support faculty adoption of implicit bias awareness raising activities into the nursing curriculum.

Increased awareness of the effect of implicit bias may positively impact the level of health disparity for the Black, Hispanic, and American Indian populations as compared to the White population. The theoretical model for my improvement research is Critical Race Theory. Critical Race Theory is action oriented, focuses on the historical and present effects of racism, and confronts the historical dominance of one group over another (Devine et al., 2012; Crenshaw et al., 1995).

Major components of Critical Race Theory are described below:

- Recognition of the dominance of racism - Racism and oppression has been present in America since White Settlers landed on this continent. Recognition includes a straightforward look at the overt and unconscious racism in our society acknowledging White privilege and the default outcome of “othering” everyone else.
- Counter story telling - Naming one's own reality, sharing a personal story which represents a perspective that is different from the majority White population. This element may be especially helpful in this improvement initiative considering recent episodes of racist behavior by our university students and the lack of diversity in faculty.
- Whiteness as a property - Having White skin is similar to having property, it brings privilege to the owner that a “renter” would not be allowed. This privilege includes elements such as: assumed elevation of social standing, reputation, access to “the

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American dream”, and the right to exclude others from attainment of that dream.

This element occurs frequently in the university setting where criteria for admission may prevent admission for many Black, Hispanic, and American Indian students who did not have access to adequate preparation for college or who had been socialized to believe that college was not possible.

- Interest convergence - Black people achieve civil rights only when it serves the White agenda. For example, Black students are recruited to a college to fulfill the White leadership’s goals for the college to build a sports program, however, the students are not encouraged or supported to excel academically. There is no active recruitment for Black, Hispanic or American Indian students to the general student population.
- Color Blindness is a method of thinking and communication that prevents open recognition and discussion of social inequity between White, Black, Hispanic and American Indian populations and therefore maintains status quo. Some incremental changes may occur however, they do not appreciably address the marginalizing conditions or oppression.
- Intersectionality describes how people experience discrimination and disadvantage differently based on the overlapping (intersections) and interconnectedness of race, class, gender, disability, sexual orientation, and other social characterizations. People are members of many groups and have complex identities which impact the way they experience racism and bias (Gillborn, 2015).

Critical Race Theory (CRT) helps us understand structural and personal representation of racial bias and will be used to frame the activities for the improvement initiative. I was not aware of CRT prior to the suggestion that this theory would be a good fit for my improvement initiative. As I read the history of the theory’s development and how it is used to identify and address

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structural, implicit, and explicit racial bias in the legal and education systems I could see the value of CRT to inform my action research in the nursing education arena. However, CRT has recently become very controversial. In early 2021 CRT became a hot topic in mainstream media and unfortunately has been grossly misrepresented as a divisive, destructive concept. One of the pioneers of CRT, Kimberlee Crenshaw, shared her disbelief that a theory that supports the 13th, 14th and 15th amendments to the United States of America Constitution could meet such opposition. She declared that “we can’t get to equality.....if we can’t confront and talk honestly about inequality” (Cillizza, 2021, p.1). In another conversation she reinforced the need for more conversation... CRT “ just says, let’s pay attention to what has happened in this country, and how what has happened in this country is continuing to create differential outcomes” (Gray, 2021, para 2).The current controversy about CRT promulgated by the media has detoured what could have been a healthy discourse about historical and present structural racial oppression into a stand-off where the subject cannot even be discussed in a civil manner.

Christopher F. Rufo is credited as the engineer for the development of the anti-CRT agenda as a political weapon (Wallace-Wells, 2021). Rufo challenged conservatives to “wake up” calling CRT an “existential threat to the United States...the bureaucracy is being weaponized against core American values” (Wallace-Wells, 2021, para. 8). He went on to say the “phrase critical race theory connotes hostile, academic, divisive, race-obsessed, poisonous, elitist, anti-American..... its connotations are all negative to most middle-class Americans” (Wallace-Wells, 2021, para. 7). Rufo encouraged President Biden to issue an executive order to “abolish critical race theory training from the federal government..... to stamp out this destructive, divisive, pseudoscientific ideology” (Wallace-Wells, 202, para. 8). Unfortunately, people often listen to the loudest voice and trust that what they hear is fact without question. Sadly, the anti-CRT movement has distracted public conversation away from a productive

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discourse regarding the very real issues of structural racism, racial/ethnic inequity, and health disparity.

As a counterpoint, in an article posted on CNN/The Point, Cillizza (2021) describes the anti-CRT rhetoric as “engineered panic over critical race theory.... it’s the perfect tool for scaring White conservative voters with a made-up problem - mobilizing them against the racial awakening of the past year” (para 1). CRT challenges systemic racial inequity and can support the disruption of the status quo (Patton, 2016). CRT is not focused on labeling oppressors and creating division, it is focused on understanding the present impact of historical oppression and the negative effect of structural racism and inequity.

Inclusion of the tenets of CRT in nursing education may be helpful to raise awareness of racial/ethnic bias and provoke conversation about unconscious bias and structural racism. The university setting is the ideal arena to question processes which maintain the status quo and support removal of barriers to the recruitment and retention of a multicultural/multiracial student body, staff, and faculty. The focus for this improvement initiative is to raise awareness of the presence and impact of implicit racial/ethnic bias in nursing faculty. I hope that this will be the stimulus to support program and curricular changes which facilitate raised awareness of racial/ethnic bias for our students and will promote recruitment of a multicultural student body which will become an aware nursing workforce which can support the reduction of health disparity for the Black, Hispanic, and American Indian populations.

The Improvement Initiative

The focus for this improvement initiative, raising nurse awareness of implicit racial/ethnic bias, was established after I became conscious of the presence and impact of implicit racial/ethnic bias in my nursing career. This decision was further reinforced by the dramatic, ongoing evidence of health disparity between the Black, American Indian, and Hispanic and White population despite more than 40 years and millions of dollars dedicated to research and implementation of multiple health improvement initiatives. Chronic health disparity in these populations prompted the review of root causes for health inequity and pointed me to the impact of implicit racial/ethnic bias on the quality of health care provided to the Black, Hispanic, and American Indian populations.

The Driver Diagram (Figure 8 below) is a tool designed to succinctly describe the theory of change for the development of research activity by presenting a visual representation of what will drive, or contribute to, the improvement process's aim, or desired outcome for a complex problem (Langley et al., 2009). This clarity is important for the researcher as well as the participants in any improvement activity. A Driver diagram consists of three sections: the Aim, the Primary Drivers, and the Secondary Drivers. The Aim states the desired outcome (the overall goal) of the improvement initiative, which is, in this Driver diagram, to raise faculty awareness of implicit racial/ethnic bias and its effect on the health of minority populations in order to support raised awareness in nursing program graduates through inclusion of this content in the nursing curriculum. Due to the time limitation for this improvement initiative, my focus was limited to the measurement of change with the faculty participating in this improvement initiative; however, I intend to continue to engage with the school of nursing to advance this implicit bias raising goal with future activities. The Primary Drivers, or key drivers, in the driver diagram are the focus areas to be influenced by the intervention initiative. The Secondary

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However, the initiatives generally lose steam during implementation and disappear before real improvement can be realized. This failure to implement phenomenon has been identified in the realm of education as well. Education leaders “tend to adopt, attack, and abandon” (Rohanna, 2017, p. 16). Improvement science is “a methodological framework that is undergirded by foundational principles that guide scholar-practitioners to define problems, understand how the system produces the problems, identify changes to rectify the problems, test the efficacy of those changes, and spread the changes (if the change is indeed an improvement)” (Hinnant-Crawford, 2020, p. 25). This model, using small tests of change, is an ideal approach due to the sensitive, very personal nature of the topic implicit bias. The aim for this action research is to raise faculty awareness of implicit racial bias as an antiracism strategy toward the elimination of health disparity for the Black, Hispanic and American Indian population. Improvement science has strong applicability to issues of equity and justice. The improvement science Model for Improvement includes five fundamental principles:

Knowing why you need to improve

Developing an effective change that will result in improvement

Testing a change before attempting broad implementation

Having a feedback mechanism to tell you if the improvement is happening

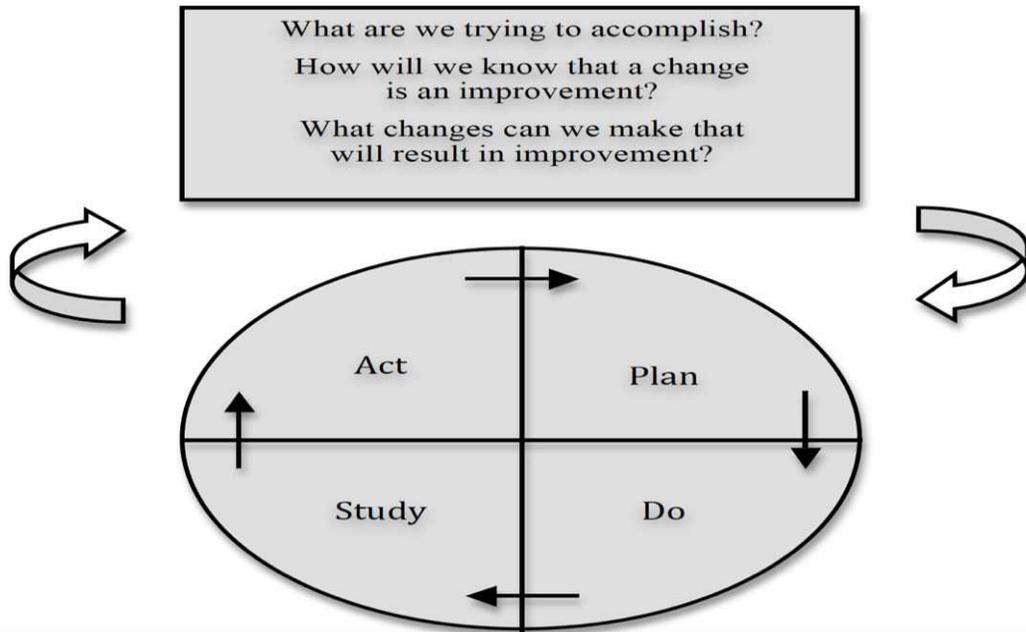
Knowing when and how to make the change permanent (implement the change)

(Langley, et. al, 2009).

The Model for Improvement methodology (Langley et al., 2009) (see Figure 9 below) begins with development of the statement of purpose which describes the focus area for the improvement initiative using three foundational questions: What are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in improvement?

Figure 9

The Model for Improvement: Aim, Feedback, and Changes.



(Langley et al., 2009, p. 24)

What are we trying to accomplish? The purpose for this improvement initiative was to raise faculty awareness of the presence of implicit racial/ethnic bias. *How will we know that a change is an improvement?* Formative and summative measures were defined and a plan for data collection was developed which provided information to indicate whether the experience generated an increase in awareness of implicit racial/ethnic bias and if certain activities were more effective than others. *What change can we make that will result in improvement?* Interactive activities designed to provoke self-awareness of implicit racial/ethnic bias were developed to be the foundation for a series of online group meetings for the initiative participants.

Once the purpose was defined, I moved to the plan phase in the Model for Improvement: **Plan**, Do, Study, Act. First, I determined that the intervention activities would occur in the

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online teaching environment using the Zoom meeting platform. Zoom is the platform currently used for our online classes and faculty meetings therefore, the discomfort of learning a new system while working with somewhat uncomfortable content could be avoided. Furthermore, it was important for me to be able to use findings from this research experience to inform curricular changes in my courses which are exclusively provided in an online platform. Second, the invitation for participation would be limited to the full-time faculty in the school of nursing which would allow for a mix of tenured, tenure track and non-tenure track faculty perspectives. Opportunities to participate in implicit bias raising experiences will be offered for adjunct faculty in the future. Using fulltime faculty for the improvement initiative was essential to the goal to create a critical mass of faculty able to support raising awareness of implicit bias across the school of nursing.

The next step in the Plan process was to create the documents required to gain approval for my research from the University Institutional Review Board (IRB). Working closely with the IRB staff, my Disquisition Committee Chair, and the IRB reviewer, the required documents for the improvement initiative: Request for Initial Review of Research (Appendix A) and the Consent to Participate in a Research Study (Appendix B), were submitted and approved.

Recruitment of participants was a multi-step process. Each full-time faculty member of the school of nursing received a personal invitation from me via university email sharing the opportunity to participate in this research essential to improvement of patient care for Black, Hispanic and American Indian populations (Appendix C). The email included a brief explanation about the purpose of the research, the process, and anticipated time commitment with an invitation for interested faculty to reach out to me if they had questions. Eight faculty members, which represented all of the programs in the school of nursing, responded positively to the invitation. Each one received a copy of the Consent Form to Participate in a Research Study

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(Appendix B) which detailed the purpose of the research, expectations for the participant, data collection plans, protection of participant data, a description of the initiative, and the risks and benefits related to participation. An opportunity to ask questions was provided. When all questions were satisfied, all eight of the participants signed the consent and submitted the completed document to me via secure email. The group collaborated to determine the Zoom meeting dates and times.

Following the recruitment of participants, a timeline was developed for the intervention structure, educational content, and activities (Appendix C). The improvement initiative was designed to consist of pre-session activities which included reading assignments, completion of the Intercultural Development Inventory (IDI), Harvard Implicit Association Tests (IAT), and post session reflections. Six virtual sessions were scheduled over the course of eight weeks each one lasting for a period of one to two hours simulating the typical online class format. The virtual sessions were designed to use different learning activities commonly experienced in the online learning environment. The session format included the discussion of various pre-session readings as well as the completion of the IDI and IAT, sharing relevant personal experiences, viewing video recordings of patients sharing their healthcare experiences, and viewing special topic videos. The Improvement Plan went through several ideations to create an improved flow and incorporate other awareness raising elements (Appendix D).

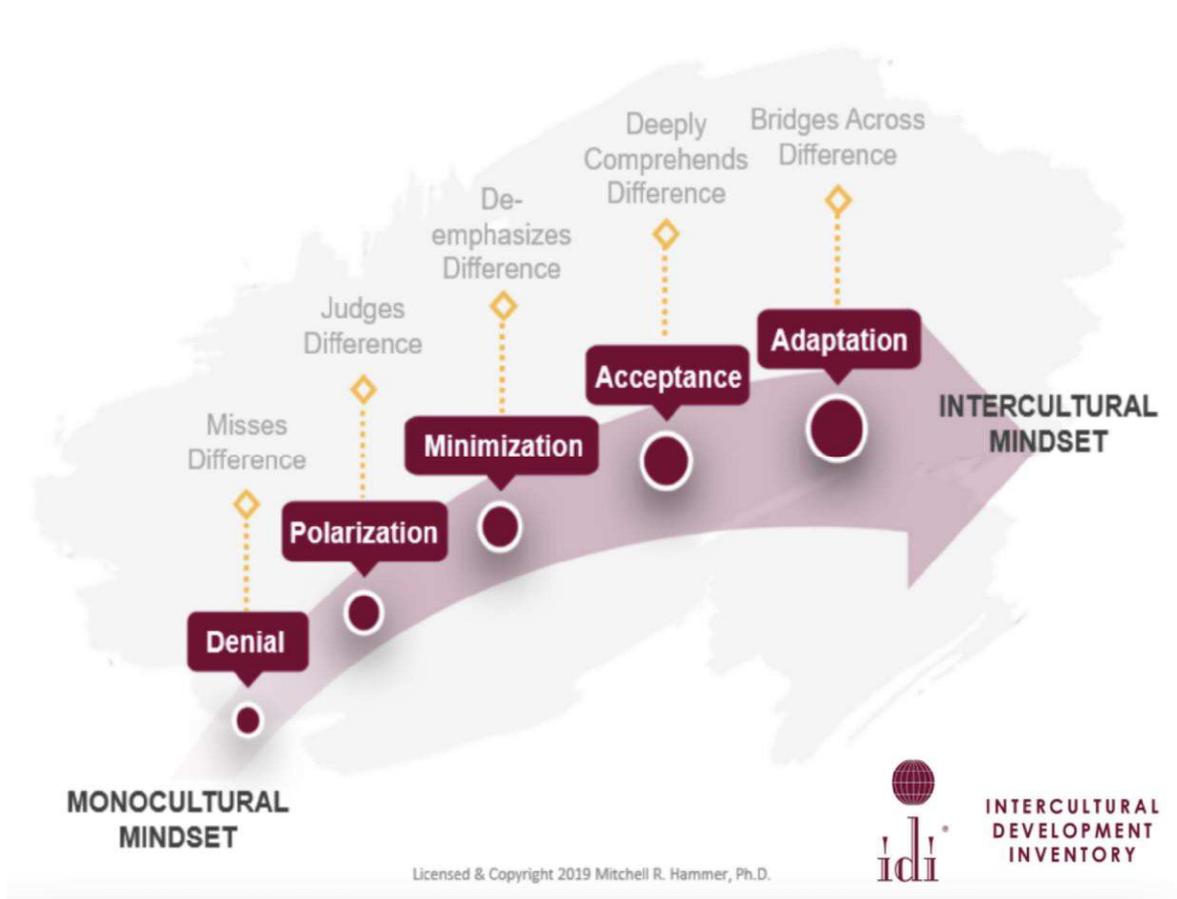
Following each session participants completed a blinded qualitative survey which included prompts to provide focused reflection on the activities, perspectives and feelings generated by the experience. To assist participants in understanding their own bias and how the intervention potentially changed their biases, a pre- and post- test instrument seemed logical. The Intercultural Development Inventory (IDI) was selected to provide feedback and summative data for analysis regarding effect of the improvement initiative.

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Mitchell Hammer developed the IDI in 1989. The assessment is grounded on Bennett's theoretical framework, the Developmental Model of Intercultural Sensitivity (1986) which proposed six "worldview orientations toward cultural difference...Denial, Defense, Minimization, Acceptance, Adaptations, and Integration to help understand how people interpret cultural difference" (Hammer, Bennett, & Wiseman, 2003, p.1). Hammer's framework reduced the orientations to five and framed these orientations across a continuum, called the Intercultural Development Continuum (see Figure 10) beginning with a Monocultural mindset (ethnocentric), having a single cultural viewpoint or understanding, and moving to an Intercultural (ethnorelative) mindset, striving to understand different cultures and thereby gaining a new perspective on the way we interact with each other. The first two mindsets in the continuum, Denial and Polarization, are described as ethnocentric, assessing other cultures using one's own culture as the standard. Minimization is the transition mindset moving from the ethnocentric mindsets toward the ethnorelative mindsets, Acceptance and Adaptation where cultural differences are acknowledged, however one culture is not deemed superior to another.

Figure 10

Intercultural Development Continuum



Movement across the Intercultural Mindsets does not occur in a stepwise fashion. It is a developmental growth process that is fluid and occurs over a lifetime based on the level of awareness and experience.

The IDI is a 50-item test that measures a person's response to difference, an attribute the developer of the instrument calls intercultural sensitivity or competence. This measurement of intercultural competence is based on the assumption that behavior is guided by the individual or group orientation toward other cultures (IDI Sample Report, n.d.). The findings from the IDI are summarized into three measures: the Perceived Orientation Score, Developmental

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Orientation Score and the Orientation Gap. The placement of the Developmental Orientation Score on the Intercultural Development Continuum indicates the mindset for the participant, or in this case, the group. The goal for use of the IDI feedback is rather straightforward; raising awareness of a person's cultural orientation to provide a motivation to ask, how do I do things, interact, and think about people differently and improve relationships?

Through extensive validation over time, the IDI has demonstrated reliability and validity across international and domestic cultural groups. Comprehensive reliability and validity studies have been performed to confirm that the IDI is free from cultural bias. Paige, Jacobs-Cassuto, Yershova, and DeJaeghere (2003) completed a psychometric analysis of the IDI regarding the validity of the inventory's results. Their purpose was to determine whether this tool could produce a reliable measure for intercultural sensitivity that could be useful for profiling and diagnosis in their research. Data analysis was completed for 375 participants of various ages, level of education, and intercultural experiences. While not specifically a measure of implicit racial/ethnic bias, the IDI was proven to be a reliable instrument which can be useful to provoke introspection regarding perceptions about difference between populations and cultures to promote development of intercultural sensitivity.

Each participant in the study completed the IDI prior to the first session of the improvement initiative. The IDI reports provided summative data for this study using the following measures aggregated to provide a group score: the Perceived Orientation Score, the Developmental Orientation Score and the Orientation Gap. The Perceived Orientation Score represents the person's appraisal of their cultural competence. The Developmental Orientation Score reflects the actual measure of the person's cultural competence. The Orientation Gap is the difference between the Perceived Orientation Score and the Developmental Orientation Score.

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The Director of Intercultural Affairs at our university is a Certified IDI Facilitator and agreed to administer the IDI assessment tool and debrief the findings. The IDI was administered prior to the first and last sessions of the research activity. The aggregated group scores from the two IDI assessments were used to measure change in the level of orientation toward cultural difference and commonality across the Intercultural Development Continuum (Figure 10 above) as a result of the intervention experiences. Feedback from the IDI assessment was an important part of the improvement initiative strategy to encourage self-awareness of implicit bias. Improvement initiative sessions one and six were devoted to receiving the feedback from the aggregated group findings from the IDI assessment taken prior to each session, sharing initial reactions to the data, and discussion about the validity and usefulness of the findings. Formative data was collected from the six post session reflections and observations from review of the session videos. Greater detail regarding the IDI findings and feedback from the reflections is found in the Improvement Initiative section.

Do is the next step in the Model of Improvement: Plan, **Do**, Study, Act. This step represents the implementation of the improvement interventions created in the plan phase described above. The content for each of the six sessions is described in detail in the Improvement Initiative section. The major focus areas for the sessions were:

- Session one – Participants complete the IDI assessment prior to the session. During the session the IDI facilitator debriefs the findings in aggregate: the Perceived Orientation Score, the Developmental Orientation Score and the Orientation Gap.
- Session two – Whiteness as property. The discussion of privilege, power, assumed social standing, and the social impact of not being White.
- Session three – Recognition of the existence of racism. Looking at overt and unconscious personal and structural racism and “othering”.

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- Session four – Colorblindness. Fallacy of the concept that we are all alike, I treat everyone the same as a method for countering racism. Use the Implicit Aptitude Test experience to raise consciousness of personal bias.
- Session five - Counter Story Telling. Lived experience discussion. Sharing the personal experience of Black, American Indian and White persons, living in our region, in healthcare situations.
- Session six- IDI facilitator debriefed the findings from the IDI test taken by participants prior to this session. Discuss future activities that may be helpful to engage the school of Nursing.

Twenty-four hours after every session, participants received an email to complete a reflection and share comments regarding their experience. These comments were used as part of the improvement research evaluation process.

During the next phase of the Model of Improvement: Plan, Do, **Study**, Act, data were compiled and evaluated to assess the effectiveness of each individual intervention and, an evaluation of the overall level of achievement with the improvement initiative's goal to raise awareness of implicit racial/ethnic bias. Pre and post IDI assessment data were compared to provide summative data at the completion of this improvement initiative. Measurements used for evaluation were the pre and post Perceived Orientation Score, the Developmental Orientation Score, and the Orientation Gap. IDI results were reported in aggregate for each category and also blinded results for each participant. score. The IDI facilitator made the individual IDI results available to participants upon request.

Formative data were collected from observation during the sessions, review of session videos, and review of the post session reflections. Prompts were included in the qualtrics survey to provoke thoughtful reflection. There was also space for additional comments. To promote a

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safe environment for participants to share their feelings and provide truthful, meaningful feedback, the participants created a pseudonym within the qualtrics product for use in completion of the survey. Feedback was submitted to me in a consolidated email generated by qualtrics with the participant's pseudonym as the only identifier so I could not relate the data to a particular participant and their privacy was protected. Recordings and transcripts of each session were reviewed to assist in the evaluation of the impact of each session toward awareness of implicit bias. Information from review of the meeting videos and feedback from the qualtrics surveys were used not only to measure change in awareness of racial/ethnic bias but also to inform modification for the next session, if indicated. Various versions of the post session reflection questions were used evaluate the depth of reflection feedback between different prompts. Detailed analysis of the session activities is provided in the weekly session descriptions in the Improvement Initiative section.

The **Act** phase of the Model of Improvement: Plan, Do, Study, **Act** is where the researcher uses findings from the Study phase to inform future action. After each session I reviewed the session video and post session reflections about the experience to identify anything related to the format or content that could improve the experience for the subsequent session. I also used this step to determine whether there was demonstration of raised awareness by the participants. The review resulted in small changes to the prompts for the post reflection survey to test the effect of variation in phrasing. Based on the feedback the pre-session assignment was modified for one session to be more interactive. Details related to these changes are provided in the Improvement Initiative section. Another action from the Act phase will be to use the information gained from this improvement initiative to make modifications to classes I teach in the school of nursing which can support raised awareness of implicit racial/ethnic bias with my post licensure Bachelor of Science in Nursing students. I will also share the findings of this

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research with our School of Nursing faculty and faculty in the College of Health Human Sciences (CHHS). It is my desire to encourage further activities which support movement from a passive recognition of the existence of implicit bias to an active, action-oriented antiracism approach that motivates nursing program graduates to effectively engage with patients to provide equitable high-quality care for all patients, reduce health disparity and create a work environment that welcomes diversity in the healthcare workforce.

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Implementation of the Improvement Initiative

The table format for representation of the Improvement Initiative Plan was chosen to provide a visual demonstration of the focus areas, processes, and activities included in the improvement initiative and the measures used to demonstrate the level of achievement of the improvement initiative goal to raise awareness of implicit racial/ethnic bias. The table is organized in six categories of activity: Session number, Session Focus, Activity, Facilitation Prompts, Formative Measure, and Summative Measure. Below each heading there is a brief statement describing that activity. If there is no content in a block, there is no activity for that area during that session.

Table 3

Improvement Initiative Session Plan: Week One

Session Number	Session Focus	Activity	Facilitation Prompts	Formative Measure	Summative Measure
Prior to Week 1 Pre-Work to be completed prior to Session One Time commitment, about 30 minutes	Establish a baseline measure of implicit bias.	Participants received an email link with instructions to complete the Intercultural Development Inventory (IDI).		Results from the IDI	
Session 1 Debrief IDI results. Time commitment: up to two hours. Facilitator: Co-PI Sheila Price, Topic expert: Certified IDI Consultant	Debrief of the group findings from the IDI assessment, facilitated by IDI consultant. 24 hours post session participants will receive qualtrics reflection survey.	Review the validation of IDI instruments and debrief elements of the IDI assessments. Provide space for reaction and discussion of the information	Provided by Certified IDI Facilitator who will lead the session.	Aggregated Group IDI findings: Perceived Orientation Score, Development Orientation Score, and Orientation Gap.	Collect artifacts from qualtrics guided reflections and review of the session video. Use info to inform next session's discussion.

Prior to the first session, participants completed the Intercultural Development Inventory (IDI)

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Educational version via the internet. Information regarding the development and validation of the IDI is found in the Research Design section of this document. The first session of the improvement initiative was a debrief of the IDI findings by a Certified IDI Facilitator. The findings presented at this session were consolidated into a group report with the offer to debrief individual findings upon request. The IDI facilitator provided an overview of the development and validation of the IDI assessment and shared several videos produced by IDI relating the IDI mission and the IDI corporate vision for use of the assessment. It was emphasized that the information from the assessment should be perceived as a point in time measurement which can be useful to provoke self-reflection and to formulate a personal development plan. The debrief activity proceeded with an explanation of the mindsets that are represented on the IDI Intercultural Development Continuum. These elements are arranged on the continuum to demonstrate a progression from Denial to Adaptation. They are not experienced as precise steppingstones. People may move up and down the continuum many times as they develop awareness and new ways of thinking and engaging with other cultures.

The first two mindsets in the IDI Mindset Continuum, Denial and Polarization, are considered monocultural mindsets. The monocultural mindset is described as an orientation where the person makes “sense of cultural differences and commonalities based on one’s own cultural values and practices, uses broad stereotypes to identify difference, and supports less complex perceptions and experiences” (IDI Sample Report, p. 3). Minimization is considered the transition phase between monocultural and intercultural mindsets. The upper two mindsets, Acceptance and Adaptation, are considered intercultural mindsets. People who have a more intercultural mindset are developing a deeper understanding of cultural difference and are able to interact in more culturally appropriate ways.

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The person in the Denial mindset may rely on stereotypes to see cultural difference, is likely to be less attentive to cultural difference and may have had limited or no experience with other cultures. This might be demonstrated by an overly critical view of another culture's values. This person may become offended if a someone from another culture does not interact in the way that matches their cultural norm. The IDI facilitator shared the following example of someone in this mindset; a leader challenged a Chinese coworker for showing disrespect to the leader by avoiding direct eye contact, not recognizing that this is a cultural trait of respect common in Chinese culture.

Polarization is represented by an us/them approach to cultural difference. A person in this mindset sees cultural difference as an obstacle and the dominant culture as superior. The person living in polarization will not understand why others don't think like they do. An example shared with the group by the IDI facilitator was the dismay expressed by a leader in Spain who proudly shared with her American guests that she had arranged for them to have the honor of attending a bullfight. She was astonished when they refused to participate sharing their disgust and dismay at celebrating animal cruelty. The person in Polarization is very intolerant of anyone who "doesn't get it", meaning the person doesn't have the same viewpoint.

Minimization is the third level in the continuum. Minimalization is considered the transition mindset moving the person from the monocultural mindsets toward an Intercultural Mindset. The person in this level may look to find commonalities between cultures, however, they may mask differences and struggle when approaching deeper understanding. Go along to get along is a phrase that is often heard from a person in minimization. This person may also lack self-awareness about power and privilege, People from the dominant culture may make reference to helping "those people" but would not be interested in the viewpoint of the person from that culture. People from the non-dominant culture may choose to blend in not allowing their cultural

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differences to make them stand out. They will rarely raise differing opinions and will support “everyone getting on the same page”.

Next on the IDI Mindset Continuum is Acceptance, an orientation where the person is beginning to recognize difference between cultures and is working to gain deeper understanding, however, this person may not know what to do about difference. There is an effort by a person from the dominant culture to understand another person’s culture. Unfortunately, cultural differences may at times be seen and addressed as a performance issue. The person from the nondominant culture may feel understood but not engaged.

Adaptation is at the height of the continuum – intercultural competence. The IDI definition of Intercultural Competence is “the capability to shift perspective and adapt behavior to cultural difference and commonality” (IDI group report, p. 3). All cultures are valued, involved, and engaged in the mission of the organization. Diversity is perceived as a resource. The phrase used to describe the communication goal at this level is to use a mutually adaptive solution perspective. One participant, LCP, asked whether “the goal” is to achieve adaptation. The answer from the facilitator was that the goal is always growing! The question struck me as representative of American culture. We want to study the material, pass the test and check the box. The facilitator was diligent in the reinforcement of the concept of continuous personal development in the development of cultural awareness and recognition of bias. People are always moving back and forth on the Intercultural Development Continuum as we become aware of our biases and encounter difference with the desire to move toward adaptation.

The IDI group report provided data for three measures: Perceived Orientation, Developmental Orientation, and Orientation Gap. Perceived Orientation represents the level of intercultural competence that the person perceives they have. The Developmental Orientation defines the person’s actual level of intercultural competence as measured by the assessment tool.

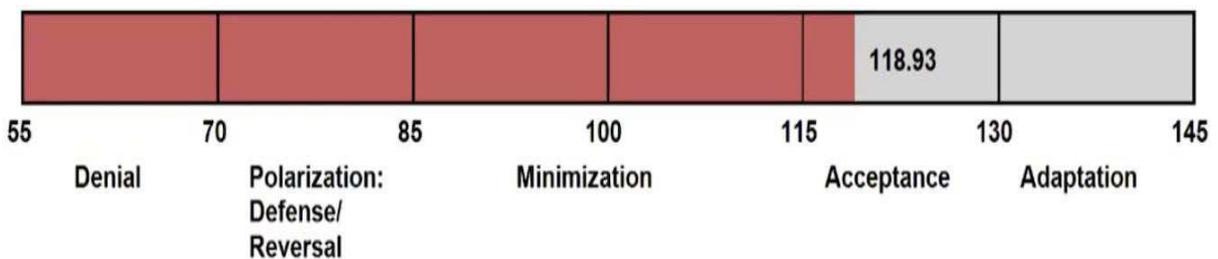
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The Orientation Gap is the difference between the two measures. An Orientation Gap greater than seven points demonstrates a meaningful variance between the perceived and assessed level of intercultural competence.

The group's aggregated Perceived Orientation (PO) score was 118.93. This score falls in the lower quartile of the Acceptance Orientation on the Intercultural Development Continuum as demonstrated in Table 4 below. The Acceptance Orientation represents a recognition of cultural differences and some appreciation of differences. A person in this mindset is able to appreciate their own culture and also see and appreciate the differences in other cultures.

Table 4

IDI Group Profile: Perceived Orientation (PO)

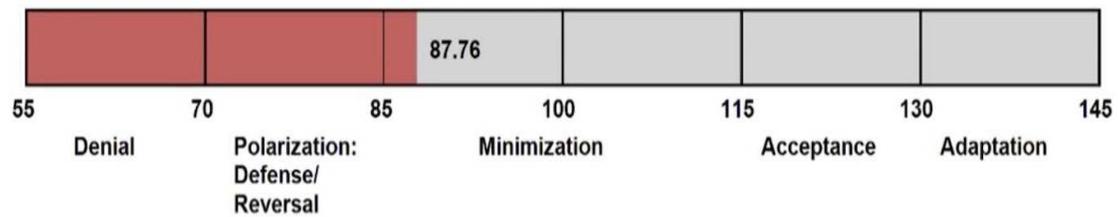


The Developmental Orientation (DO) score, which demonstrates measurement of the person's actual intercultural competence, was 87.76 which is in the lower quartile of the Minimization Orientation on the Intercultural Development Continuum (see Table 5 below).

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Table 5

IDI Group Profile: *Developmental Orientation (DO)*



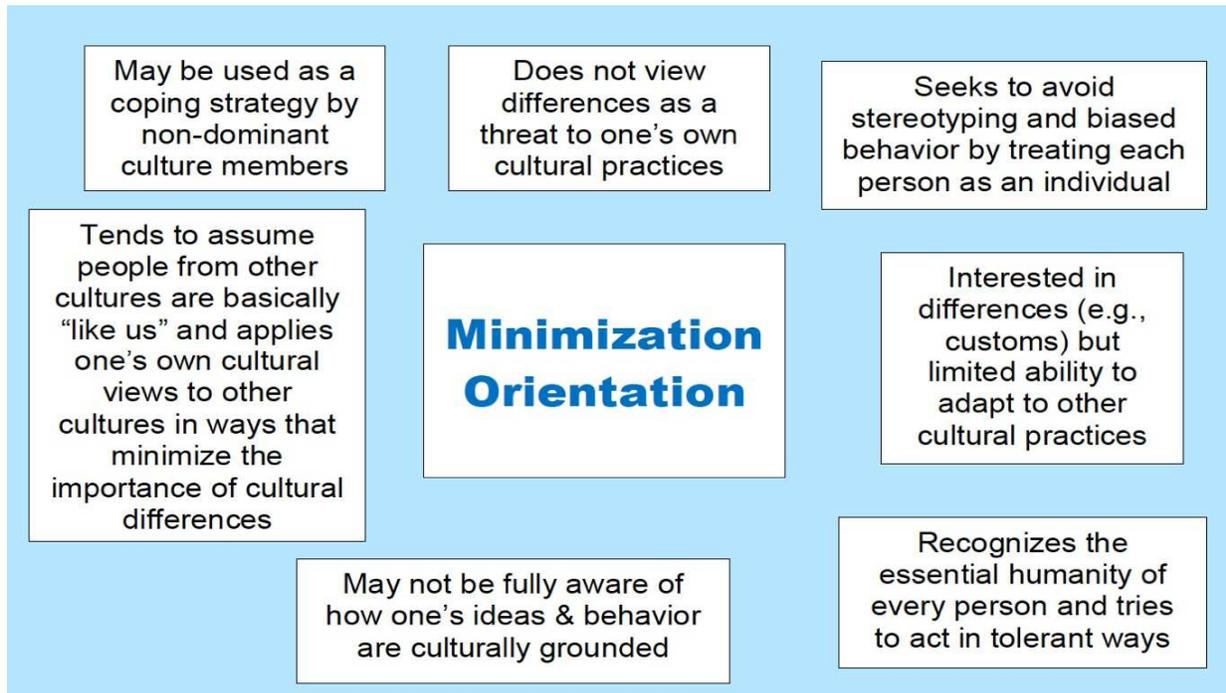
The Minimization Orientation is a transition phase from a monocultural to intercultural mindset. These transitions between mindsets do not occur in definitive steps. A person will move up and down the mindset orientation continuum as they develop cultural and self-awareness. A person with a Minimization Orientation has a tendency to have the following strengths and opportunities.

Strength: Your group likely has found some success interacting with people from diverse cultures when commonalities can be drawn upon.

Developmental Opportunity: Your group may struggle to bridge across diverse communities when differences need to be more deeply understood and acted upon. Your task is to develop a deeper understanding of your own culture, cultural self-awareness, and increased understanding of culture general and culture specific frameworks for making sense of and more fully attending to cultural differences (IDI Group Report, 2021, p.9). Figure 11 is an excellent resource to promote understanding of the Minimization Orientation.

Figure 11

Characteristics of the Minimization Mindset

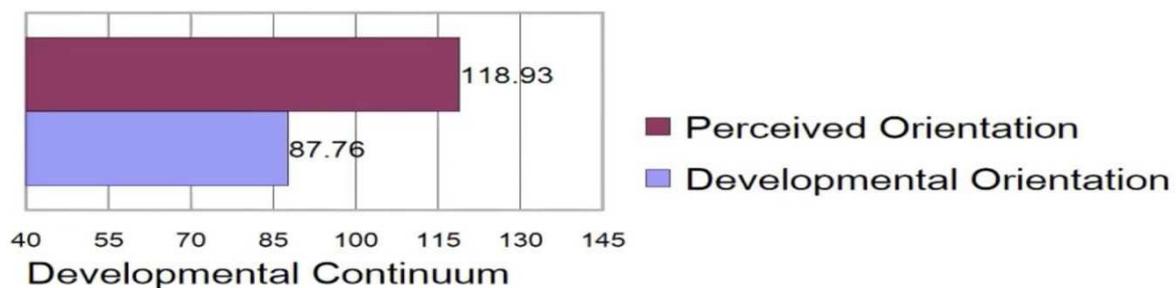


Intercultural Development Inventory Group Profile Report March 9, 2021, p.9.

The Orientation Gap (OG) represents the difference between the two scores, Perceived Orientation and Developmental Orientation. The Orientation Gap (see Table 6) for this group was 31.17 which represents a substantial overestimation of cultural competence.

Table 6

IDI Group Profile: *Orientation Gap (GO)*



The group expressed surprise and dismay at the level of overestimation of cultural competence represented by the Perceived Orientation score and the Orientation Gap. Several

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participants shared that their first reaction was that the report was not a true representation of who I am and how I feel about people. The IDI facilitator shared that this reaction as well as the degree of variance between the Perceived and Developmental orientation is not unusual. Unconscious, implicit, bias allows us to believe we are more adaptable to other cultures than we actually are. Placement in the Minimization mindset also points to a colorblind mentality toward difference. Nursing has taken great pride in the claim that we treat all patients the same, regardless of race, creed or color because everyone deserves the same high-quality level of care. Sadly, this approach has not resulted in the same high-quality care for all. I have come to realize that this desire to treat everyone the same really means that I believe everyone thinks, believes, and responds the same as I do. Unfortunately, this means that people who are not like me can experience miscommunication, misunderstanding, and a lesser quality of care.

TWP, (generic initials have been assigned to the participants to honor their privacy) shared the following concern about the validity of the findings. “I think I overanalyzed the questions on the assessment and maybe did not answer them in a way that the question was intended. I tried to answer the questions based on populations I work with, not globally”. The IDI facilitator explained that the questions and analysis processes were designed to measure an overall perspective and had been validated to provide an accurate assessment in spite of a person’s overthinking the answer. Concern was also expressed about the overwhelming magnitude of trying to know about all cultures. The IDI facilitator shared the following thought. It is not about what you know, it is about how you shift your presence and interaction after you know. The goal is not to memorize elements of culture. The first step is awareness, then how do I do things differently with new information. Memorization of cultural distinctions is not the answer, it is connecting with people and learning from them.

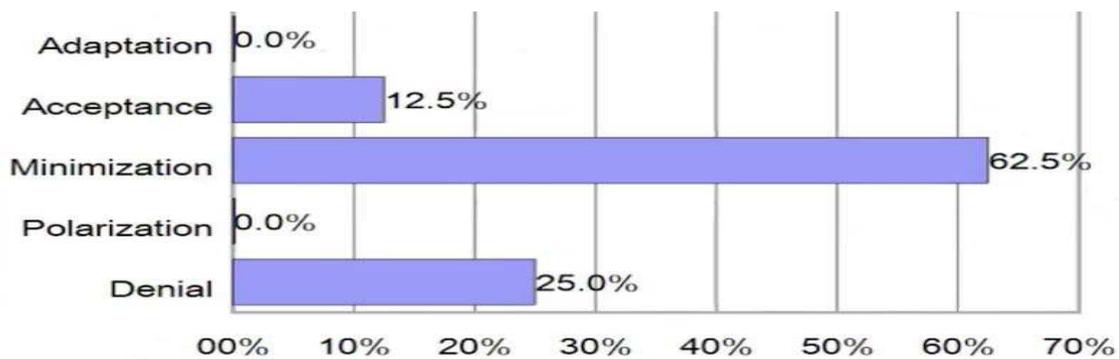
The IDI facilitator then shared a table showing the range of orientations demonstrated in

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our group (see Table 7). Some were a bit surprised that there wasn't a bell-shaped curve and others were surprised that there was this much variation. The graphic does not represent the placement within the range of each mindset orientation, merely that their findings placed them within an orientation level.

Table 7

Range of Developmental Orientation Scores



A take-away message about the range of Developmental Orientation scores for the group is confirmation that there is variability in every gathering of people. We have developed at the pace that our experiences and awareness has inspired and there is room in all of us for further growth and development in our cultural awareness and mindfulness of personal bias. Session One lasted for a very active two hours and included the IDI Facilitator's presentation with time for participants to ask questions and share their reactions while they were processing the feedback. The session ended with guidance to focus less on placement within the range of Development Orientation, better to focus on learning how to be more self-aware.

A qualtrics survey using prompts to provoke reflection about the experience was distributed via email 24 hours after the session. The summary report from the qualtrics reflection survey included the pseudonym used by the responding participants, however, the comments were reported without connection to the pseudonym or the identity of a particular respondent.

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Responses from the post session reflection survey responses are summarized below. The themes from the feedback were mixed. Some felt that the report was exactly as expected, others stated that they thought they were, as a group, more culturally aware than the data revealed. The large gap between perceived and actual was a shock for some. The following quote from a participant was insightful “when I am biased, it’s just due to ignorance of a culture, it is not that I believe that my culture is better. It is a lack of understanding, it is upbringing, and it is from being isolated from those in other cultures and how their values guide their culture”. All of the participants expressed an eagerness to learn more about implicit bias, how to help raise their awareness and then support others in this developmental process. As part of the iterative process of improvement science, the reflection prompts for session two were revised to see if different prompts affected the depth of the responses.

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Table 8

Improvement Initiative Session Plan: Week Two

Session Number, Focus Area	Session Focus	Activity	Facilitation Prompts	Formative Measure	Summative Measure
<p>Prior to Week 2</p> <p>Pre-Work to be completed prior to Session 2</p> <p>Time commitment: about one hour</p>		<p>Participants will complete the Privilege Responsibility Curricular Exercise survey (PRCE) (Appendix E).</p> <p>Read the designated selections from the book, <i>Is everybody really equal?</i> by Sensoy and DiAngelo</p>			
<p>Facilitator: Co- PI, Sheila Price</p>	<p>The effects of White Privilege, how it impacts access to “the American Dream” and identify implications at the school of nursing.</p> <p>One day post session: Complete guided reflection via qualtrics</p>	<p>Sheila will share the story of the impact of her implicit bias and privilege on patient care in an OB department.</p>	<p>If you shared your experience with anyone, what was their reaction?</p> <p>Let’s talk about the PRCE survey. How did it make you feel?</p> <p>How do we increase the diversity in the student and faculty population?</p> <p>Think about your nursing experience. Can you remember a situation where you knew someone was cared for differently because of race, English language skills, etc.?</p> <p>How did you respond?</p>	<p>How did your results make you feel?</p> <p>Do your results make you feel differently about how you approach patient care? If so, how?</p>	<p>Use info, as appropriate to inform the next session.</p>

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Prior to the second session participants were asked to complete a survey called the Privilege and Responsibility Curricular Exercise (PRCE) (Holm, et al., 2017) (Appendix E) which was adapted from the groundbreaking White Privilege Checklist by McIntosh (1989) (Appendix F) and selected readings from the book, *Is everybody equal?* (Sensoy & DiAngelo, 2012). *Is everybody equal* uses a farcical story to represent societal biases toward people who look different. The PRCE survey was designed to help participants begin to recognize and understand the privilege that results from the 400-plus years of White dominance in the United States. The survey presents a list of 22 statements: participants were requested to put yes by the statements that are applicable to their life experience. Here are a few statements from the survey.

I can look at the cafeteria menu and expect to see that the special of the day reflects my culture's traditional foods.

If I walk towards a security checkpoint in the airport, I can feel that I will not be looked upon as suspect.

I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children's magazines featuring people who look like me.

I can take a job with an affirmative action employer without having coworkers on the job suspect that I got it because of race or gender.

The survey has been an important tool to help White people recognize the integration of privilege into their daily experience and to prompt discussion.

The Week Two session began with a discussion about the participants' experience with the White Privilege Survey and the representation of the concept of White Privilege. White Privilege has been described as preferential treatment and opportunity that is not earned by merit but is based solely on the color of your skin. It is the effect of historical domination by the White population. The early reactions from the group were of frustration and even anger at the concept

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of White privilege. It was an awkward start while participants described their disbelief at the White privilege concept and uneasiness about the personal implication of implicit racism. One participant (RGN) shared frustration “I can’t stand the topic, White privilege. It makes me angry. I can’t change it. It is weird for me to even think about Whiteness. I was raised in a very diverse environment where race just wasn’t a big thing. I went to school in a very diverse school. I didn’t see color; I didn’t see culture”.

As a child I was far removed from privileged. I grew up in a two-bedroom home with my parents and four siblings. Neither of my parents went to college, however, they told me from an early age that I would go to college. It was never a question. We were well fed and cared for but our family lived at a low-income level, in other words, we were poor. In hindsight, it is interesting to me that during my public education there was never a conversation about how I would pay for college or whether I would be denied admission. I would get a part-time job, get loans to pay for college, but it was never a question, I would be going to college! I certainly did not feel privileged! I worked hard to achieve my goals. However, my White privilege was strongly affirmed as I answered yes to all 22 statements in the White Privilege Survey

LHR shared an experience about attending a racial diversity workshop that she felt really represented unconscious bias and privilege. There were only a few Black people in a large group of White attendees. The speaker was describing examples of overt and implicit racism. While listening to the examples of injustice and prejudice against Black people LHR was thinking, this has nothing to do with me, I’m not racist, I don’t see color, I am not prejudiced. Then a Black gentleman spoke up “I have lived the things you are describing; I experience these things every day”. A White woman in the group became emotional and started crying. Instead of maintaining their focus on the Black man who bravely stood up in a room full of White people to share the pain of his life, the crowd rallied around the crying White woman to comfort her because she

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was sad, the Black man's pain was ignored. The irony of the group's reaction made a huge impression on the participant. LHR ended with the thought that White people tend to only think of racial bias in the extreme context of 'BAD' people who do savage things to Black people such as hangings, spitting on people, burning down towns, or refusing participation in social events. Racism is BAD. LHR believes that White people avoid facing the issue of systemic and personal racism by telling themselves, I am a good person, I would never do something BAD like that, therefore, I am not racist.

I shared my story demonstrating my own implicit bias when I accepted a low standard of care for our Hispanic Obstetrical (see the Introduction section for more details). I allowed financial considerations and peer pressure from the other administrators to stifle my request to provide basic Spanish/English translation services to support care for patients in our labor and delivery unit. Would I/they have made the same decision to provide substandard care for our White patients? Sadly, I don't think there would have been any hesitation to make the purchase if the situation was reversed and the request met a need for our White patients.

Participant WBY raised this concern, "I don't know how to be less White. I can't undo myself, but I feel like that is what we are being asked to do" Another participant commented "do we have to be less who we are to be able to relate to others?" This question transitioned us into a discussion led by participant SCN who had experience working with Hispanic and American Indian populations. Participant SCN shared that you learn what can be a barrier to communication and development of a meaningful relationship and you work to manage that behavior. One example of learning about another culture was how difficult it was to learn to pause in a conversation to provide time for someone whose culture is to be thoughtful and not respond quickly to a question. It was a challenge to accept the silence, however, it was necessary to learn to wait and honor the person's culture. That seemingly small thing helped to develop the

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therapeutic relationship that was required to support a therapeutic relationship. Recognize and respect difference; accept the person without judgement.

We live in a rural area with a high majority White population. The school of nursing faculty is majority White and so is the student body. When asked the question, how can we increase our diversity in the nursing program, most replied that we must find ways to engage Black, Hispanic and American Indian students early in their public-school experience so they can believe that being a nurse is possible. The group discussed strategies to increase minority group access to nursing as a career. The greatest concern was that there is no resource available to support interested students during their public-school education to ensure they complete the science and grade point average requirements to be considered for admission.

Our closing discussion circled back to our aversion to the term White privilege, how uncomfortable the concept is, and what can we really do about it? It is easy to be overwhelmed under the weight of the question, what can I do to impact the ongoing effect of centuries of privilege? The answer we settled with was that with raised awareness comes responsibility. We cannot change the past; however, we can work to change the future through intentional efforts to raise awareness of personal and systemic racial bias so we can influence change that informs future nursing care and improves outcomes. We must find ways to have these awareness raising conversations with our colleagues. Somehow, we need to help minority students realize that a nursing career is possible. We must reach out to school systems to determine how to support minority students with this goal. The group voiced commitment to learning more about our own implicit bias and work to address systemic bias in the School of Nursing.

Twenty-four hours after Session 2 the participants received an email with a link to a qualtrics survey - post session reflection tool. The reflection survey was revised after Session One to contain the following two prompts: I was surprised by, What I found most challenging

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was. The feedback can be summarized as feeling denial, grief, and annoyance with the topic of White privilege. One participant shared surprise at “How defensive my initial reaction was and still is”. There was agreement that the White population has a history of conquest and dominance which has shaped today’s society, however, it is difficult to see how we can overcome four hundred years of dominance. These topics are hard to talk about and can be difficult to share with others. sometimes difficult to answer. The readings were found to be helpful in stimulating thought and conversation.

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Table 9

Improvement Initiative Session Plan: Week Three

Session Number, Focus Area	Session Focus	Activity	Facilitation Prompts	Formative Measure	Summative Measure
<p>Prework for Week 3 Review Videos Time Commitment: About an hour</p>	<p>Review Videos: Let's get to the root of racial injustice - Megan Ming Francis 19.37 min. Racial Disparities in Healthcare are Pervasive 6.01 minutes Minority Health Disparities, Michelle's Story 5.08 minutes How racism makes us sick 17.27 minutes</p>				
<p>Week 3 Recognition of the Existence of Racism Time commitment one hour Facilitator: Co-PI Sheila Price</p>	<p>Look at overt and unconscious, personal and structural racism, and “othering”. Racism in the healthcare system. Complete guided reflection one day post session.</p>	<p>Discuss the essence of the videos and shared their reactions to the content.</p>	<p>Share your first thought after you reviewed the videos. Tell me a story about what you have seen... in the healthcare setting, the classroom, our recruitment and admission systems, etc. Share a time when you experienced Bias.</p>		<p>Collect artifacts from the qualtrics guided reflections and review of the session video. Use info to inform next session's discussion.</p>

Session three began with more tension than the previous sessions. It was obvious from the conversation before we started that the group was weary from a hectic workday. The prework for this week included viewing videos that presented very pointed scenarios sharing personal

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experiences with racial bias. I knew the discussion for tonight's session was going to be intense, so we took some time before beginning the session to talk about the frustrations of the day and attempt to "detox" the anxiety and fatigue. When I opened the session, I shared the following message:

I would like to remind everybody that if we do this work right, we're going to be uncomfortable, perhaps embarrassed, perhaps angry, perhaps indifferent, perhaps frustrated, and that's okay. The idea of this conversation is to open up a little and maybe think deeper about what we have heard, felt, and seen from the videos and from our life experiences, opening our mind to see racism from another viewpoint.

There were four videos assigned as pre-work for session three that spoke to aspects of the reality and the effect of racial bias. *Racial disparities in healthcare are pervasive* shared data and observations of the ways that implicit bias impact care and quality for people of color. The message from *Minority health disparity: Michelle's story* is that everybody needs to get involved to eliminate health disparity. The speaker in the video discussed why people do not take ownership of their health and how the Black neighborhood learned ways to support each other in overcoming and preventing disease and disability that they previously believed was inevitable. The community came together with the healthcare system and government representatives to make services available and accessible. *How racism makes us sick* shared data that demonstrates the negative effect on health for people of color regardless of education and financial status. There is a physiological response to the stress of implicit and explicit racism.

The session began with discussion about the message in the fourth video, *Let's get to the root of racial injustice*. Megan Ming Francis began the Ted/Talk by sharing her brother's experience with racism. He and a friend were sitting on the stoop of their apartment when police officers suddenly stopped their vehicle in front of their apartment, ran to the two Black young

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men and threw them to the ground. After placing them in hand cuffs they pressed them against the wall while shouting repeatedly, “DO YOU HAVE DRUGS?” Her brother quietly responded that he did not do drugs and was a student at Temple University. This seemed to upset the officers even more. Finally, they allowed him to retrieve his wallet. When they saw his student identification card, they left them alone. The speaker sadly shared with her brother that she knew this would not be the last time that he, a Black man, would be stopped and frisked by the police looking for drugs.

I opened the discussion with the following question, when you watched the video of the woman who was talking about her brother’s experience with the police, what was the first thing that popped into your mind when she was telling the story? BRW responded with “Here we go again is a little strong, but I'm like Okay, I've heard this story quite a few times. I just read Isabelle Wilkerson's book, *Caste*, it's great. It's not like I don't believe it (bias and prejudice), I know it happens and it's bad, but I'm like, Okay I'm over talking about it. I want to move forward. It's enough just to stop talking about this and figuring out how we're going to fix it”. Others shared that it was interesting when the woman in the video talked about how black skin triggers fear in the police and other people and just throwing education at the issues is not changing anything. We are educators, what else can we do? We further discussed how good intended White people tried to solve the Black population’s housing problem by building huge high rise apartment buildings so they would have a place to live not understanding that the outcome of so many people in a small area would result in the loss of “community” and become a recruitment haven for gangs. When the conversation moved to the presence of bias in our own experience, a participant asked if there were several young Black men or boys sitting on the porch of a house in your neighborhood, even if they didn’t look like gang guys what would your first reaction be? Just like the police reaction in the video, we might become a little tense and

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assume the worst. It was notable that we discussed how White people tried to solve Black people's problems rather than how to support Black people in solving them.

LHR said that she reacted negatively to the request in one of the videos to "be less White". She then shared the following story, paraphrased. This is embarrassing, but when I was much younger and working in a Critical Care Unit, a lot of the staff that I worked with were African-American. My mom had raised us not to see color so in a conversation with one of the Black nurses I said something to the effect of, racism is gone. This was a long time ago, probably early eighties. She was surprised at my remark. I said Really! I never saw any racism when I was growing up. She said, do you remember watching the Mr. Monte show on television? It was a local cartoon show, Mr. Monte and Bozo the clown. The setup was that children would be sitting on the stage and watch the cartoons during the show. It was a great thrill to be on television. She reminded me that there was one day a month that the black kids got to be on Mr. Monte. In my mind, it was like, oh black kids are on Mr. Monte today. Yay! But she reminded me that the Black children were never on stage with the White kids. Also, when she was a teenager she had to sit in the balcony to watch a movie, she continued sharing from a long list of limitations she experienced because she was Black. LHR said, that's what apologizing for my whiteness is about for me, my total lack of awareness, me thinking everything was fine and it wasn't. I'm embarrassed also to say that I didn't know it was the '60s before Black people could vote. I'm embarrassed about that. Several other examples were shared by the group.

The conversation progressed to the university environment, particularly faculty and student selection criteria. There was conflict shared about race-based recruitment. RGN has participated on many hiring committees and noted that you can increase the racial mix in the number of applicants by posting in certain magazines or websites, however, at the end of the day it is hard to recruit someone to be the only person of color, or male, in a White middle-class

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female dominated school. I shared a recent conversation with the university Diversity Officer about this topic. Here is a summary of that conversation. Part of the problem with the past recruitment is they were recruiting for color and not for fit, and not for what they bring to the university. It was we need one more Black person, we need one more of this, one more of that. If we just make it a recruitment goal for a certain number of people of color, then we'll end up with people that are miserable.

Creating a holistic admission process has been posited as a remedy, however, BWR shared a concern that it is very hard to do a holistic process when you have 20 students you can select from 100 applicants. The students who get selected have a grade point average at the top four percent of the applicant pool. “And plus you have to figure out, well, okay this person's been through a lot and it looks they bring a great depth of character and culture to the program. However, I don't know if they're going to pass their boards. They got all Cs in their grades. So, it's not easy”. There is a disconnect between meeting the university's current measurements for program success and the impact of increased diversity in our student body.

The issue of the distress of discrimination, described in the How Racism Makes Us Sick video, was a new concept for most of the group. Genetics, culture, healthy behaviors, and the food you eat are all factors that influence health but I never even thought about the effect of discrimination on the production of stress hormones. The speaker in the video talked about discrimination chipping away at someone's value raising stress hormones that contribute to obesity and high blood pressure. WBY shared that this was aa aha moment. I teach about stress and stress hormones in my mental health class but I never thought of associating that with discrimination. Someone raised a concern about determining a valid measure of our success in raising implicit bias awareness. There was agreement that the approach we must take is one to make changes in our program to have an effect with the people we interface. We may not see a

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measurable impact of the of these incremental changes until a critical mass is achieved.

One of the final comments of the session put our challenge into perspective. The immigrant gentleman that spoke in the TedTalk, *How Racism Makes Us Sick*, remarked at one point that police officers aren't necessarily bad, it's that they are raised in that culture of suspicion. And so, it's that culture of suspicion that they're living in and performing their jobs in. He said what clicks with me is the idea “that just like the police officer, we have to change the mindset, but we can't change the officer in the uniform until we change the officer way before they climb into that uniform”. This is applicable to our goal for our nursing students. As anticipated, the atmosphere throughout the session cycled through frustration, confusion, conflict, awareness, and possibility repeatedly as we processed the content and tried to bring into focus any intervention that could begin to change the impact of implicit and explicit bias in nursing care, recruitment and selection of faculty and students. We must do something! This statement is the challenge that we will continue to explore.

Twenty-four hours after the session a qualtrics survey was shared with the participants to share their reflections of the experience. (Note, two participants did not respond to the survey). The following is a summary of comments from the respondents: the problem is overwhelming, it feels hopeless and so frustrating, but I want to do something, anything, now! One participant stated that she had already decided to include some of the experiences and content in her course this summer.

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Table 10

Improvement Initiative Session Plan Week Four

Action Research Plan	Session Focus	Activity	Session Facilitation Prompts	Formative Measure	Summative Measure
Prework for Week 4 Complete the IAT tests		During the week prior to session five, participants will be sent the web link to complete the Race version of the Implicit Association Test (IAT) (Black/White) and the Skin Tone IAT.			
Week 4 Color Blindness Virtual Group Meeting: time commitment, 1 hour Facilitator: CoPI Sheila Price	Colorblindness. We are not all alike. Recognition that implicit bias is a reality One day post session: complete guided reflection via qualtrics	Share reactions to the IAT test results. Discuss the impact of the color blindness method of thinking and communication on decision making, interactions, and discussion of social equity.	Were you disturbed by your results? If so, please explain. How did your results make you feel? Do your results make you feel differently about how you approach patient care? If so, how?		Collect artifacts from qualtrics survey-guided reflection and review of discussion in the session video. Use info to inform next session's discussion.

The Implicit Association Test (IAT) was developed in 2011 (implicit.harvard.edu) as a method to educate the public about the existence of implicit bias as well as to collect data through an online virtual laboratory. The test requires quick decisions when presented with

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pictures and words. The assumption is that the response rate is faster when the person sees a match that agrees with their perspective. In answer to the question, What was your first reaction when you got your report? the group stated a distrust for the validity and logic of the text. TWP stated that by the second question we got to the facial recognition, and I thought, I know where this is going to go, yes, I am prejudiced so I may as well stop right now. They are setting me up for bias already. It was noted that the test asked questions about your zip code, “sort of like they are already going to put you into a group, you are from the South so probably biased”. LHR had taken the IAT previously and noted that her findings had changed. Previously, the finding was preferred people of color over lighter skinned people. This time it reported no preference either way for color or race. I proposed to the group that even if we take the position that the IAT is not an accurate representation of our values and biases, it may be helpful for us take a moment to think and have a “what if it is true?” discussion.

The next conversation was about being sensitive to a patient’s preferences related to their care. WBY shared an observation with students in an accelerated Bachelor of Science in Nursing (BSN) class when discussing an American Indian tradition; women take the placenta home after the birth of their babies. The placenta is important in their traditions, so it is part of the cultural competence education to ask the mother, do you want to take the placenta home with you. “The students got kind of worked up about this topic. Some reacted at how gross this concept is and others were bothered by generalizing a whole culture; how can you say that everybody in that culture will want to do this?” The discussion continued with other participants sharing similar concerns about making assumptions about culture. One suggestion was to ask everyone about their preferences for the disposition of the placenta so no patient felt like they are singled out or left out. The perception being that as long as you are respectful in your communication, people seem to be okay with the question. The consensus was that people are able to sense when the

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nurse is communicating caring, is showing respect during the interaction, and taking the time to listen.

The participants' frustrations were again expressed in the question, this is too big, we can't change the world, what can we do? At first, the suggestions were tactical, diversify the mannequins in the simulation lab or order a black mannequin hand so the students can get experience with the differences in starting an IV with patients with dark skin. Then the following perspective was shared, the take-home message is to listen to people, where they are. What are their needs? Don't go in assuming you know what someone needs. Ask what support is needed and listen.

The reading about equity talk and equity walk produced the following statement from RSD "I thought, whoever walks through my door is who I educate. I don't have a lot of control on who that is". This was exactly the discussion starter that we needed. What can we control? This awareness moment was very frustrating for everyone. The emotion stated by several participants continued to be hopelessness, it is just too big to fix. Nurses and physicians are doers; make the diagnosis, prescribe the remedy, administer the cure, and celebrate wellness. Equity, bias, and historical oppression is not the kind of problem that can be remedied by teaching a course and taking a test. This is frustrating, however, at least we were opening up to look toward solutions versus denial.

The group continued to struggle trying to deal with this awareness of White privilege and implicit bias. Nurses like to fix things, people, solve problems and this issue does not lend itself to a "fix". Frustration and discovery were evident in post session reflection comments such as: I want to bring about change, I feel like a little progress is being made, I am frustrated by the continual surveys - I got it - I am White. RGN provided the following paraphrased perception. I'm still moderately annoyed, mainly with the word privilege, but that's just my own personal

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bias. There are inequities that exist among the students we teach, patients we care for. And we have a responsibility to try to understand and to try to find ways to target those things (inequities) so that we can minimize them for people and for students. One of the things that some people of color and people that are marginalized have issues with is communication and reaching out to people and verbalizing what they need. So one of the things I think this points to is that we have a responsibility to ask what folks need and try to understand our biases.

Twenty-four hours after the session a qualtrics survey was distributed to gain reactions to the session. The prompts used for this week's session were: My aha moment was, The most interesting thing was, and I feel. Responses included the perception that most higher education leaders are white. Understanding whiteness as privilege and power is not something they have been taught. as culturally competent that I want to be and as educated that I think that I am - I am still surprised at the level of emotion this can cause in me. I look forward to learning to implement some specific tasks, items in the syllabus and teaching methods that raise awareness of these issues with our students. Hearing about the reactions to the IAT from the other faculty was helpful. Participants expressed a need to move to the solution: I feel helpless to bring about change. It seems like we are making a little progress, frustrated by the continual surveys - I got it - I am white.

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Table 11

Improvement Initiative Session Plan: Week Five

Action Research Plan	Session Focus	Activity	Session Facilitation Prompts	Formative Measure	Summative Measure
Prewrite for Week 5 None					
Week 5 Counter Story Telling Naming one's own reality. Time commitment, 1 hour Facilitator: CoPI Sheila Price	Lived experience discussion. One day post session: Complete guided reflection via qualtrics	Guest speakers via prerecorded conversations with a Black, American Indian, and White patient who shared their experience as a patient in the healthcare system. CO-PI will share her experience and participants will have an opportunity to share their experiences.			Collect artifacts from qualtrics guided reflections and review of the session video. Use info to inform next session's discussion.

The discussion during this session was in response to the voices of a Black, White, and American Indian who shared their experience with bias in their local healthcare delivery system. The first recording was with a well-educated professional Black woman who has a chronic condition which causes episodes of severe pain. From arrival at a hospital Emergency Department through the hospital stay she suffered intense pain, experienced inadequate treatment, and felt a sense of indifference from the physician and nurse caregivers. In fact, it was obvious from their questions and behavior to that they considered her a drug seeker and therefore did not provide appropriate assessment or treatment of her symptoms. This was not a new

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experience for her. She has experienced the same bias and indifference to her agony at many Emergency Departments because they had judged her as not worthy of deeper scrutiny. The drug seeker stereotype guided their interactions and treatment.

The second recording was the voice of an American Indian mother with a child who has a chronic condition that was diagnosed some years ago. This is a well-educated, articulate professional. She receives very appropriate care by the Indian Health Center/Hospital; however, her child occasionally requires services beyond the capability of the local facility. Every time her child is admitted to a regional hospital the medical providers talk to her in a simplistic condescending manner that implies their perception that she could not be capable of understanding the complexity of her daughter's condition or treatment plan.

The third recording an interview with a middle-aged White woman with multiple chronic conditions and a high school education. She went to the local Emergency Department (ED) with a complaint of severe chest pain. She was immediately taken to a room, had a physical exam, a chest Xray, and blood was collected for testing which were all negative for a heart attack. By the time the diagnostic testing was complete the pain had subsided. The doctor returned with the information that they could not find a source for the pain she had experienced and gave her a prescription for 16 Oxycontin in case she had another episode. She refused the meds because of her history with drug addiction, however, the care provider insisted. She brought the pills to her physician the next day for disposal.

Three different people of different races, each had an experience with the healthcare system based solely on the color of their skin or nationality. The discussion began with acknowledgment that staffing in hospitals and EDs have been reduced to the point that providers do not have time for anything but a cursory examination and speedy disposition. This pressure prompts reliance on quick decisions and treatment based on presentation thus bias guides the

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decision-making process. Almost everyone in the group shared a story where similar experiences where care was based on stereotype rather taking time to customize care based on the person's unique needs and situation.

I asked the group to answer the question, how can we incorporate the things we are talking about into our curriculum in a meaningful way? Role play activities were suggested with patient care scenarios where the effect of bias could be observed. The Institute for healthcare Improvement modules were shared by one of the participants as a resource that was used in her class this week. Students were assigned the health equity module and were directed to write a reflection on that reading. Another suggestion was to use prompts during clinical rotations asking students, have you ever seen something like this while in your clinical experience? We can use their observations in particular to draw out issues of bias and equity. This conversation continued as the participants processed different ways to use the student's perceptions to identify personal biases during class, simulation, and their clinical experiences. It was encouraging to see the group move into the action phase and hear how some instructors are already implementing bias awareness activities.

Twenty-four hours after the session an email was sent to participants with the prompts for reflection. In summary, the findings were positive about feeling some freedom to discuss this difficult subject, although it was very uncomfortable. There were expressions of encouragement that there were small steps that we could take to support awareness while still acknowledging the feeling of being helpless to make a difference with such a huge issue. Overall, there was an energy about learning more and taking some action to engage others in the conversation.

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Table 12

Improvement Initiative Session Plan: Week Six

Action Research Plan	Session Focus	Activity	Session Facilitation Prompts	Formative Measure	Summative Measure
<p>Week 6 Virtual Group Meeting, Time Requirement: no more than 2 hours</p> <p>Facilitator: CoPI Sheila Price, Topic Expert: Certified IDI Facilitator</p>	<p>Evaluation of the effect of the intervention sessions.</p>	<p>Findings from the two IDI assessments will be debriefed by the topic expert with facilitated discussion.</p> <p>Participants will share perceptions of the overall experience.</p>	<p>Session led by the IDI facilitator</p> <p>What stands out to you from this experience?</p> <p>How do we continue this discussion with the rest of the faculty?</p>	<p>IDI findings for the following components: The Perceived Orientation Score, Developmental Orientation Score and Orientation Gap</p> <p>Compare the Pre and post-intervention IDI findings. Assess level of change in the three components</p>	<p>Collect artifacts from qualtrics guided reflections and review of the session video.</p>

The Certified IDI Facilitator returned for the last session to lead the debrief discussion for the IDI results and the impact of the improvement initiative experience. We began with a review of the definitions of the key measures, Perceived Orientation, Developmental Orientation, and Orientation Gap and the results from the IDI assessment taken during the prior week. The Perceived Orientation (PO) score, which reflects what the person believes about their competence when interacting with culturally diverse individuals and groups, increased by 2.23 points, The Developmental Orientation (DO) score, defines the person’s primary orientation toward cultural differences and commonalities as measured by the IDI, increased by 4.84 points. The Orientation Gap (OG), represents the difference between the Perceived Orientation and Developmental Orientation scores, increased by 2.63 points. The Post Improvement Initiative

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Orientation Gap findings ranged from 13.33 to 43.43. The range of the change in OG scores was -2.46 to 14.39. According to the IDI Individual Profile Report (2021)

The larger the gap, the more likely you may misread how effective you are in bridging across cultural differences. Also, the larger the Orientation Gap, the more likely you may be “surprised” by the discrepancy between your Perceived Orientation score and Developmental Orientation score (p.5).

We were pleased to see improvement in all three metrics with an increase in scores for the Perceived Orientation, Developmental Orientation, and a decrease in the Orientation Gap (demonstrated by green highlight). The increased Perceived Orientation score demonstrates a continued overestimation of cultural competence. The increased Developmental Orientation score demonstrates growth in personal awareness of cultural difference and self-awareness. The reduction in the range for the Orientation Gap is particularly encouraging as it represents that the group has become more aware of how they adapt to cultural differences; the actual, measured level of awareness is closer to their perceived level of awareness. The perceived orientation mindset remained in Acceptance. The Developmental Orientation moved from the lower quarter of Minimization to the midpoint. The rate of change was small, but it was a change toward increased awareness. We were pleased to see some improvement in the measures after such a brief experience. We then discussed the possibility of using similar experiences for future action with students.

Lagging Measure of the Effect of the Improvement Initiative

Four months after the last session, while reviewing the data and preparing this document, I realized that there was an opportunity to gather some data regarding the latent effect of the improvement initiative on the participants using a follow-up qualtrics survey. The survey prompts were: “In order to support raising awareness of implicit bias in the School of Nursing I recommend”, and “As a result of my improvement initiative experience, I have... “. Six responses were received. The following represents a summary of the responses

In order to support raising awareness of implicit bias in the School of Nursing I recommend

We must begin with the faculty through facilitated discussions.

We must introduce conversations about implicit bias early in the programs and find effective ways to integrate prompts regularly throughout the program for ongoing conversations.

The clinical experience should include identification, and discussion, of the existence and the effect of implicit bias observed during clinical experiences with students immediately after the clinical experience.

As a result of my improvement initiative experience

I have learned a lot more about myself and my bias. I understand that my generation had different experiences than the younger generation, however, societal messaging reinforces bias, therefore, the conversations must include everyone.

It was apparent that the participants were continuing to process their feelings and thinking about options for future action. I regret that I did not include a prompt requesting the participants to share any changes they made, or plan to make, to their teaching and curriculum as a result of this experience.

Analysis of the Data

My theory of improvement holds that intentional engagement in experiential learning techniques that stimulate self-reflection regarding implicit racial bias will increase nursing faculty self-awareness of implicit bias. This improvement research initiative was designed to determine if the use of various educational methods common in an online environment would have an effect on raising awareness of implicit bias on a volunteer group of School of Nursing faculty. The participant population included full-time faculty teaching in the Undergraduate, Master, and Doctoral levels. This study used a combination of qualitative and quantitative measures for evaluation of the effect of the improvement initiative on raising awareness of implicit and explicit racial/ethnic bias.

Quantitative Analysis of Findings

Data from the pre and post improvement initiative assessments using the Intercultural Development Inventory (IDI) were used to evaluate the effect of the improvement initiative on raised awareness of implicit racial bias. It was important to me to supplement the use of qualitative data from my observations and participant feedback with assessment data from a reputable provider. A colleague pointed me toward the IDI as a tool that could provide valuable feedback for growth and discussion. The IDI is an assessment instrument that has been used extensively as a "credible and useful measure of intercultural competence" (Hammer, 2013, p. 20). This test was selected, in part, because it is well-known as a highly validated instrument and our university has a Certified IDI Facilitator on staff. The assessment is theory based, has been validated across a wide range of what they call "other culture" groups, and provides valid quantitative feedback to provide focus for growth and development. The feedback from the assessment includes specific information about how a person in each mindset engages with cultural difference and suggestions to support increased intercultural competence. We were

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fortunate to have the IDI facilitator available to guide us through the assessment findings.

The IDI was administered via the internet during the week prior to the first session of the improvement initiative and during the week prior to the last session. The IDI results are presented as Perceived Orientation, Developmental Orientation and the Orientation Gap.

Perceived Orientation represents the level of intercultural competence that the person perceives they have. The Developmental Orientation describes the person's actual level of intercultural competence as measured by the assessment tool. The Orientation Gap is the difference between the two measures. An Orientation Gap greater than seven points demonstrates a meaningful variance between the perceived and assessed level of intercultural competence. The IDI post-intervention group score for Perceived Orientation and Developmental Orientation increased and the Orientation Gap decreased (See Table 13 below).

Table 13

IDI Pre and Post Intervention Scores: Perceived Orientation, Developmental Orientation, Orientation Gap

Intercultural Development Inventory (IDI) Group Profile Data	Pretest	Post test	Change in Score	Assessment
Perceived Orientation Where the group places itself on the Intercultural Development Continuum	118.93	121.16	2.23	Increase may represent increased awareness
Developmental Orientation Where the IDI places the group on the Intercultural Development Continuum	87.76	92.62	4.86	Higher Score is Favorable
Orientation Gap The numerical difference between the perceived and development orientation	31.17	28.54	2.63	Reduced Gap is Favorable

The Perceived Orientation score increased by 2.23 points. The finding demonstrates an

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overestimation of intercultural competence, however, the increase in the score may also represent a person's assumption of their increased awareness of raised consciousness as a result of the improvement research activities. The Developmental Orientation score increased by 4.86 points which demonstrates the actual improvement in intercultural competence. The Orientation Gap decreased by 2.63 points, which is a small change and yet is encouraging as it demonstrates an increased awareness of how to adapt to cultural differences, i.e. the actual, measured level of participants' awareness has moved slightly closer to their perceived level of awareness.

Intercultural competence is defined in the IDI as “ the capability to shift perspective and adapt behavior to cultural difference and commonality. It reflects the degree to which cultural differences and commonalities in values, expectations, beliefs, and practices are effectively bridged, an inclusive environment is achieved, and specific differences that exist... are addressed from a mutual adaptation perspective” (IDI Group Profile Report , 2021, March 9, p. 3). The desired change is to see a decrease in the Orientation Gap representing improved self-awareness of implicit bias. The data indicates decrease of 2.63 points in the Orientation Gap.

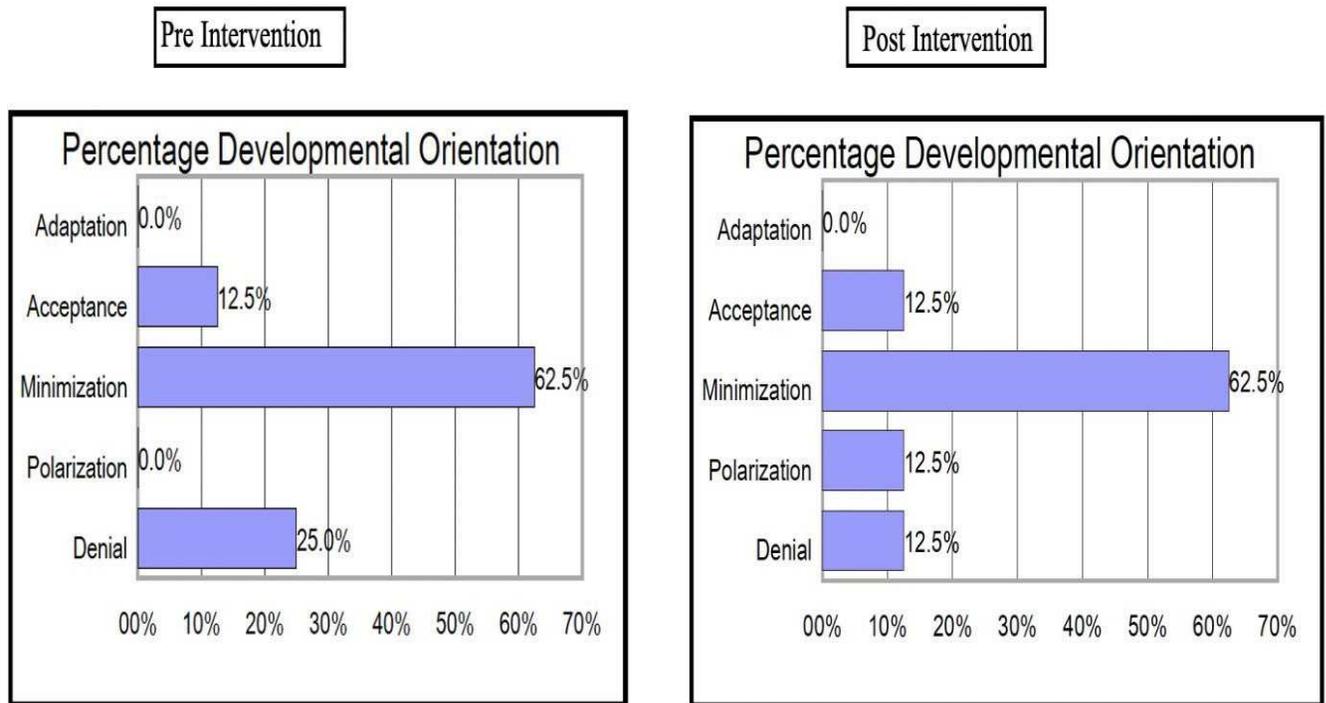
The IDI reports the person's orientation toward cultural difference on a continuum from Denial, Polarization, Minimization, Acceptance, to Adaptation. The findings from the IDI taken prior to the improvement initiative placed the group's Perceived Orientation mindset in Acceptance and it remained in Acceptance in the post-test. The Developmental Orientation moved from the lower quarter of Minimization to the midpoint of Minimization.

The Range of Developmental Orientations measured prior to the improvement initiative and again prior to the last session are presented in Table 14 below. The table shows movement of one individual from the Denial mindset and one individual now appearing in the Polarization mindset demonstrating forward movement on the Intercultural Development Continuum.

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Table 14

Pre and Post Intervention Range of Developmental Orientations on the Intercultural Development Continuum



The group data demonstrated some improvement in the Orientation Gap (a 2.63 point reduction) which can indicate raised awareness of cultural bias. There was also movement in a positive direction on the Intercultural Development Continuum as represented in Table 14 above, with one person leaving the Denial mindset and one person moving to polarization. While these are incremental improvements, they do represent a positive change and therefore can provide some support for the premise that experiential activities in an online setting may have an effect to raise awareness of bias.

Table 15 below provides the individual data from the pre and post improvement initiative IDI assessments. The desired effect of the experiential activities was that the Orientation Gap

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would decrease. The larger the Orientation Gap, the more surprised the person may be by the findings because they are believing that they are more adaptive to other cultures than they really are.

Table 15

Individual Pre and Post-Intervention IDI Scores for Orientation Gap

<u>Pre Initiative</u>	<u>Post Initiative</u>	<u>Difference</u>
30.33	27.87	-2.46
38.97	43.34	4.37
9.05	13.33	4.28
48.1	47.5	-0.6
32.16	29.85	-2.75
32.6	32.23	-0.37
22.12	29.41	14.39
15.02	18.73	3.71

(IDI Individual Profile Report, 2021, April 20, p. 5).

I particularly focused on the findings for the Orientation gap, which demonstrates the difference between the person's Perceived Orientation toward cultural difference and the measured primary orientation toward cultural difference, the Developmental Orientation. The desired outcome for the improvement initiative was that Orientation Gap would have decreased. It did not. It is interesting but not shocking that there was such a range in responses to the experience.

The goal for the intervention was to decrease the Orientation Gap through implicit racial bias awareness-raising activities. The preintervention range for the Orientation Gap was 9.05 to 29.97 with one score of 48. The post-intervention Orientation Gap was 13.33 to 32.23 with one score of 47.5. The elevated Orientation Gap at 47-48 represents a wide disconnect between the person's perceived cultural competence and what is being measured by the assessment. Two of the eight participants showed a decreased Orientation Gap of -2.46 and -2.75 demonstrating

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closer agreement between the participant's Perceived Orientation and Developmental Orientation. Two of the participants had a statistically insignificant increase in the Orientation Gap of 0.6 and 0.37 points. There was an increase in the Orientation Gap for two of the participants of 4.37 and 4.28 points and one participant had an increased Orientation Gap of 14.41.

I used a paired t-test to compare the data from the pre and post intervention IDI findings for the Orientation Gap in order to determine whether the level of change was significant.. I selected the t-test because it is a tool commonly used in inferential statistics to measure whether the intervention had the desired effect. The analysis process for the t test begins by making an assumption that the means of data distribution for two groups are the same, thus establishing a null hypothesis; the intervention had no impact on the group's perception of their implicit bias. The probability value (p-value) represents the likelihood that the data occurred by chance, otherwise stated, a 0.1 p-value means that there is only a 1% probability that the findings were the result of chance. A p-value can range from 0% to 100%, however, lower is better. A paired t Test is appropriate for this analysis as there are two sets of measurements (pre and post intervention) samples from the same group.

The t test provided the following findings. The mean of the pretest group minus the mean of posttest group is 0.1387. The two-tailed p value equals 0.9474. The high p value demonstrates a strong probability of observing a similar level of difference between other groups. While there were individual data elements that demonstrate a level of personal raised awareness, the quantitative data analysis supports the null hypothesis, that the scores for the pre and post IDI assessments did not represent a measurable change.

Qualitative Analysis of Findings

I chose to evaluate the effect of the improvement initiative using quantitative and

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qualitative measurements in order to glean as much information from the experience as possible. I want to promote the use of experiential activities in my online teaching and I felt that the limited time frame for the improvement initiative might not be measurable quantitatively. It was important to not only learn about the effect of different activities but also to be able to identify the best approaches for ongoing intervention to raise awareness of implicit racial bias.

The goal of the improvement initiative was to evaluate the effectiveness of the use of typical online teaching methods to raise awareness of implicit bias in a virtual environment. Four of the sessions. Elements used for qualitative analysis of intervention effectiveness included a review of the session videos, session transcripts, and responses in the post-session reflections. The comments and observations are summarized within the descriptions of each of the sessions.

The range of emotions which emerged during the sessions prompted a comparison to the stages of grief described in Kubler Ross model, Stages of Grief (Kubler-Ross, 2005). Kubler-Ross identified five stages of grief from the moment of awareness to acceptance: Denial, Anger, Bargaining, Depression, and Acceptance (1969). Nursing programs have taught the Kubler Ross model for many years, therefore the faculty may be comfortable with the use of this model to help understand and process their own and their student's emotions when coming to terms with their implicit bias. Kessler added a sixth stage of grief, Finding Meaning, to the five stages of grief: Denial, Anger, Bargaining, Depression, and Acceptance developed by Kubler Ross and the (Kessler, 2020). Using this information to support participants when they are working through their feelings as they become aware of their racial bias would have been helpful to manage their emotions. The statements recorded below beside the phases of grief represent some of the comments shared during the sessions, and in the reflections. The following comments are not quotes but represent feelings expressed during the intervention initiative which demonstrate that the intervention activities promoted some self-awareness.

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Denial: I am not accountable for what happened 400 years ago, I know what it is like to grow up poor. I am not racist. I would never treat anyone with such disregard or cruelty. I care about everybody

Anger: This is stupid. I don't even see color. I am kind and caring to everyone. There is nothing I can do! This problem is too big for me to even make a small difference.

Bargaining: I am not a bad person. I don't have overt racist ideations. I know people who are really racist. They are the ones this awareness is really intended to help. I support the migrant ministry and the clothes drive for the people of color and we feed the homeless. This shows you that I am caring.

Depression: I am overwhelmed by the burden of guilt, anger, and distress over the magnitude of the issue of racism and the feeling of that the problem is too big. Also my ignorance about how to make a real difference to reverse such an entrenched societal norm. I am helpless to make a real difference. I am helpless, this is hopeless.

Acceptance: I can't change the past, but I don't have to accept the present. Systemic and personal bias is real and a new norm in my awareness has been established. Everywhere around me I hear and see examples of the expression of racism. I can make a difference in my program, in my classes, with my colleagues. I will do what I can do.

Meaning: What can I do with this new perspective that will make a difference within my circle of influence? What does this look like in my life, my teaching, my relationships, my daily interactions?

I recommend inclusion of this content in future intervention sessions to help us more consciously process through the emotions which arise during discovery.

Recommendations for Leadership and Continued Research

An element that was not addressed during this Improvement Research Initiative was an activity to support participants in processing the emotional impact of their recognition of implicit racial bias. We shared our discomfort; however, we did not have a focused discussion on how to manage these feelings. A recommendation for design in future activities would be to strategically engage participants in processing their feelings about their raised awareness using the Kubler-Ross/Kessler model to guide the discussions.

The most important role for the School of Nursing at this point is to keep the conversation going about further tests of change using the Improvement Process model so we can identify effective methods to raise awareness of the presence and impact of implicit bias for our faculty and students. This process will enable us to identify and implement effective, ongoing curricular activities throughout all of our nursing programs in order to ultimately improve the healthcare and health outcomes for the Black, Hispanic, and American Indian populations.

Conclusion

The purpose for this action research initiative was to evaluate the effect of experiential activities in an online setting designed to raise faculty awareness of the presence of implicit racial bias. Awareness is the first step in a strategy to reduce health disparity in the Black, Hispanic, and American Indian Populations and as the largest healthcare profession in the United States nurses are in the unique position to have the greatest opportunity to support improvement in health disparity, but only if they are aware of the root cause of the problem.

There is a long-standing unacceptable level of health disparity between the Black, Hispanic, American Indian and White populations in spite of investment in research initiatives and billions of dollars dedicated to fund programs intended to reduce health disparity without negligible improvement. The data indicate that the USA has the highest per capita cost for health care and the lowest health status of the developed countries in the world. Even though nurses enter the profession committed to care for and support healing for all people, healthcare provider bias is a major factor that perpetuates inequity in the provision of health care and health status. I believe that we can have the greatest impact on improving care by making this issue visible in our nursing education processes and curriculum. This work cannot be accomplished through a two hour inservice education at the workplace, or a one day workshop, it requires ongoing focused time. My goal is that this activity focused on raising awareness of implicit bias and its impact on health care improvement initiative can be the impetus to support a more equitable healthcare system through our School of Nursing curricular focus on personal implicit bias.

This improvement research used qualitative and quantitative measures to evaluate the effect of the experiential activities in an online setting designed to increase awareness of implicit racial bias. Qualitative measurement included analysis of the session videos and responses to a weekly post session reflection. In summary the effect of the six-week initiative demonstrated

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mixed results with some demonstration of raised consciousness, conflict with the recognition of bias in conflict with our sense of self as caring and unbiased, and avoidance of addressing the concept. The experience definitely opened the door to increased, and hopefully ongoing, self-evaluation by each individual regarding their understanding of implicit bias and the subtle effect of implicit bias and systemic/structural factors that diminish the quality of the healthcare provider-patient experience, discourage Black, Hispanic, and American Indian patients from accessing the healthcare system, and reduce compliance with treatment plans.

Quantitative data was provided by results of the Intercultural Development Inventory tool. The IDI is a well-known, validated measurement which provides feedback regarding the mindset/skillset related to cultural differences. Participants completed the Intercultural Development Inventory, a validated assessment tool which measures intercultural competence, prior to the first and last online session to provide a quantitative measure of mindset change as a result of the experience. Interpretation was provided by a Certified IDI Facilitator. The individual findings demonstrated a range of mindsets across the five-category spectrum from Denial to Adaptation. While there was growth demonstrated in some of the individual scores the aggregated group results demonstrated no effect from the experience. My analysis of the qualitative and quantitative results is that reframing a mindset developed over a lifetime is not reset quickly. It requires a deliberate ongoing effort.

In order to be effective in our goal for patient centered excellent quality of care for all patients we must first recognize that the current nursing practice has not improved the quality of health care or improved health status for minority populations. Nursing faculty must understand their implicit bias and then create curricular activities designed to introduce students to the existence and impact of implicit bias. We must then integrate an ongoing discussion of the existence and impact of implicit bias on patient care and outcomes while maintaining continuous

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self-awareness activity for students and faculty.

We have an opportunity to evaluate the effectiveness of the different approaches used in this improvement initiative for use in the classroom as well as the virtual environment and to identify best practices from the literature to support our continuous improvement in our curriculum. Current research indicates that interventions to raise awareness of implicit bias have a short life span. To sustain awareness, there must be ongoing intentional reinforcement of awareness. One benefit of this improvement initiative was that the participants have committed to support discussion of the causes of health disparity, particularly provider bias, in our School of Nursing faculty meetings, our program meetings, and curriculum planning activities in order to promote an ongoing conversation and increase and maintain awareness.

My goal for this work is that this experience will be the launch pad for intentional ongoing awareness raising activities with the faculty and will be incorporated into our teaching methodology and interaction with students. I look forward to the integration of experiential implicit bias awareness activities into the School of Nursing curriculum at all levels to promote increased awareness, improve the equitable provision of healthcare, advocate for health system change, and reduce health disparity. Prelicensure nursing students are particularly vulnerable to the overt and covert pressure to conform to the norm when they graduate and enter healthcare institutions. Providing awareness-raising experiences in the education setting can change their perspective about the reality of implicit bias, begin the process to change their perceptions, and empower them to become the voice for equity in the workplace. In many ways, raising awareness of implicit racial bias and promoting ongoing action to reduce health inequity is much like throwing a rock into a pond, it starts small but the ripples grow and spread and then disappear. The only way to have continuous ripples is to keep on tossing rocks.

References

- American Association of Colleges of Nursing (2011). The essentials of baccalaureate education for professional nursing practice.
<https://www.aacnnursing.org/portals/42/publications/baccessentials08.pdf>
- American Association of Colleges of Nursing (2019, April 1). Nursing fact sheet
<https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Fact-Sheet>
- American Association of Colleges of Nursing (2021, April 6). The essentials: Core competencies for professional nursing education.
<https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf>
- American Nurses Association Code of Ethics for Nurses with Interpretive Statements (2015).
Nursesbooks.org,
- Anderson, J. M., Rodney, P., Reimer-Kirkham, S., Browne, A. J., Khan, K. B., & Lynam, J. (2009). Inequities in health and healthcare viewed through the ethical lens of critical social justice: Contextual knowledge for the global priorities ahead. *Advances in Nursing Science* 32(4), 282-294. Doi:10.1097/ANS.Ob013e3181bd6955
- Arias, E. & Xu, J. (2019, June 24). United States life tables, 2017. *National Vital Statistics Report* 68(7). https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_07-508.pdf
- Artiga, S., Foutz, j., Cornachione, E., & Garfield, R. (2016). Key facts on health and health care by race and ethnicity. <http://files.kff.org/attachment/Chartpack-Key-Facts-on-Health-and-Health-Care-by-Race-and-Ethnicity>
- Artiga, S., & Orgera, K. (2019, November 12). Key facts on health and health care by race and ethnicity. KFF. <https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/>
- Balsa, A. I., & McGuire, T. G. (2003). Prejudice, clinical uncertainty and stereotyping as sources

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

of health disparities. *Journal of Health Economics*, 22, 89-116.

Doi:10.1016/s0167-6296(02)00098-x

Bekemeier, B., & Butterfield, P. (2005). Unreconciled inconsistencies: A critical review of the concept of social justice in 3 national nursing documents. *Advances in Nursing Science*, 28(2), 152-162. <https://tinyurl.com/y2rgx9f3>

Berry, L. (2018, January 10). Reclaiming health care's fundamental purpose. *Institute for Healthcare Improvement Blog*.

<http://www.ihl.org/communities/blogs/reclaiming-health-care-s-fundamental-purpose>

Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (implicit) bias and health disparities: Where do we go from here? *The Permanente Journal*, 15(2), 71-78.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140753/pdf/i1552-5775-15-2-71.pdf>

Boyd, R. W., Lindo, E. G., Weeks, L. D., & McLemore, M. R. (2020, July 2). On racism: A new standard for publishing on racial health inequities. *Health Affairs Blog*.

DOI: 10.1377/hblog20200630.939347

Bryk, A. S., Gomez, L. M., Grunow, A., & LeMahieu, P. G. (2015). *Learning to improve: How America's schools can get better at getting better*. Harvard Education Press.

Campinha-Bacote, J. (2011, May). Delivering patient-centered care in the midst of a cultural conflict: The role of cultural competence. *The Online Journal of Issues in Nursing- ANA*, 16(2). DOI: 10.3912/OJIN.Vol16No02Man05

Canales, M. K. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science*, 22(4), 16-31 <https://doi.org/10.1097/00012272-200006000-00003>

Carroll, A. (n.d.). Racial disparities in healthcare are pervasive.

PATREON.COM/HEALTHCARETRIAGE.

<https://www.youtube.com/watch?v=T2mirYemCmo>

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

Carter-Pokras, O. & Bacquet, C. (2002). What is a “health disparity”? *Public Health Reports*, 117(5), 426-434. Doi: 10.1093/phr/117.5.426

Centers for Disease Control and Prevention (2008). Community health and program services (CHAPS): Health disparities among racial/ethnic populations.

<https://www.cdc.gov/healthyyouth/disparities/>

Chin, M. H., Walters, A. E, Cook, S. C., & Huang, E. S. (2007, October). Interventions to reduce racial and ethnic disparities in health care. *Medical Care Research Review*, 64(5)

CNN/The Point. Cillizza (2021). Critical Race Theory.

College Factual. Ethnic diversity of Nursing Bachelor’s Degree Students 2019. Retrieved June 20, 2021 <https://www.collegefactual.com/colleges/western-carolina-university/academic-life/academic- majors/health-care-professions/nursing/#diversity>

Crenshaw, K., Gotanda, N., Peller, G. & Thomas, K. (Eds.) (1995). Critical race theory: The key writings that formed the movement. The New Press.

Crow, R., Hinnant-Crawford, B. N., & Spaulding, D. T. (Eds.) (2019). The education leader’s guide to improvement science: Data, design and cases for reflection. Myers Education Press.

Data USA (2019). Admissions Data. <https://datausa.io/profile/university/western-carolina-university#admissions>

Department of Health and Human Services (1990). Healthy People 2000: National health promotion and disease prevention objectives for the year 2000. Washington, D.C.

Department of Health and Human Services (2020). Healthy People 2030: National health promotion and disease prevention objectives for the year 2030. Washington, D.C.

<https://health.gov/healthypeople>

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

- Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. K. (2012). Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *Journal of Experimental Social Psychology, 48*(6), 267-1278. Doi:10.1016/j.jesp.2012.06.003
- DiTomaso, N. (2015). Racism and discrimination versus advantage and favoritism: Bias for versus bias against. *Research in Organizational Behavior, 35*, 57-77.
Doi:10.1016/j.riob.2015.10.001
- Figueroa, J. F., Burke, L. G., Horneffer, K. E., Zheng, J., Orav, E. J., & Jha, A. K. (2020). Avoidable hospitalizations and observation stays: Shifts in racial disparities. *Health Affairs (Millwood), 39*(6), 1065-1071. Doi: 10.1377/hlthaff.2019.01019
- Fitzgerald, C. & Hurst, S. (2017). Implicit bias in healthcare professional: A systematic review. *BMC Medical Ethics, 18*(19). DOI. 10.1186/s12910-017-0179-8
- Francis, M. M. (2016, March 2021). Let's get to the root of racial injustice. TEDxRainier
<https://www.youtube.com/watch?v=-aCn72iXO9s>
- Funge, S. P. (2011). Promoting the social justice orientation of students. The role of the educator. *Journal of Social Work Education, 47*(1), 73-90.
<https://doi.org/10.5175/JSWE.2011.200900035>
- Giddings, L. S. (2005). Health disparities, social injustice, and the culture of nursing. *Nursing Research, 54*(5), 304-312. Doi:10.1097/00006199-200509000-00004
- Gillborn, D. (2015, February 25). Intersectionality, Critical Race Theory, and the primacy of racism: Race, class, gender, and disability in education.
<https://doi.org/10.1177/1077800414557827>
- Gray, D. M. (2021, June 30). Critical race theory: What it is and what it isn't. *The Conversation*
<https://theconversation.com/critical-race-theory-what-it-is-and-what-it-isnt-162752>
- Hammer, M. R. (2013, October 10). A resource guide for effectively using the Intercultural

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

- Development Inventory (IDI). <https://idiinventory.com/wp-content/uploads/2014/08/Intercultural%20Development%20Inventory%20Resource%20Guide1.pdf>
- Hammer, M. R., Bennett, M. J., & Wiseman, R. (2003, July). Measuring intercultural sensitivity: The intercultural development inventory 27(4), 421-443
[https://doi.org/10.1016/S0147-1767\(03\)00032-4](https://doi.org/10.1016/S0147-1767(03)00032-4)
- Healthy People 2030: Building a healthier future for all* (n.d.). health.gov/healthypeople
- Hinnant-Crawford, B. N. (2020). *Improvement science in education: A Primer*. Myers Education Press. Kindle Edition.
- Holland, A. E. (2011). *The place of race in cultural nursing education: The experience of white BSN faculty* (Doctoral dissertation). <https://conservancy.umn.edu/handle/11299/101771>
- Holroyd, J., Scalfe, R., Stafford, T. (2017). Responsibility for implicit bias. *Philosophy Compass*, 12(3). <https://doi.org/10.1111/phc3.12410>
- Horne, R., Chapman, S. C. E., Parham, R., Freemantle, N., Forbes, A., & Cooper, V. (2013, December 2). Understanding patients' adherence-related beliefs about medicines prescribed for long-term conditions: A meta-analytic review of the necessity-concerns framework. *PLOS ONE*. <https://doi.org/10.1371/journal.pone.0080633>
- Hughes, R. (2011, May) Overview and summary: Patient-centered care: Challenges and rewards. *OJIN: The Online Journal of Issues in Nursing* 16(2).
DOI: 10.3912/OJIN.Vol16No02ManOS
- Implicit Aptitude Test - Frequently asked questions – Is the IAT related to behavior?
Retrieved July 6, 2021, 0p-[<https://implicit.harvard.edu/implicit/faqs.html#faq12>
- Institute of Medicine (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. The National Academies Press <https://doi.org/10.17226/12875>

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

Institute of Medicine (2012). How far have we come in reducing health disparities?

Progress since 2000: Workshop Summary. National Academies Press

<https://pubmed.ncbi.nlm.nih.gov/23193624/>

Intercultural Development Inventory Sample Group Report (n.d.) Retrieved 2/9/2022 from

<https://idiinventory.com/wp-content/uploads/2019/05/Sample-IDI-Individual-Profile-Report.pdf>

Johns Hopkins Medicene (n.d.). Minority health disparities.

<https://www.youtube.com/watch?v=vIVZKZNXyBA>

Jones, C. P. (2000). Going public, Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health, 90*(8), 1212-1215.

Doi:10.2105/alph.90.8.1212

Kessler, D. (2019). *Finding meaning: The sixth stage of grief*. Simon and Schuster.

Kubler-Ross, E. (1969). *On death & dying: What the dying have to teach doctors, nurses, clergy & their own families*. Macmillan.

Kula, Y., Cohen, O., Clempert, N., Grinstein-Cohen, O., & Slobodin, O. (2021). Educating nursing students for cultural competence in emergencies: A randomized controlled trial. *BMC Nursing, 20*(1),1-184. <https://doi.org/10.1186/s12912-021-00704-1>

KFF (n.d.). 2018 State health facts: Births of low birthweight as a percent of all births by race/ethnicity.

https://www.kff.org/other/state-indicator/low-birthweight-by-race_ethnicity/

Kirkham, S. R., & Browne, A. (2006). Toward a critical theoretical interpretation of social justice discourses in nursing. *Advances in Nursing Science, 29*(4), 324-339.

Doi:10.1097/00012272-200610000-00006

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

Kumas-Tan, Z., Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007, July). Measures of cultural competence: Examining hidden assumptions. *Academic*

Medicine: Journal of the Association of American Medical Colleges 82(6), 548-57.

DOI:[10.1097/ACM.0b013e3180555a2d](https://doi.org/10.1097/ACM.0b013e3180555a2d)

Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L.P. (2009),

The improvement guide: A practical approach to enhancing organizational performance

(2nd ed.). Josey-Bass.

Lomotey, K. (2018). The Disquisition at Western Carolina University: The Capstone Experience

in the University's EdD Program. Unpublished manuscript, Western Carolina University,

Cullowhee, NC.

Marcelin, J. R., Siraj, D. S., Victor, R., Kotadia, S., & Maldonado, Y. A. (2019), The impact of

unconscious bias in healthcare: How to recognize and mitigate it. *The Journal of*

Infectious Diseases, 220, Issue Supplement, S62-S73.

<https://doi-org.proxy195.nclive.org/10.1093/infdis/jiz214>

March of Dimes. 2018 Premature Birth Report Card.

<https://www.marchofdimes.org/materials/PrematureBirthReportCard-United%20States-2018.pdf>

March of Dimes, Healthy Moms, Strong Babies (2020, October 20). Peristats.

<https://www.marchofdimes.org/Peristats/ViewTopic.aspx?reg=37&top=4&lev=0&slev=4>

March of Dimes Report Card 2021. [https://www.marchofdimes.org/materials/March-of-Dimes-](https://www.marchofdimes.org/materials/March-of-Dimes-2021-Full-Report-Card.pdf)

[2021-Full-Report-Card.pdf](https://www.marchofdimes.org/materials/March-of-Dimes-2021-Full-Report-Card.pdf)

McCarthy, N. (2020, April 7). COVID-19's devastating impact on African Americans. Statista.

<https://www.statista.com/chart/21364/african-american-share-of-covid-19-deaths/>

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

McDowell, M. J., Goldhammer, H., Potter, J. E., & Keuroghlian, A. S. (2020). Strategies to mitigate clinician implicit bias against sexual and gender minority patients. *Psychosomatics*, 61(6), 655-661. <https://doi.org/10.1016/j.psych.2020.04.021>

McIntosh, P. (1989). White Privilege: Unpacking the invisible knapsack (excerpt). <https://admin.artsci.washington.edu/sites/adming/files/unpacking-invisible-knapsack.pdf>

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

McLeod, S. (2018). Sigmund Freud's theories. *Simply Psychology*.

<https://www.simplypsychology.org/Sigmund-Freud.html>

Meghani, S. H., & Gallagher, R. M. (2008). Disparity vs inequity: Toward reconceptualization of pain treatment disparities. *Pain Medicine*, 9(5), 613-623. Doi:10.1111/j.1526-4637.2007.00344.92

Millman, M. (Ed.) (1993). *Access to health care in America. Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services*. National Academies Press.

Miller, R. W., Nigg, J. T, & Miller, R. K. (2008). Attention deficit hyperactivity disorder in African American children: What can be concluded from the past ten years?

<https://doi.org/10.1016/j.cpr.2008.10.001>

Minority health and health disparities strategic plan 2021-2025: Taking the next steps.

National Institutes of Health. <https://nimhd.nih.gov/docs/nimhd-strategic-plan-2021-2025.pdf>

Narayan, M. C. (2019). Addressing implicit bias in nursing. *American Journal of Nursing*, 119(7), 36-43. doi:10.1097/01.NAJ.0000569340.27659.5a

National Institutes of Health-Wide Strategic Plan 2021-2025 (2021, July 30).

<https://www.nih.gov/sites/default/files/about-nih/strategic-plan-fy2021-2025-508.pdf>

National Center for Health Statistics [NCHS] (2019, April). Racial and ethnic disparities in heart disease. *Health, United States Spotlight*.

https://www.cdc.gov/nchs/hus/spotlight/HeartDiseaseSpotlight_2019_0404.pdf

National Vital Statistics Reports (2019, June 24).

https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

- Ndugga, N. & Artiga, S. (2021, May 11). Disparities in health and healthcare: 5 key questions and answers. The Henry J. Kaiser Family Foundation (KFF). <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/>
- Oberg, C., Colianni, S., & King-Schultz, L. (2016). Child health disparities in the 21st Century. *Current Problems in Pediatric and Adolescent Health Care*, 46(9), 291–312. <https://doi.org/10.1016/j.cppeds.2016.07.001>
- Office of Equal Opportunity and Diversity Programs. EODP Vision, Western Carolina University. <https://www.wcu.edu/discover/diversity/eodp/>
- Paige, R. M., Jacobs-Cassuto, M., Yershova, Y. A., & DeJaeghere, J. (2003). Assessing intercultural sensitivity: An empirical analysis of the Hammer and Bennett Intercultural Development Inventory, Elsevier. [https://doi.org/10.1016/S0147-1767\(03\)00034-8](https://doi.org/10.1016/S0147-1767(03)00034-8)
- Patton, L. D. (2016). Disrupting postsecondary prose: Toward a Critical Race Theory of higher education. *Urban Education*, 51(2), 315-342. DOI: 10.1177/0042085915602542
- Peterson-KFF (2020, October 18). Health system tracker: What do we know about infant mortality in the U.S. and comparable countries? <https://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries/>
- Project Implicit - How the IAT is scored. Retrieved 10/2/2021 from <https://www.projectimplicit.net/resources/about-the-iat/>
- Rohanna, K. (2017). Breaking the “Adopt, Attack, Abandon” cycle: A case for improvement science in K–12 education. In C.A. Christie, M. Inkelas, & S. Lemire (Eds.). *Improvement science in evaluation: Methods and uses*. *New Directions for Evaluation* (153), 65–77. <https://doi.org/10.1002/ev.20233>

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

Ruger, J. P. (2004). Health and social justice. *Lancet*, 364 (9439), 1011-1012.

[https://doi.org/10.1016/S0140-6736\(04\)17064-](https://doi.org/10.1016/S0140-6736(04)17064-)

Samuel, V. J., Biederman, J., Faraone, S. V., George, P., Mick, E., Thorness, A., Curtis, S., Taylor, A., & Brome, D. (1998) *Clinical characteristics of attention deficit hyperactivity disorder in African American children. The American Journal of Psychiatry*, 155(5). 696-698. <https://doi.org/10.1176/ajp.155.5.696>

Sawyer, B. & Cox, C. (2018, December 7). Health System Tracker: How does health spending in the U.S. compare to other countries? Peterson-KFF.

<https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-relative-size-wealth-u-s-spends-disproportionate-amount-health>

Sawyer, B. & McDermott, D. (2019, February 14). How do mortality rates in the U.S. compare to other countries? Peterson-KFF Health System Tracker.

<https://www.healthsystemtracker.org/chart-collection/mortality-rates-u-s-compare-countries/>

Sensoy, O., & DiAngelo, R. (2012), *Is everybody really equal? An introduction to key concepts in social justice education.* Banks (Ed). Teachers College Press Columbia University

Simmons, A. Challel, A., Kolbe, A.R., Bush, L., & Sommers, B.D. (2021, March 16). Health disparities by race and ethnicity during the COVID-19 pandemic: Current evidence and policy approaches. Assistant Secretary for Planning and Evaluation.

<https://aspe.hhs.gov/system/files/pdf/265206/covid-equity-issue-brief.pdf>

Sitzman, K. & Watson, J. (2014). *Caring science, mindful practice: Implementing Watson's Human Caring Theory.* Spring Publishing

Smedley, D. D., Stith, A. Y. & Nelson, A. R. (Eds.) (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* National Academies Press

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

<http://nap.edu/12875>

Smith, T. M. (2020, May 13). Population care: Why COVID-19 is decimating some Native American communities. American Medical Association.

<https://www.ama-assn.org/delivering-care/population-care/why-covid-19-decimating-some-native-american-communities>

Thurman, W., Pfitzinger-Lippe, M. (2017). Returning to the profession's roots: Social justice in nursing education for the 21st century. *Advances in Nursing Science*, 40(2).

doi:10.1097/ANS.0000000000000140

University of Texas at Tyler School of Nursing (n.d.). Nursing Pinning Pledge.

<https://www.uttyler.edu/nursing/college/undergraduate/convocation.php>

USAFACTS (n.d.) Health. Retrieved September 19, 2020

<https://usafacts.org/data/topics/people-society/health/>

United States Census Bureau (2019, September). Income, poverty, and health insurance: 2018.

<https://www.census.gov/newsroom/press-releases/2019/income-poverty.html>

<https://www.uttyler.edu/nursing/college/undergraduate/convocation.php>

U.S. Department of Justice, (2015, July29). Community relations services toolkit for policing,

Understanding bias: A resource guide. <https://www.justice.gov/crs/file/836431/download>

Van Ryn, M., & Fu, S. S> (2003). Paved with good intentions: Do public health and human service providers contribute to Racial/Ethnic disparities in health? *American journal of Public Health*, 93(2), 248-244. doi:10.2105/ajph.93.2.248

Wallace-Wells, B. (2021, June 18). How a conservative activist invented the conflict over critical race theory. *The New Yorker: Annals of Inquiry*. <https://www.newyorker.com/news/annals-of-inquiry/how-a-conservative-activist-invented-the-conflict-over-critical-race-theory>

Walsh, C. (2020, April14). COVID-19 targets communities of color. *The Harvard Gazette*,

ENHANCING NURSING AWARENESS OF IMPLICIT BIAS

Health and Medicine.

<https://news.harvard.edu/gazette/story/2020/04/health-care-disparities-in-the-age-of-coronavirus/>

Williams, D. R. (2016, November). How racism makes us sick-TEDMED.

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

World Health Organization (1948). Constitution of the World Health Organization (1948).

<https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1>

World Health Organization (n.d.). *Social determinants of health: Backgrounder 3: Key concepts.*

Retrieved July 2, 2020

https://www.who.int/social_determinants/final_report/key_concepts_en.pdf?ua=1

Wyatt, R., Laderman, W. R., Botwinikh, M., Mate, K., & Whittington, J. (2016). Achieving health equity: A guide for health care organizations, IHI White Paper. Institute for Healthcare Improvement.

<http://www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>

Xu, K., Nosek, B., & Greenwald, A. G. (2014). Psychology data from the Race Implicit Association Test on the Project Implicit Demo website. *Journal of Open Psychology Data*, 2(1), e3. DOI: <http://doi.org/10.5334/jopd.ac>

Zestcott, C. A., Blair, I. V., & Stone, J. (2016). Examining the presence, consequences, and reduction of implicit bias in health care: A narrative review. Sage Publishing.

DOI:10.1177/136843021664202

Appendix A

Initial Invitation to Participate in Research

February 2021, Sheila Price (Sent via email to all fulltime faculty at the School of Nursing)

I am very excited to invite you to participate in my research study as part of the requirements for the Ed.D. program in Educational Leadership at WCU. This Doctoral program follows an Improvement Science model. This theoretical and methodological guide is the foundation of this graduate program and an integral part of the Carnegie Classification. As such, some aspects of this project might seem different from what you are familiar with.

The project title is “Enhancing Nursing Faculty Awareness of implicit Racial Bias: An Antiracism Strategy for the Reduction of Health Disparities in Black, Hispanic, and American Indian Populations”. You're eligible to be in this study because you are a current faculty member in the School of Nursing at Western Carolina University. This improvement initiative is designed to develop an effective online teaching strategy to raise faculty awareness of implicit racial bias through implicit bias self-awareness activities which can then be applied to the nursing curriculum. The ultimate goal is to support movement from a passive recognition of the impact of implicit bias to an active, action-oriented antiracism approach that motivates nursing graduates to provide equitable high-quality care for all patients, reduce health disparity and create a work environment that welcomes diversity in the health care environment workforce.

We will engage in a series of weekly virtual group meetings, lasting between one and two hours, each week for six consecutive weeks. Study participants will determine the optimal day of the week and hour of the day for the weekly virtual group meetings in order to improve the ability to attend all meetings. Consistent participation in the virtual group meetings is important, however,

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if an unforeseen situation arises, you may miss a meeting and continue in the study. Prior to each session, participants will be asked to engage with specific materials (i.e. videos, book chapters, journal articles, tests, etc.) that will serve as the foundation for discussion at the meeting. Prior to the first and sixth virtual group meetings participants will complete the Intercultural Development Inventory (IDI) via the internet. A group summary of findings will be debriefed by Dr. Dana Patterson, WCU certified IDI administrator at the first and sixth group meeting. I will not have access to the individual responses or findings for the IDI test. After each virtual group meeting participants will be asked to provide feedback on their experience via a qualtrics survey. The final qualtrics survey will include the same reflection prompts as the previous post virtual group meeting surveys and also include an opportunity for the participant to reflect on any differences noted in their personal IDI outcomes and the group findings as well as change in self-awareness as a result of the experience.

The only personal information collected will be your name on the consent form. Transcripts of the recordings of the virtual group meetings will use a pseudonym and no document connecting the pseudonym to the participant's identity will be maintained. Recordings will be deleted after transcript accuracy is confirmed.

No significant risks are identified. Some discomfort during the process of self-reflection is anticipated. It may also be uncomfortable at first to disclose to colleagues. We will talk about this during our first session and reinforce the need for group confidentiality. You may refuse to answer any of the questions, take a break or stop participation in this study at any time. The CO-PI will observe carefully to identify signs of extreme distress. Should a participant demonstrate or express extreme distress, the opportunity to not participate and direction for counseling or psychiatric support will be offered. Remember, this is completely voluntary. You can choose to be in the study or not without any impact on employment or job-related performance evaluation

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or measures.

If you are interested in this study and would like more information please contact Sheila Price, CoPI, who will be facilitating this research study, at scprice@xxxxx.edu or XXX XXX XXXX or Dr. Yancey Gulley, the principal investigator and faculty advisor for this project, at ygulley@email.xxxxx.edu.

If you are willing to participate in this important research and have had the opportunity to have any questions regarding participation answered, please review the attached Informed consent document, complete the check boxes and signature section at the bottom of the form and return the document to me at scprice@xxxx.edu via **XXX email by XX/XX/2021**

Thank you for your consideration of this opportunity. I look forward to working with you on this meaningful improvement research study.

Be well,

Sheila Price

"Nobody made a greater mistake than he who did nothing because he could only do a little"

Edmund Burk

Appendix B

Consent to Participate in a Research Study

You are being invited to participate in a research study of various virtual methodologies intended to raise awareness of implicit racial bias. You were selected as a possible participant because you are a faculty member of the Western Carolina University School of Nursing. Please read this form carefully and ask any questions you may have before agreeing to be in the study.

Participation is completely voluntary.

Please submit the signed consent to scprice@wcu.edu by XX/XX/XXXX via WCU email

Project Title: Enhancing Nursing Faculty Awareness of implicit Racial Bias: An Antiracism Strategy for the Reduction of Health Disparities in Black, Hispanic, and American Indian Populations

This study is being conducted by: Sheila Price (CoPI) and EdD Disquisition Committee Chair, Dr. Yancey Gulley (PI). Together referenced as the research team in this document.

Description and Purpose of the Research: You are invited to participate in improvement research designed to evaluate the impact of various teaching methods intended to raise awareness of the existence of implicit racial bias. There is persistent variance in health status between the Black, Hispanic, and American Indian populations when compared to the better overall health status of the White population. There is no evidence that health disparity has its foundation in a genetic or racial predisposition that would contribute to the variance in health status for these populations. There is, however, evidence that health disparity is influenced by socioeconomic status, culture, health system processes, English language skills, and the relationship between a patient and their care provider. This improvement research is designed to develop an effective online teaching strategy to raise faculty awareness of implicit racial bias through self-awareness activities which can then be applied to the nursing curriculum. The ultimate goal is to support

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movement from a passive recognition of the impact of implicit bias to an active, action-oriented antiracism approach that motivates nursing graduates to provide equitable high-quality care for all patients, reduce health disparity and create a work environment that welcomes diversity in the health care environment workforce.

What you will be asked to do: Participants will engage in a series of six virtual group meetings, each session lasting between one and two hours over the course of six consecutive weeks. The day and time for the virtual group meetings will be determined collaboratively with the participants. Consistent participation in the virtual group meetings is important, however, if an unforeseen situation arises, the participant may miss a meeting and continue in the study. Prior to each session, participants will be asked to engage with specific materials (ie. videos, book chapters, journal articles, tests, etc.) that will serve as the foundation for discussion at the session. Meetings will be facilitated by Sheila Price, CoPI, (sometimes with an invited topic expert). After each virtual session participants will be asked to complete a brief qualtrics survey (with guiding questions) to provide feedback on their experience and to inform the next session. At the end of the six weeks, participants will complete a final qualtrics survey reflecting on any difference in outcomes while providing the Co-PI with reflections on the activities in which they engaged and their own learning and growth or challenges across them. The virtual group meetings will be recorded for review and data collection and will be deleted after they are transcribed.

The only personally identifiable data collected will be the informed consent which will be maintained in a secure location. Test data will be reported as a group aggregate, transcripts of the virtual group meetings will identify the participant with a pseudonym. Session recordings will be deleted after completion of the research study. Information connecting the identity of the participant to the pseudonym will be maintained in Sheila Price's secure password protected

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WCU provided computer.

Risks and Discomforts: There are no anticipated serious risks from participating in this research. Participation is optional and has no impact on employment or job-related performance evaluation or measures. There is some risk of discomfort as the researcher and participants are colleagues. Participants may feel pressure to say something to make the researcher (a colleague) look good, may be hesitant to reveal true feelings with their colleagues or may struggle with self-discovery. Some discomfort during the process of self-reflection is anticipated. Some of the discussions that evolve as part of this study may make you feel uncomfortable. You may refuse to answer any of the questions, take a break or stop your participation in this study at any time. The researcher will observe carefully to identify signs of extreme distress. Should a participant demonstrate or express extreme distress, the participant has the opportunity to discontinue participation and/or receive counseling and psychological resources. National hotlines are being provided due to participants' dispersed geographical locations. <https://www.nami.org/help>
<https://www.crisistextline.org>

Use of the virtual environment may pose some risk. This is being minimized by using the WCU Zoom product for the virtual group meetings and WCU email for communication. Your participation presents no greater risk than everyday use of the Internet.

Benefits to the Individual: There are no direct benefits to you for participating in this research study, however, this action research may help us better understand how our implicit bias affects our collegial interactions, clinical decisions, and quality of patient care. Participants will have the opportunity to positively impact health disparity by supporting awareness within the nursing student population through inclusion of implicit bias in the nursing curriculum and ultimately improve nursing care for the Black, Hispanic and American Indian populations and thereby reduce health disparity. Results of the study will be made available to participants upon request.

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Benefits to Society: Movement from a passive recognition of the impact of implicit bias to an active action-oriented antiracism approach that motivates nursing graduates to provide equitable high-quality care for all patients may have a positive effect on society as demonstrated by reduced health disparity, creation of a work environment that welcomes diversity in the health care environment workforce, and a reduction in the overall cost for health and healthcare.

Privacy/Confidentiality/Data Security: The data collected in this research study will be kept confidential. Participation in research may involve some loss of privacy. We will do our best to make sure that the information about you is kept confidential, but we cannot guarantee total confidentiality. Your personal information may be viewed by individuals involved in the research and may be seen by people including those collaborating, funding, and regulating the study. We will share only the minimum necessary information in order to conduct the research. Your personal information may also be given out if required by law, such as pursuant to a court order. While the information and data resulting from this study may be presented at scientific meetings or published in a scientific journal, your name or other personal information will not be revealed.

The only personally identifiable information will be the participant's name on the informed consent document. All data will be recorded using a pseudonym. No record connecting the participant to their pseudonym or the data to the individual will be maintained. Your information will be collected through transcripts of the virtual group meeting recordings and the post meeting qualtrics surveys. Participant data will be identified using a pseudonym. While the information and data resulting from this study may be presented at scientific meetings or published in a scientific journal, your name or other personal information will not be revealed.

Some data is collected using a qualtrics survey submitted via WCU email: The research team will work to protect your data to the extent permitted by technology. It is possible, although

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unlikely, that an unauthorized individual could gain access to your responses because you are responding online. This risk is similar to your everyday use of the internet.

Data collected during the virtual group meetings: We will request that all participants respect the confidentiality of the group and do not share any other participant's responses outside of the group. However, we cannot guarantee your privacy or confidentiality because there is always the possibility that another member of the group could share what was said. Pseudonyms will be assigned to each participant when transcribing the session videos. No record connecting the individual to the pseudonym will be maintained. The videos will be deleted after verification of transcript accuracy. Your data will not be used or distributed for future research studies.

Use of direct quotes in dissemination: If you give the researcher permission to quote you directly, the researchers will use a pseudonym and will generalize your quote to remove any information that could be personally identifying (see area to declare or deny permission to use a quote below)

Voluntary Participation: Participation is voluntary, and you have the right to withdraw your consent or discontinue participation at any time without penalty of any kind.

Compensation for Participation: None

Contact Information: For questions about this study prior to completion of the consent process, please contact Sheila Price, who will be facilitating this research study, at scprice@wcu.edu or 828 421 0101. You may also contact Dr. Yancey Gulley, the principal investigator of record and faculty advisor for this project, at nygulley@wcu.edu

Please check the appropriate boxes on this document and complete the signature section.

Return the document to scprice@wcu.edu via encrypted WCU email by XX/XX/2021 (instructions for WCU Email encryption are attached to the recruitment email).

If you have questions or concerns about your treatment as a participant in this study, you may

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contact the Western Carolina University Institutional Review Board through the Office of Research Administration by calling 828-227-7212 or emailing irb@wcu.edu. All reports or correspondence will be kept confidential to the extent possible.

You will be given a copy of this information to keep for your records.

I do or do not give my permission to the investigators to quote me directly in their research. (If you give the research team permission to quote you directly, you will be identified with a pseudonym and your quote will be generalized to remove any information that could be personally identifying).

I understand what is expected of me if I participate in this research study. I have been given the opportunity to ask questions and understand that participation is voluntary. My signature shows that I agree to participate, permit recording of the virtual group meetings as described above and am at least 18 years old.

Participant Name (printed): _____

Participant Signature: _____ Date: _____

Name of Researcher Obtaining Consent: Sheila C. Price

Researcher Signature: _____ Date: _____

Name of principal investigator and faculty advisor: Dr. Needham Yancey Gulley

Researcher Signature: _____ Date: _____

If you would like to receive a summary of the results, once the study has been completed, please write your email address (as legibly as possible) here

Please return the signed consent via encrypted WCU email to Sheila Price

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Appendix C

Final Improvement Initiative

Plan Improvement Plan: Week 1

Session Number	Session Focus	Activity	Facilitation Prompts	Formative Measure	Summative Measure
<p>Prior to Week 1</p> <p>Pre-Work to be completed prior to Session One</p> <p>Time commitment, about 30 minutes</p>	<p>Establish a baseline measure of implicit bias.</p>	<p>Participants received an email link with instructions to complete the Intercultural Development Inventory (IDI).</p>			
<p><u>Session 1</u></p> <p>Debrief IDI results.</p> <p>Time commitment: up to two hours.</p> <p>Facilitator: Co-PI Sheila Price, Topic expert: Certified IDI Consultant</p>	<p>Debrief of the group findings from the IDI assessment, facilitated by IDI consultant.</p> <p>24 hours post session participants will receive qualtrics reflection survey.</p>	<p>Review the validation of IDI instruments and debrief elements of the IDI assessments.</p> <p>Provide space for reaction and discussion of the information.</p>	<p>Provided by Certified IDI Facilitator who will lead the session.</p>	<p>Aggregated Group IDI findings: Perceived Orientation Score, Development Orientation Score, and Orientation Gap.</p>	<p>Collect artifacts from qualtrics guided reflections and review of the session video.</p> <p>Use info to inform next session's discussion.</p>

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Week 2

Session Number, Focus Area	Session Focus	Activity	Facilitation Prompts	Formative Measure	Summative Measure
<p>Prior to Week 2</p> <p>Pre-Work to be completed prior to Session 2</p> <p>Time commitment, about one hour</p>		<p>Participants will complete the Privilege Responsibility Curricular Exercise survey (PRCE) (Appendix E).</p> <p>Read the designated selections from the book, <i>Is everybody really equal?</i> by Sensoy and DiAngelo</p>			
<p>Week 2</p> <p>Whiteness as Property</p> <p>Time commitment: one hour</p> <p>Facilitator: Co- PI, Sheila Price</p>	<p>What Is Whiteness? Should people be proud of membership in a group marked by power and privilege?</p> <p>The effects of White Privilege, how it impacts access to “the American Dream” and identify implications at the school of nursing.</p> <p>One day post session:</p>	<p>Debrief reactions from the Privilege survey and the readings.</p> <p>Sheila will share the story of the impact of her implicit bias and privilege on patient care in an OB department.</p>	<p>What surprised you from last week’s discussion?</p> <p>If you shared your experience with anyone, what was their reaction?</p> <p>Let’s talk about the PRCE survey. How did it make you feel?</p> <p>How do we increase the diversity in the student and faculty population?</p> <p>Think about your nursing experience. Can</p>	<p>Were you disturbed by your results? If so, please explain. How did your results make you feel? Do your results make you feel differently about how you approach patient care? If so, how?</p>	<p>Collect artifacts from qualtrics guided reflections and review of the session video.</p> <p>Use info, as appropriate to inform the next session.</p>

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	<p>Complete guided reflection via qualtrics</p>		<p>you remember a situation where you knew someone was cared for differently because of race, English language skills, etc.?</p> <p>How did you respond?</p>		
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Improvement Plan Week 3

Session Number, Focus Area	Session Focus	Activity	Facilitation Prompts	Formative Measure	Summative Measure
<p>Prework for Week 3</p> <p>Time Commitment: About an hour</p>	<p>Review Videos:</p> <p>Let's get to the root of racial injustice - Megan Ming Francis 19.37 min.</p> <p>Racial Disparities in Healthcare are Pervasive 6.01 minutes</p> <p>Minority Health Disparities, Michelle's Story 5.08 minutes</p>				
<p>Week 3 Recognition of the Existence of Racism</p> <p>Time commitment one hour</p> <p>Facilitator: Co-PI Sheila Price</p>	<p>Look at overt and unconscious, personal and structural racism, and “othering”. Racism in the healthcare system.</p> <p>Complete guided reflection one day post session.</p>	<p>Discussed the essence of the videos and shared their reactions to the content.</p>	<p>Share your first thought after you reviewed the videos.</p> <p>Tell me a story about what you have seen... in the healthcare setting, the classroom, our recruitment and admission systems, etc.</p> <p>Share a time when you experienced Bias.</p>		<p>Collect artifacts from the qualtrics guided reflections and review of the session video.</p> <p>Use info to inform next session's discussion.</p>

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Improvement Plan Week 4

Action Research Plan	Session Focus	Activity	Session Facilitation Prompts	Formative Measure	Summative Measure
Pework for Week 4		During the week prior to session five, participants will be sent the web link to complete the Race version of the Implicit Association Test (IAT) (Black/White) and the Skin Tone IAT.			
<p>Week 4</p> <p>Color Blindness</p> <p>Virtual Group Meeting:</p> <p>Time commitment: 1 hour</p> <p>Facilitator: CoPI Sheila Price</p>	<p>Colorblindness.</p> <p>We are not all alike.</p> <p>Recognition that implicit bias is a reality</p> <p>One day post session: complete guided reflection via qualtrics</p>	<p>Share reactions to the IAT test results.</p> <p>Discuss the impact of the color blindness method of thinking and communication on decision making, interactions, and discussion of social equity.</p>	<p>Were you disturbed by your results? If so, please explain.</p> <p>How did your results make you feel?</p> <p>Do your results make you feel differently about how you approach patient care? If so, how?</p>		<p>Collect artifacts from qualtrics survey-guided reflection and review of discussion in the session video.</p> <p>Use info to inform next session's discussion.</p>

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Improvement Plan Week 5

Action/Research Plan	Session Focus	Activity	Session Facilitation Prompts	Formative Measure	Summative Measure
Prewrite for Week 5					
<p>Week 5 Counter Story Telling Naming one's own reality.</p> <p>Time commitment: 1 hour</p> <p>Facilitator: CoPI Sheila Price</p>	<p>Lived experience discussion.</p> <p>One day post session: Complete guided reflection via qualtrics</p>	<p>Guest speakers via prerecorded conversations with a Black, American Indian, and White patient who shared their experience as a patient in the healthcare system. CO-PI will share her experience and participants will have an opportunity to share their experiences.</p>			<p>Collect artifacts from qualtrics guided reflections and review of the session video.</p> <p>Use info to inform next session's discussion.</p>

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Improvement Plan: Week 6

Action Research Plan	Session Focus	Activity	Session Facilitation Prompts	Formative Measure	Summative Measure
<p>Pework for Week 6 Complete IDI, Time required: about 20 minutes</p>		<p>Prior to session 6 participants complete the IDI assessment</p>			
<p>Week 6 Virtual Group Meeting, Time Requirement: no more than 2 hours</p> <p>Facilitator: CoPI Sheila Price</p>	<p>Evaluation of the effect of the intervention sessions.</p>	<p>Findings from the two IDI assessment will be debriefed with discussion. Participants will share perception of the overall group experience</p>	<p>Session led by the IDI facilitator.</p> <p>What stands out to you from this experience? How do we continue this discussion with the rest of the faculty?</p>	<p>IDI findings for the following components:</p> <p>The Perceived Orientation Score, Developmental Orientation Score and</p>	<p>Collect artifacts From qualtrics guided reflections and review of the session video.</p>
<p>Topic Expert: Certified IDI Facilitator</p>				<p>Orientation Gap</p> <p>Compare the IDI findings from Week 1 and week 6 IDI to assess level of change in bias.</p>	

Appendix D

Privilege and Responsibility Curricular Exercise (PRCE)

	<p>Directions: Read each of the statements below and put yes beside those that you feel describe your experience. Count your total number of affirmative responses and write it in the space below.</p>
	If I should need to move, I can be pretty sure of renting or purchasing a home in an area that I can afford and in which I would want to live.
	If I ask to talk to the person in charge, I will be facing a person similar to me.
	If I walk towards a security checkpoint in the airport, I can feel that I will not be looked upon as suspect.
	If I walk into an emergency room, I can expect to be treated with dignity and respect.
	If I walk through a parking garage at night, I don't have to feel vulnerable.
	I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children's magazines featuring people who look like me.
	I can easily trust that anyone I'm speaking to will understand the meaning of my words.
	I can feel confident that my patients feel that I am qualified upon first impression.
	When a patient asks where I'm from, I simply think that it's because they're being friendly.
	My employer gives days off for the holidays that are most important to me.
	I can come to work early or stay late whenever needed and know that my children will be cared for.
	I can speak in a roomful of hospital leaders and feel that I am heard.
	I can go home from most meetings feeling somewhat engaged, rather than isolated, out-of-place, or unheard.

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	I can look at the cafeteria menu and expect to see that the special of the day reflects my culture's traditional foods.
	My age adds to my credibility.
	My body stature is consistent with an image of success.
	I can bring my spouse or partner to an office gathering without thinking twice.
	I can be sure that if I need legal or medical help, my race will not work against me.
	I can take a job with an affirmative action employer without having coworkers on the job suspect that I got it because of race or gender.
	I feel confident that if I don't understand something then it wasn't written clearly enough for most others to understand.
	I can feel confident that if a family member requires hospital or emergency treatment, they would be treated with dignity and respect even if they don't mention my connection with the hospital.
	I have no medical conditions or cultural/religious dietary restrictions that require special arrangements or that make others see me as different.
	Total Number of Affirmative Answers
	Please reflect on this survey in this space.
<p><i>Holm AL, Rowe Gorosh M, Brady M, White-Perkins D. Recognizing privilege and bias: an interactive exercise to expand health care providers' personal awareness. Acad Med.2017;92(3):360-364.</i></p>	

Appendix E

White Privilege Checklist

White Privilege: Unpacking the Invisible Knapsack

by Peggy McIntosh

“I was taught to see racism only in individual acts of meanness, not in invisible systems conferring dominance on my group”

DAILY EFFECTS OF WHITE PRIVILEGE

I decided to try to work on myself at least by identifying some of the daily effects of white privilege in my life. I have chosen those conditions that I think in my case attach somewhat more to skin-color privilege than to class, religion, ethnic status, or geographic location, though of course all these other factors are intricately intertwined. As far as I can tell, my African American coworkers, friends, and acquaintances with whom I come into daily or frequent contact in this particular time, place and time of work cannot count on most of these conditions.

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1. I can if I wish arrange to be in the company of people of my race most of the time.
2. I can avoid spending time with people whom I was trained to mistrust and who have learned to mistrust my kind or me.
3. If I should need to move, I can be pretty sure of renting or purchasing housing in an area which I can afford and in which I would want to live.
4. I can be pretty sure that my neighbors in such a location will be neutral or pleasant to me.
5. I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed.
6. I can turn on the television or open to the front page of the paper and see people of my race widely represented.
7. When I am told about our national heritage or about "civilization," I am shown that people of my color made it what it is.
8. I can be sure that my children will be given curricular materials that testify to the existence of their race.
9. If I want to, I can be pretty sure of finding a publisher for this piece on white privilege.
10. I can be pretty sure of having my voice heard in a group in which I am the only member of my race.
11. I can be casual about whether or not to listen to another person's voice in a group in which s/he is the only member of his/her race.
12. I can go into a music shop and count on finding the music of my race represented, into a supermarket and find the staple foods which fit with my cultural traditions, into a hairdresser's shop and find someone who can cut my hair.
13. Whether I use checks, credit cards or cash, I can count on my skin color not to work against the appearance of financial reliability.
14. I can arrange to protect my children most of the time from people who might not like them.
15. I do not have to educate my children to be aware of systemic racism for their own daily physical protection.
16. I can be pretty sure that my children's teachers and employers will tolerate them if they fit school and workplace norms; my chief worries about them do not concern others' attitudes toward their race.
17. I can talk with my mouth full and not have people put this down to my color.
18. I can swear, or dress in second hand clothes, or not answer letters, without having people attribute these choices to the bad morals, the poverty or the illiteracy of my race.
19. I can speak in public to a powerful male group without putting my race on trial.
20. I can do well in a challenging situation without being called a credit to my race.
21. I am never asked to speak for all the people of my racial group.

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22. I can remain oblivious of the language and customs of persons of color who constitute the world's majority without feeling in my culture any penalty for such oblivion.
23. I can criticize our government and talk about how much I fear its policies and behavior without being seen as a cultural outsider.
24. I can be pretty sure that if I ask to talk to the "person in charge", I will be facing a person of my race.
25. If a traffic cop pulls me over or if the IRS audits my tax return, I can be sure I haven't been singled out because of my race.
26. I can easily buy posters, post-cards, picture books, greeting cards, dolls, toys and children's magazines featuring people of my race.
27. I can go home from most meetings of organizations I belong to feeling somewhat tied in, rather than isolated, out-of-place, outnumbered, unheard, held at a distance or feared.
28. I can be pretty sure that an argument with a colleague of another race is more likely to jeopardize her/his chances for advancement than to jeopardize mine.
29. I can be pretty sure that if I argue for the promotion of a person of another race, or a program centering on race, this is not likely to cost me heavily within my present setting, even if my colleagues disagree with me.
30. If I declare there is a racial issue at hand, or there isn't a racial issue at hand, my race will lend me more credibility for either position than a person of color will have.
31. I can choose to ignore developments in minority writing and minority activist programs, or disparage them, or learn from them, but in any case, I can find ways to be more or less protected from negative consequences of any of these choices.
32. My culture gives me little fear about ignoring the perspectives and powers of people of other races.
33. I am not made acutely aware that my shape, bearing or body odor will be taken as a reflection on my race.
34. I can worry about racism without being seen as self- interested or self-seeking
35. I can take a job with an affirmative action employer without having my co-workers on the job suspect that I got it because of my race.
36. If my day, week or year is going badly, I need not ask of each negative episode or situation whether it had racial overtones.
37. I can be pretty sure of finding people who would be willing to talk with me and advise me about my next steps, professionally.

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38. I can think over many options, social, political, imaginative or professional, without asking whether a person of my race would be accepted or allowed to do what I want to do.
39. I can be late to a meeting without having the lateness reflect on my race.
40. I can choose public accommodation without fearing that people of my race cannot get in or will be mistreated in the places I have chosen.
41. I can be sure that if I need legal or medical help, my race will not work against me.
42. I can arrange my activities so that I will never have to experience feelings of rejection owing to my race.
43. If I have low credibility as a leader, I can be sure that my race is not the problem.
44. I can easily find academic courses and institutions which give attention only to people of my race.
45. I can expect figurative language and imagery in all of the arts to testify to experiences of my race.
46. I can choose blemish cover or bandages in “flesh” color and have them more or less match my skin.
47. I can travel alone or with my spouse without expecting embarrassment or hostility in those who deal with us.
48. I have no difficulty finding neighborhoods where people approve of our household.
49. My children are given texts and classes which implicitly support our kind of family unit and do not turn them against my choice of domestic partnership.
50. I will feel welcomed and “normal” in the usual walks of public life, institutional and social.