



The State of the Science of Nurses' Implicit Bias

A Call to Go Beyond the Face of the Other and Revisit the Ethics of Belonging and Power

Holly Wei, PhD, RN, CPN, NEA-BC, FAAN;
Zula Price, PhD, FNP-BC, RN, CNE[®] cl, CD(DONA);
Kara Evans, MSN, RN, NPD-BC, NEA-BC;
Amanda Haberstroh, PhD, MLIS, AHIP;
Vicki Hines-Martin, PhD, PMHCNS, RN, FAAN;
Candace C. Harrington, PhD, DNP, MSN, APRN, AGPCNP-BC, CNE, FAAN

This article summarizes the current state of nurses' implicit bias and discusses the phenomenon from Levinas' face of the Other and ethics of belonging, Watson's human caring and unitary caring science, and Chinn's peace and power theory. Nurses' implicit bias is a global issue; the primary sources of nurses' implicit bias include race/ethnicity, sexuality, health conditions, age, mental health status, and substance use disorders. The current research stays at the descriptive level and addresses implicit bias at the individual level. This article invites nurses to go beyond "the face of the Other" and revisit the ethics of belonging and power. **Key words:** *belonging, ethics, health care, health inequities, implicit bias, nursing, responsibility, the face of the Other*

Author Affiliations: *East Tennessee State University College of Nursing, Johnson City, Tennessee (Dr Wei); Physician Services, Novant Health, Winston-Salem, North Carolina (Dr Price); Atrium Health, Charlotte, North Carolina (Ms Evans); Laupus Health Sciences Library, East Carolina University, Greenville, North Carolina (Dr Haberstroh); and Office of Community Engagement and Diversity Inclusion (Dr Hines-Martin), University of Louisville School of Nursing (Dr Harrington), Louisville, Kentucky.*

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THE NURSING DISCIPLINE, within a caring science framework, practices on a moral and ethical foundation, valuing human beings' dignity, wholeness, and relationships. The current focus on health equity and racial health disparities has brought another

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Correspondence: *Holly Wei, PhD, RN, CPN, NEA-BC, FAAN, East Tennessee State University College of Nursing, 1276 Gilbreath Dr, Johnson City, TN 37614 (weibl1@etsu.edu).*

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Statements of Significance

What is known or assumed to be true about this topic?

The current focus on health equity and racial health disparities has brought another critical concept, implicit bias, to the forefront of health care delivery.

As inequity and disparity in health status and outcomes grow, research studies on health care professionals' attitudes and behaviors have also increased.

The broad and pervasive impacts of implicit bias have been examined across social and cultural institutions and systems, including health care, education, and housing.

What this article adds:

This article presents the current state of the science of nurses' implicit bias and the primary sources of nurses' implicit bias—race/ethnicity, sexuality, health conditions, age, mental health status, and substance use disorders.

Nurses' implicit bias is analyzed and described using Levinas' face of the Other and ethics of belonging, Watson's human caring and unitary caring science, and Chinn's peace and power theory.

This article invites nurses to go beyond "the face of the Other" and revisit the ethics of belonging and power.

critical concept, implicit bias, to the forefront of health care delivery. The term "bias" is commonly used to imply stereotypes and prejudices disproportionately weighted in favor of or against an idea, a thing, or a type of individual, usually in a preconceived or unreasoned way.¹ Biases can be positive or negative, *within or outside* a person's level of awareness, involve a significant emotional component, and result from multiple influences.^{2,3} Biases can be grouped into 2 primary categories—explicit (conscious) or implicit (unconscious).

Explicit bias refers to circumstances in which individuals *are aware* of their preju-

dices and attitudes, which may be expressed as discriminatory language, stigmatizing behavior, or microaggression.⁴ Overt sexism and associated language or exclusionary practices are examples of explicit biases. On the contrary, implicit bias refers to the unconsciousness of the prejudice individuals perceive about another person, group, or action.^{2,3} It involves subconscious feelings, perceptions, attitudes, and stereotypes that result in automatic positive or negative preferences based on one's subconscious thoughts, not associated with planned discriminatory intentions or actions.⁵ The identification of the term "implicit bias" began with psychologists Anthony Greenwald and Mahzarin Banaji,⁶ who theorized that implicit attitudes influence human beings' explicit social behaviors. Greenwald et al⁷ are credited for the Implicit Association Test (IAT), the most widely used method of measuring implicit bias. Irrespective of the category or nature of the bias, responses based on quick categorization, in many circumstances, can and do often result in harmful and damaging decisions and actions.

Implicit biases may occur among individuals across health care disciplines, and nurses' implicit bias toward patients may significantly impact nursing care quality.^{8,9} If holding back implicit biases, nurses could diffuse the inequalities experienced by those prone to discrimination due to race, ethnicity, sexual orientation, disability, or religious activities.^{8,9} The broad and pervasive effects of implicit bias have been examined across social and cultural institutions and systems, such as health care, education, and housing. In the context of health care, studies illustrated that implicit bias perpetuated health inequity by interfering with clinical assessment, decision-making, and provider-patient relationships.¹⁰ As inequity and disparity in health status and outcomes grow, research studies on health care professionals' attitudes and behaviors have also increased. These studies attempted to identify the prevalence and impact of implicit bias. As a major health care workforce, it is important to understand the current state of the science of nurses'

implicit bias and provide recommendations for nursing practice based on the foundations of the ethics of belonging, human caring, peace, and power. This state-of-science literature review describes the current literature on nurses' implicit biases and reflects on the basis of Levinas'¹¹ face of the Other and ethics of belonging, Watson's unitary caring science,¹²⁻¹⁴ and Chinn's peace and power theory.¹⁵⁻¹⁸

METHODS

Design

This is a state-of-science literature review with critical reflections from a theoretical perspective. Our literature search was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.¹⁹ The review was conducted on the basis of the steps proposed by Cooper,²⁰ including identifying a problem, forming the purpose, developing a search plan, searching the relevant databases related to health care and nurses, screening literature, extracting data, synthesizing data, writing, and reporting.

Search and screening process

The first author worked with a university research librarian and developed a search plan. The search for the literature was conducted on the basis of the PRISMA guidelines.¹⁹ The electronic databases searched included PubMed, CINAHL, and PsycINFO. These databases were used to capture the scope of implicit bias in nursing. The following subject terms and key words were used for the search: (1) implicit bias, (2) nursing profession, nurses, and (3) impacts in health care. Subject terms were mapped across the selected databases. The inclusion criteria were studies related to nurses' implicit biases in clinical settings and primary research studies published between January 2010 and April 2022. Studies were excluded if they were not data or outcome measure-based primary research

studies. Three authors screened the literature independently and agreed with the final selection of the studies. The authors also conducted a manual search from the selected articles' reference lists to detect missed articles. The search process is shown in the PRISMA flowchart (see Supplemental Digital Content Diagram 1, available at: <http://links.lww.com/ANS/A61>).

Data extraction

We extracted data following the recommendations by the Joanna Briggs Institute's methodological guidance for conducting mixed-methods systematic reviews.²¹ The data extracted included author names, year of publication, country of the corresponding authors, study aims, study methods (designs, settings, samples, and instruments), and major findings. Two authors independently conducted the initial extraction and cross-checked afterward, and a third author was involved in solving discrepancies based on the original articles. The data extraction was further confirmed by the third author independently.

Data synthesis

We used a constant comparative method to identify overarching themes. A constant comparative approach is an analytical approach to systematically categorize extracted data into themes based on patterns and commonalities.²² The constant comparative method was used to identify the overarching patterns regarding nurses' implicit biases.

Theoretical framework

This article critically analyzed the current literature on nurses' implicit biases through the lens of Levinas'¹¹ "I," "the Other," "Face," and "Belonging," Watson's unitary caring science,¹²⁻¹⁴ and Chinn's peace and power.¹⁵⁻¹⁸ These theories are intricately connected and linked to implicit biases because of their foci on human dignity, connection, and equality. Emmanuel Levinas' "Belonging" is considered the first in philosophy

and serves as a foundation for Watson's unitary caring science and human caring theory, addressing the core value of the nursing profession and practice. Chinn's peace and power focuses on human beings' group relationships.

Emmanuel Levinas, a French philosopher, is renowned for his work in philosophy, existentialism, and phenomenology. His work enlightened the relationships among ethics, metaphysics, and ontology. Specifically, Levinas¹¹ elucidated the relationships of "I," "the Other," "Otherness," "the face of the Other," responsibility, belonging, and ethics as the first philosophy. These concepts and notions provided the philosophical founda-

tion for Watson's¹²⁻¹⁴ unitary caring science and Chinn's¹⁵⁻¹⁸ peace and power theory. It takes bold initiatives to seek open minds and hearts to initiate and catalyze change in nursing.²³ All these 3 theories become an essential element of human being interactions and help understand implicit biases (Figure).

RESULTS

The article searches and selection process are indicated in the PRISMA flowchart. The initial literature search identified 934 records. After duplicates and title/abstract screening, we identified 23 articles for full-text review,

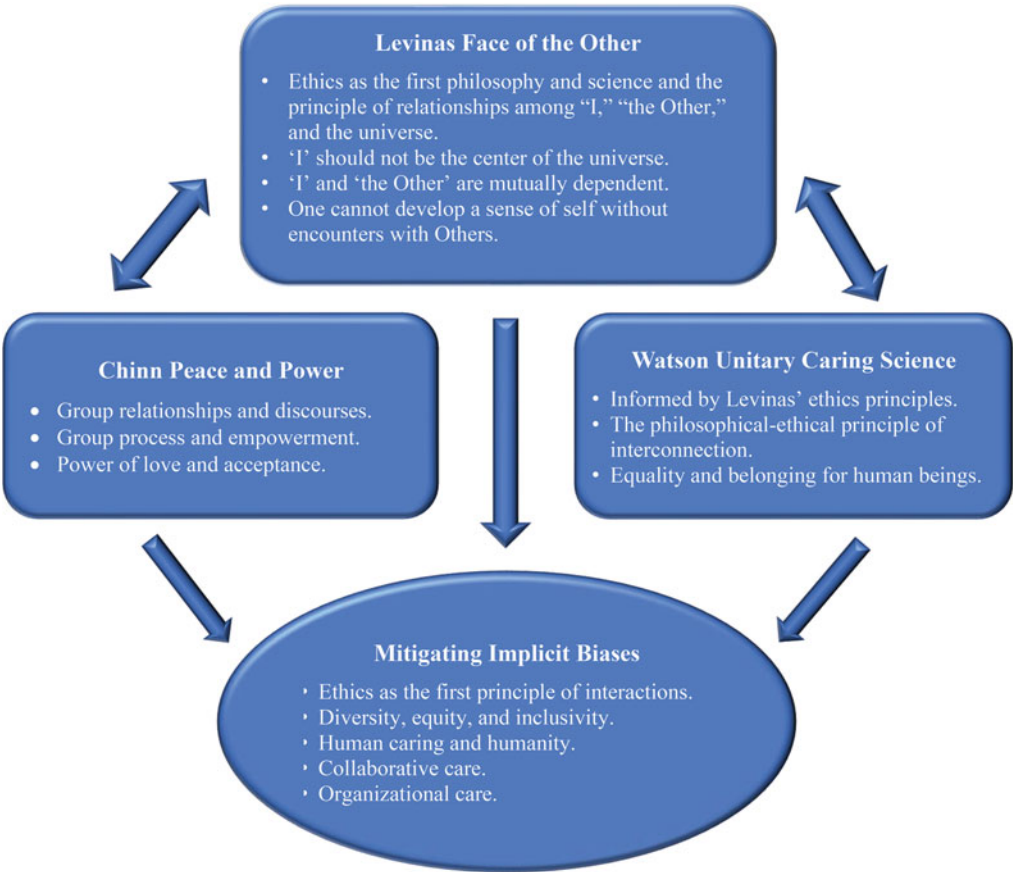


Figure. The theoretical perspectives on human relations. This figure is available in color online (www.advancesinnursingscience.com).

after which we identified 20 articles studying the impacts of nurses' implicit bias on health care quality. The other 3 articles were excluded because they were not primary research studies.

The literature reviewed came from countries around the globe, including Australia, Belgium, Brazil, Canada, Israel, Norway, Singapore, Indonesia, Jordan, and the United States. The primary sources of implicit bias centered on race/ethnicity, sexuality, health conditions, age, mental health status, and substance use disorders in health care, which are described in the following text. The summary of the studies is displayed in Supplemental Digital Content Table 1 (available at: <http://links.lww.com/ANS/A62>).

Race/ethnicity implicit bias

Researchers used various strategies to explore the prevalence and impact of implicit bias on nursing care. A common finding in the studies was the presence of implicit bias that favors White populations over others, such as Blacks, Hispanics, and Native Americans.²⁴⁻²⁸ Researchers used qualitative approaches to investigate the impact of implicit bias on the nursing profession and found that the nursing profession was complicit in perpetuating bias that negatively affected nurses and patients of color.^{26,27}

The studies that took a quantitative approach to explore racial and ethnic bias in nursing care found varying degrees of bias toward Black individuals across care settings. Colón-Emeric et al²⁴ used modifiable fall risk factors and the audit and feedback report to measure and track nursing home staff's performance and implicit bias and reported significant staff implicit bias toward Black patients. Haider et al²⁵ studied 245 critical care, medical-surgical, and emergency department nurses and found significant levels of implicit preference toward White patients despite most participants denying that they had implicit biases. Comparing implicit bias levels by race and occupation, researchers found that White health care workers had

the highest level of pro-White bias.²⁸ While most of the articles in this review were patient focused, Moceris's²⁶ study focused on the impact of implicit bias on Hispanic nurses. Moceris²⁶ uncovered an overarching theme of disrespect from patients, coworkers, and leaders that Hispanic nurses in the United States experienced in the workplace from patients, coworkers, and leaders.

Sexuality implicit bias

Nurses possessed insufficient knowledge of the lived experience of persons who identify as LGBTQIA (lesbian, gay, bisexual, transgender, queer, intersex, and asexual) and implicit preference for providing care to heterosexual patients.²⁹⁻³¹ Sabin et al³⁰ explored 10 452 health care providers' sexuality IAT (including 5379 nurses). Heterosexual providers showed implicit preferences toward heterosexuals over lesbian or gay people and favored heterosexual men more than women. Heterosexual nurses demonstrated the strongest implicit preference for heterosexual men over gay men.³⁰ In a study of LGBTQIA older adults (N = 2463), those who identified as bisexual were largely invisible in their communities.³² These individuals had accumulated social, medical, and economic disadvantages across life, with increased health disparities as they age.³²

Aging implicit bias

The body of literature explicitly associated ageism with poorer physical and mental health, increased social isolation, loneliness, greater financial insecurity, decreased quality of life, and premature death for health care professionals and patients.³³⁻³⁵ Ageism was a falsely validated untruth that legitimized and justified oppression, discrimination, abuse, and mistreatment of older adults across cultures, including health care professionals.^{36,37} For example, oncology nurses with a negative view of aging were less likely to encourage reconstructive surgery for older patients with breast cancer and

less likely to recommend immunotherapy, chemotherapy, and breast reconstruction to older patients.³⁸ The stereotypes and assumptions about older adults could be detrimental to the older adults and affect the culture and attitudes of society and health care professionals.³⁹

Ageism resulted from socially constructed mindsets, language, decisions, and institutional policies and practices based solely on age. The reviewed literature suggested that ageism was pervasive in global health care across cultures and nationalities.^{40,41} The stereotypes, prejudice, and discrimination of ageism were counterintuitive because they affected our future regardless of profession or social status.⁴² Structural ageism in the nursing workforce was a barrier to health care equity and patient safety.^{34,43,44} The COVID-19 pandemic and the necessity to quarantine catalyzed concerns about pervasive ageism.^{37,41} The findings were mixed regarding nurses' attitudes of justified ageism during a pandemic when the need exceeded the human and material resources, which precipitated the position statements by gerontology organizations to support equitable health care for all individuals.⁴⁵⁻⁴⁷

Health conditions implicit bias

Nurses and other health care professionals also demonstrated implicit bias against patients based on their health status. Multiple studies focused on bias against patients with obesity.⁴⁸⁻⁵⁰ The mixed-methods study of Halvorson et al⁴⁸ indicated that 71% of providers exhibited moderate-to-strong implicit weight bias against overweight pediatric patients and their parents. Researchers in Norway also reported that critical care nurses had significant weight biases.⁴⁹ Significant discrimination against obese people, especially women, was identified among nursing and non-nursing students, with no significant differences between the two groups.⁴⁸⁻⁵⁰

Research indicated that nurses and other health care providers, such as physicians,

demonstrated implicit bias based on disease types. Liang et al⁵¹ found that oncology providers (93 physicians, 58 nurses) held more prejudice and implicit bias toward patients with cervical cancer than those with ovarian cancer. Patients diagnosed with cervical cancer reported more emotions related to anger/frustration and riskier health behaviors than the empathy feelings experienced by patients with ovarian cancer. In addition, older and more experienced nurses and other health care providers held stronger implicit anger toward cervical cancer than those who were younger and less experienced.⁵¹ In a national observational longitudinal national study (N = 7905), researchers noted that Black women (n = 1842) had more cervical cancer screenings than their White counterparts (n = 6063), slightly higher odds of reporting receipt of an abnormal Papanicolaou test result, and lower odds of receiving a follow-up recommendation after an abnormal test.⁵² The researchers recommended further research to explore the underlying causes of the paradoxical findings.

Mental health status implicit bias

The body of evidence indicated a significant prevalence of implicit bias against patients with mental illness and substance use disorder.⁵²⁻⁵⁵ Pervasive implicit biases could negatively impact every aspect of the mental health care continuum and patient outcomes.⁵⁶ Mental health care was often provided in a patient-centered manner by a sole provider; this approach may engender more barriers for vulnerable patients to access mental health care due to the implicit biases on race, class, and sex biases.^{56,57} Black males were at the highest risk for experiencing implicit bias, being misdiagnosed with paranoia from psychosis, when they might have experienced systemic injustice and racial profiling.⁵⁶ The recurrent experiences with agitated patients could propose a broader implicit bias that all those experiencing a mental health crisis were dangerous and violent. Nurses and other providers' implicit

bias variances for the marginalized populations, such as those low in implicit bias in socioeconomic racial groups and high in implicit bias for age or LGBTQIA, could contribute to mental health disparities for the socially marginalized individuals.⁵⁵

Substance use disorder implicit bias

Within the substance use field, implicit bias is a largely unexplored concept.⁵⁸ The stigma associated with substance abuse and recovery was based on implicit bias explicitly articulated through language.⁵⁹ The more recent literature focused on the semantic language used for those with substance abuse. The terms used to describe these patients included “addict” or “alcoholic,” associating the individuals with their medical conditions. Evidence suggested that the use of these terms was correlated with negative perceptions and biases, for example, punitive treatment plans, suboptimal health care delivery, less access to health care, and less social engagement.⁵⁹

Implicit bias and the associated stigma were lessened when “recurrence of use” and “pharmacotherapy” were used in place of “medication-assisted treatment” and “relapse.”⁵⁸ Both “medication-assisted recovery” and “long-term recovery” were positive terms and could be used to reduce implicit biases. These findings suggest that nurses’ and other health care professionals’ word choices could positively or negatively affect implicit bias and subsequent patient outcomes in patients with substance use disorders.⁵⁹ One’s word choice and language are a discourse between individuals, the “I” and “the Other.” It is essential to be knowledgeable and competent in communicating with the Other.

DISCUSSION

This article illustrated a state-of-science review of the literature on nurses’ implicit bias. This discussion addresses implicit biases from individual, organizational, and

theoretical perspectives. The 3 significant individual strategies include self-reflection, self-awareness, and knowledge competency.

Individual perspectives

Self-reflection

Individuals’ ability to recognize or identify their own biases was essential for providers delivering health care within various settings.^{60,61} Whether through self-awareness, acknowledgment, reflection, or personal identity, consciously identifying one’s feelings shapes care delivery. Thus, when nurses connected their thoughts and feelings, their considerations influenced their behaviors and care of patients. For example, when Halvorson et al⁴⁸ explored providers’ attitudes toward children with obesity, some acknowledged feeling less sympathetic toward patients who experienced weight-related complications. Equipped with the skills to detect personal bias, nurses may alleviate negative consequences experienced by patients who contribute to health care inequities.

Nurses’ ability to pause and critically reflect on—becoming aware of—individually held biases was considered an essential component for transformative growth and mitigating implicit bias. Qualitative research explored this concept and demonstrated the importance of bringing the implicit into conscious awareness. dos Santos Silva et al³¹ identified a lack of awareness among Brazilian nurses as a significant gap in their ability to address the needs of sexually diverse patients. While recognizing explicit homophobia, nurses showed little to no knowledge of sexual diversity and lacked an understanding of the sociopsychocultural aspects and their impact on health. Research with nurses caring for Native Americans identified the importance of critical reflection and self-awareness.²⁷ Participants in this study described bias from peers but not themselves, demonstrating that the persistent influence of implicit bias was seeing or recognizing it within ourselves.²⁷

Cultural competence training that included all domains of active learning was the most effective.⁶² Clinical practicum opportunities, including simulation, objective structured clinical examination, and assessment, provided structured scenarios for open discussion and critical reflection.^{62,63}

Self-awareness

In a series of longitudinal studies, Sukhera and colleagues^{54,55,64} studied the ripple effect of raising individual awareness of bias in the workplace and highlighted the role of awareness and critical reflection. They incorporated the IAT to not only measure implicit bias but also examine participants' responses to their IAT results. The researchers probed the experience of bringing implicit bias into conscious awareness and contrasting the ideal professional versus the actual self.^{54,55,64} This tension was identified as key to changing behaviors, as the investigators noted frustration prompted reflection and explicit behavior changes.

Mindfulness has emerged as a recommended strategy for clinicians to slow down their thinking, increase self-awareness, empathy, and compassion, and reduce internal sources of cognitive load.^{9,65,66} Mindfulness, perspective-taking, and individuation (taking time to see someone as an individual rather than a group member) have been recommended but with limited success.^{9,67}

Knowledge and competency

Sukhera et al⁶⁸ found that brief knowledge and competency-building exercises changed biases demonstrated by nurses through self-awareness and reflection that led to sustained explicit behavioral changes 12 months later. Bristol et al²⁹ focused on the impact of an educational intervention, employing a pre/posttest design using the Ally Identity Measure (AIM). Total index scores improved in the areas of knowledge and skills, openness and support, and awareness of oppression regarding the LGBT community (P

$< .001$).²⁹ The results indicated participants used unitary caring science resilience model strategies that resulted in more openness, respect, and support, used more inclusive language, and asked more nonjudgmental questions related to sexual orientation and gender after the course.

Organizational perspectives

While individuals play a significant role in reducing implicit bias, it takes the efforts of all health care stakeholders to achieve optimal health outcomes.⁶⁹⁻⁷² Health care organizations play a crucial role in mitigating the effects of implicit bias in health care and organizational decision-making. The quote by Peter Drucker, *culture eats strategy for breakfast*, infers that an organization's culture determines the success of its strategy regardless of the effectiveness of the strategy or intervention. Without systematic changes, individual strategies may only deal with the symptoms temporarily instead of treating the problem. We should make patients feel that their care is coordinated and consistent. Clinicians are caring and available for them regardless of their "face," appearance, and health status.^{73,74} Facilitating factors to help nurses show acceptance and make patients feel safe and valued includes nurses' professional competence, compassion, accountability, trustworthiness, resource-sharing, and engagement. Nurses need to demonstrate their professional capability and responsibility and help "Others" feel accepted and valued. The following is the discussion about nurses' implicit bias from Levinas¹¹ face of the Other and ethics of belonging, Watson's^{12,13} unitary caring science, and Chinn's^{17,18} peace and power perspectives.

Theoretical perspectives

Based on the Code of Ethics for Nurses,⁷⁵ nurses practice with compassion and respect for all human beings with the inherent dignity, worth, and characteristics of every

person. Nurses promote, advocate for, and protect all patients' rights, health, and safety. Nurses have the authority, accountability, and responsibility to provide optimal patient care. Nurses collaborate with others to protect human rights, support health diplomacy, and decrease health disparities. These actions are illustrated via the theoretical foundations of nursing.

Levinas' "I," "the Other," "face," responsibility, and "belonging"

Levinas¹¹ emphasizes ethics as the first philosophical tenet and the relationships among "I," "the Other," "the face of the Other," responsibility, and belonging, positing that all human beings are equal and belong to the infinite love of the universe. Levinas' "I" and the construct of "the face of the Other" enlighten all biases. Levinas' face of the Other and ethics of belonging signify the interconnectedness of self with "the Other" and the human beings' desire for love, value, and respect in the environments to which they belong.^{12,76} As human beings, ethical behaviors toward Others cannot co-exist in implicit biases with an "I" paradigm. The face of the Other guides us to realize that "I" should not be the center of the universe and should go beyond our sense of self. Levinas suggests that "I" and "the Other" are mutually dependent; we cannot develop a sense of self or the world without our encounters with Others.¹¹ The construct "I" is evidenced in all biases whereby we remain superficial and thus only see "Others" as "faces," limiting our human connectedness and ethical belonging. Our self-awareness increases as we encounter and interact with Others at a deeper level beyond the superficial face of the Other. As we recognize that implicit biases exist in an "I" perspective, we have an opportunity to acknowledge the importance of the Other and the world from the Others' perspectives. When we see "the face of the Other" beyond the "face" value, we disconnect implicit biases and realize that recognizing "the Other" at the ethics level

is not a choice but a responsibility, which is consistent with the fundamental principle of Watson's unitary caring science.

Watson unitary human caring science: All connected and oneness

Watson's unitary human caring science, within which nursing caring is grounded, is informed by Levinas' ethics as the first principle of science,¹¹ unitary human beings,⁷⁷ and the ethics of belonging.¹¹⁻¹³ Caring science espouses equality and belonging for all human beings in the infinite universe, where all are metaphysically connected in oneness.^{12,13,77} Aligning with the ethics of belonging, unitary caring science accentuates that the "face of the Other" is complex and irreducible, with which one's level of humanity can reflect on the Other. Watson's unitary caring science is the philosophical-ethical principle of interconnection and describes that healing as being transformative through developing transcendent consciousness.^{13,14,78}

All humans are separate but connected beings, belonging to the infinite universe, and having the right to have dignity, love, and be loved. When guided by the unitary caring science and Watson's unitary caring science, nurses see Others as separate beings with independent cultures, values, and beliefs. Based on the mutuality between "I" and "the Others," nurses can only actualize themselves through the presence of patients. Patients, regardless of their "face"—race, ethnicity, appearance, health status, and conditions—are human beings first, with the right to be treated with dignity and respect. Treating patients from different backgrounds with caring, compassion, and dignity is not only ethical but also nurses' professional and human responsibility. As Watson and colleagues wrote,

...we can't get to "*There*" (the desired status) unless we unravel, constructively critique, creatively and intellectually disrupt, and transcend the "*Here*" (the current situation), wakening to a

unitary transformative worldview and cosmology of the universe to which we all belong.^{78(p252)}

They issued a call for action to create a world with the ethics of belonging and the face of the Other, meaning that we are all separate but connected, belong to the universe, and deserve the infinite love of the universe. The movement from the current “*Here*” to the desired “*There*” requires nurses to work collectively. A theoretical framework—peace and power¹⁵⁻¹⁸—may guide the group actions and team-building process and explain the emancipatory transformation and outcomes.

Peace and power

The peace and power theory emphasizes group relationships and dichotomous discourses,^{15,17,18} informing strategic opportunities to reduce or eliminate implicit bias in nursing and health care.^{15,16} It may help nurses develop effective transpersonal interactions with the people tending to be biased (those with different races/ethnicity, sexuality, health conditions, age, mental health status, and substance users). This theory can guide individuals and groups to understand their actions and interactions, use culturally sensitive, cooperative, and inclusive approaches to treat one another with respect and compassion, address conflicts, and share resources, leadership, and power to inform collective decisions. The peace and power theoretical framework aims to achieve optimal group status. Individuals and groups with diverse backgrounds can work together collaboratively, value one another's differences and strengths, make thoughtful choices, and prevent destructive, damaging interactions.

When reaching the optimal group state, individual members reach their inner peace, feeling emancipated, valued, and empowered. It is essential to make everyone feel included, valued, empowered, and belonging, including peers and patients, especially those vulnerable to being implicitly biased. All biases involve power, reflecting Chinn's “power-over-power” description, particularly

the power of division (the hoarding of skills and knowledge by the privileged few), power of prescription (a paternal or maternalistic paradigm imposing change by authority), power of opposites (dichotomous options in which decisions are polarized into “for” or “against” choices), power of fear (the imagination of future disaster and harm to control the behavior of others), and power of accumulation (a self-interested perspective “I worked for it, paid my dues, and deserve it.”).^{15,17,18} Human relationships contain power; it is crucial to use power to create harmony, appreciation, and collective energy to mitigate implicit bias. Furthermore, implicit bias in nursing is counterintuitive to human caring.

IMPLICATION AND RECOMMENDATIONS

Based on the current implicit bias literature, Levinas' face of the Other and ethics of belonging, Watson's unitary caring science, and Chinn's peace and power, we provide the following recommendations. The highlights are listed in the Table.

LIMITATIONS

While intending to review the effects of nurses' implicit bias, it was challenging to separate nurses' actions from those of other health care professionals. Most of the research was conducted with interprofessional team members in health care, the reality of health care delivery. Implicit bias literature is replete with intervention recommendations, but the evidence for effectiveness is mixed. This is largely due to an absence of longitudinal studies among health care workers of sufficient scale to test the effectiveness of implicit bias interventions. In addition, nurse researchers should take note of psychological research targeting individuals' implicit bias, whether through mindfulness, reflection, or education. While the IAT⁷ has been the most used instrument in implicit bias research, it is

Table. Highlights of Implications and Recommendations

Implication	Recommendation
Address the effects of implicit bias on patient outcomes and how biases impact nursing care.	<ul style="list-style-type: none"> • Nurses have an ethical obligation to reduce health disparities. Successfully addressing implicit bias will require research that demonstrates clear linkages between unconscious bias and nursing care, patient outcomes, and effective, long-term interventions to reduce bias. • These should include initiatives to increase diversity in the nursing workforce and nurse-led advocacy efforts for public policies that incorporate an understanding of the impact of social determinants on health.⁷⁸ • Nurses must be at the forefront of researching the complex interplay of individual and structural factors that culminate in health disparities, effective methods of reducing bias, and eliminating discriminatory practices that ultimately harm the health of our global community.^{76,80} It is essential to go beyond the face of the Other and revisit power in social settings to create peace and belonging and honor the unity among all human beings.
Exploring “what,” such as <i>What is nursing?</i> and <i>What is the founding principle of nursing?</i>	<ul style="list-style-type: none"> • Nursing is a profession interwoven with art and science. At the heart of nursing lies the nurses’ code of ethics, a fundamental respect for human dignity and caring for patients’ needs, which is supported by scientific knowledge and continued learning. • Caring nurses and physicians are competent in knowledge and skills, compassionate, altruistic, responsible, and empathetic.⁷⁹ These principles guide nurses’ daily actions and interactions with patients, colleagues, and collaborators.^{13,78} • It is vital for nurses and other health care professionals to promote health and care delivery by promoting social awareness, community engagement, and organizational caring culture.^{70,71} • The diverse roles and settings in which nurses function involve multiple institutions and systems, and nurses’ biases can potentially impact those environments and care delivery.
Recognize that nursing is inextricably intertwined with the interprofessional team across health care settings.	<ul style="list-style-type: none"> • The broad scope of health care research across disciplines is transferrable and generalizable to the nursing profession. • The body of literature on bias has grown, and nursing has begun to explore the concept of bias and its impact on nursing care delivery and the profession itself. • Nurses are uniquely situated to have a compelling impact on health care inequities—as scientists, care providers, and leaders—and promote cultural and social humility in all practice and education arenas. By the nature of their position in society, nurses possess the occupational and professional power to alleviate inequities and advocate for patients; however, through our professional power and status, we are likely unaware of our implicit biases unless we experience them.

subject to debate. Its utility as a predictor of behavior is unproven, with a weak prediction of racial and ethnic discrimination.⁸¹

The current literature indicates that the primary sources of nurses' implicit bias in health care focus on race/ethnicity, sexuality, health conditions, age, mental health status, and substance use disorders. The research still stays at the descriptive level, using cross-sectional designs to describe the prevalence of nurses' implicit bias. The current literature lacks measurements of health care outcome measures or correlations between implicit bias and patients' outcomes, without which it would be difficult to intervene and measure improvement. As to mitigation strategies, the literature mainly suggests approaches addressing implicit bias at the individual level, such as self-reflection, self-awareness, knowledge, and competency development. It does not include recommendations for intervening at a system or organizational level, nor does it incorporate system strategies into individual approaches.

The research reviewed is subject to several common flaws that limit its applicability. These include a lack of consistency in theoretical frameworks, reliance on self-report measures, and the use of cross-sectional, observational designs. Research findings are translational to practice only if the tools used demonstrate used predictability, reliability, and validity. There are several major flaws related to the mitigation strategies: (1) there are limited intervention studies in the current implicit bias literature; (2) among the limited intervention studies, the major strategies suggested are at the individual level through self-awareness, self-reflection, knowledge, and competency development; and (3) it lacks strategies at a system level. None of the interventions integrated systematic and organizational measures into the individual approaches. Some strategies were even developed on the basis of the IAT items to treat the symptoms but not the root of the problem. Thus, the road to reducing

or eliminating implicit bias is still long and hard.

The current literature suggests 4 main categories of mitigation strategies: self-awareness, self-reflection, knowledge, and competency development. While these strategies may provide some improvements, they stay at the individual level and lack longitudinal effects and sustainability. None of the strategies integrated systematic and organizational measures into the individual approaches, which may not be the best option to go down to the root cause and solve the problems based on the literature review. Some strategies were incorporated and developed on the basis of the IAT items, which may "fix" the "issue" and show effects on the IAT. Yet, it would be difficult to eliminate the root causes and solve the problem. It is vital to solving implicit bias from a convergent perspective, uniting stakeholders, and working together to transform policy.⁷¹

CONCLUSION

The body of literature suggests that implicit biases are pervasive in health care. The reviewed literature uncovered the need for research to alleviate biases in nursing and support health equity across populations. Because implicit bias occurs unconsciously and operates without awareness, it can directly affect one's social actions and interactions. Implicit bias is harmful because it can affect individuals' behaviors without their full awareness. This article calls for nurses to go beyond "the face of the Other" and revisit the ethics of belonging and power to nurture a caring, peaceful, respectful, and all-inclusive environment for all health care communities, especially those marginalized. While nurses are a major part of the health care workforce and a caring profession, mitigating implicit bias is a collaborative awareness and consciousness raising in practice across disciplines.

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