Should All Nurses Be Required to Complete Implicit Bias Training?

Bias mitigation requires a systematic approach.

In the past few years, several states have started to require implicit bias training for nursing license renewal or application.[1] California's landmark legislation not only requires a one-hour implicit bias course for all new nurses but also includes implicit bias education as a graduation requirement for nursing programs. In Michigan, health professionals must complete implicit bias training when renewing or obtaining a license. Maryland, Massachusetts, Kentucky, and Washington State have adopted similar policies. Should the nursing profession mandate implicit bias training for all RNs?

The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity recommends that educators prepare future nurses with the knowledge and skills to identify and mitigate implicit bias—but not all nurses agree.[2] One nurse refused implicit bias training at her workplace and was terminated.[3] The nurse penned an editorial falsely asserting that such training is rooted in a belief that if you are White, you are racist. Sadly, the nurse took a seemingly myopic view of implicit bias and inaccurately concluded that implicit bias training blames White individuals for racism.

Although many unconscious biases are based on racial and ethnic identities, implicit bias training is not code for antiracism. Implicit bias—unconscious mental associations and/or attitudes about individuals—extends beyond race and includes assumptions or stereotypes about people who are elderly; homeless; large-bodied; impoverished; identify as lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+); live with mental illness; and more. While unconscious, these negative mental associations or assumptions can influence one's actions.

In health care, implicit bias can contribute to adverse outcomes like delayed discharges, diagnostic errors, and even death. The sentinel report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* emphasizes that provider stereotypes play a role in how care is delivered and could contribute to health care disparities.[4] A retrospective study by Saha and colleagues detected racial differences in analgesic treatment for White and Black male veterans with osteoarthritis.[5] Compared to Whites, African Americans were treated less aggressively. Additionally, the authors noted that compared to White patients, African American patients were less frequently prescribed opioid medications. Still today, some people falsely believe that African Americans have deeper nerve endings, thicker skin, and feel less pain than people of other races, which could contribute to treatment disparities.[6] These false beliefs are rooted in racism, have persisted despite evidence that race is not a biological category (all humans are 99.5% to 99.9% genetically identical; the 0.1% to 0.5% genetic variation is greater *within* socially constructed racial groups than *between* racial groups[7]), and have led to actions perpetuating disparities.

Saha and colleagues also revealed additional discriminatory practices.[5] When clinicians predicted that patients would likely survive resuscitation efforts, do-not-resuscitate orders were more likely to be written for patients of color than White patients. Regarding mental illness, African American patients were more likely to be diagnosed with psychotic disorders (for example, schizophrenia) and White patients with affective disorders (for example, depression). The authors emphasized that factors contributing to the disparities in mental health diagnosis were unclear. Nevertheless, one theme emerged and helped explain a plausible contributor: clinician judgment varied according to the patient's race.

Other marginalized groups have been negatively affected by bias. Weight bias, a pervasive issue, has been shown to undermine patient–provider relationships and contribute to physiological changes in blood pressure and blood sugar.[8] For individuals who identify as LGBTQ+, feeling discriminated against could negatively impact health care visits, and provider biases could lead to missed treatment opportunities.

Implicit bias could also influence maternal mortality. When Linda P., an African American woman in her early 30s, presented at the ED with vaginal bleeding at 28 weeks' gestation, she was admitted and evaluated. (This is a real case; some identifying details have been changed.) For more than 24 hours, she was not given any explanation for her bleeding or why she needed a steroid injection. It was only after Ms. P. told the nurse that she was a malpractice attorney and had spoken to a women's health expert about her condition that several health care providers came to

her room, apprised her of her condition, and began to involve her in the plan of care. What happened? Did the providers make negative associations about Ms. P.'s race and youthful appearance? Did implicit bias influence their initial response? To what extent did Ms. P.'s occupation and personal connections influence the providers' subsequent response?

The deleterious effects of implicit bias have caught the attention of many nursing organizations that want to see nurses improve patient outcomes. In *The Essentials: Core Competencies for Professional Nursing Education*, the American Association of Colleges of Nursing recommends that nurse educators develop a curriculum that prepares students to recognize and control for bias.[9] The *Essentials* also recommends the inclusion of course content that highlights how racism impacts patient outcomes. The National Commission to Address Racism in Nursing, led by the American Nurses Association, National Black Nurses Association, National Coalition of Ethnic Minority Nurse Associations, and National Association of Hispanic Nurses, has also underscored the importance of recognizing and mitigating bias.[10]

Bias mitigation requires a systematic approach that reduces internal conflict within an organization. Bruinen de Bruin and colleagues stated that risk mitigation is most effective when there are voluntary and enforceable actions.[11] While there is no standardized approach for controlling implicit bias, there are actionable steps that nurses can take to align their professional values with actions. One fundamental action toward mitigating bias is recognizing one's own biases. Implicit biases arise from our cognitive processes, which regularly make errors and are informed by our previous experiences and social environments. They are pervasive, everyone has them, and we must each acknowledge that we can easily develop prejudices that may negatively affect others regardless of whether we also experience prejudice and discrimination. Assessing one's own biases requires the act of self-reflection. Koshy and colleagues opined that self-reflection is the intentional inspection of one's strengths and weaknesses.[12] O'Connor and colleagues used an approach called *equityXdesign* to create an Implicit Bias Clinical Teaching Program.[13] This method helps nursing students conceptualize implicit bias as a critical patient safety issue and implement bias-interrupting skills.

All nurses should be cognizant of how implicit bias could harm patients. Implicit bias training should not be weaponized. Conversely, it should be used to encourage curiosity and reflection among current and future nurses and strengthen the profession's capacity to advance health equity. All nurses, regardless of race or ethnicity, should recognize how implicit bias could weaken their ability to align behaviors with core professional values. While many nurses may espouse egalitarianism and emphatically believe their actions align with their values, it will take deep humility to appreciate how one could harbor unconscious stereotypes that contradict their values and culminate in disparate outcomes. ▼

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The authors have disclosed no potential conflicts of interest, financial or otherwise.

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