Diversity and Equity in Health Care

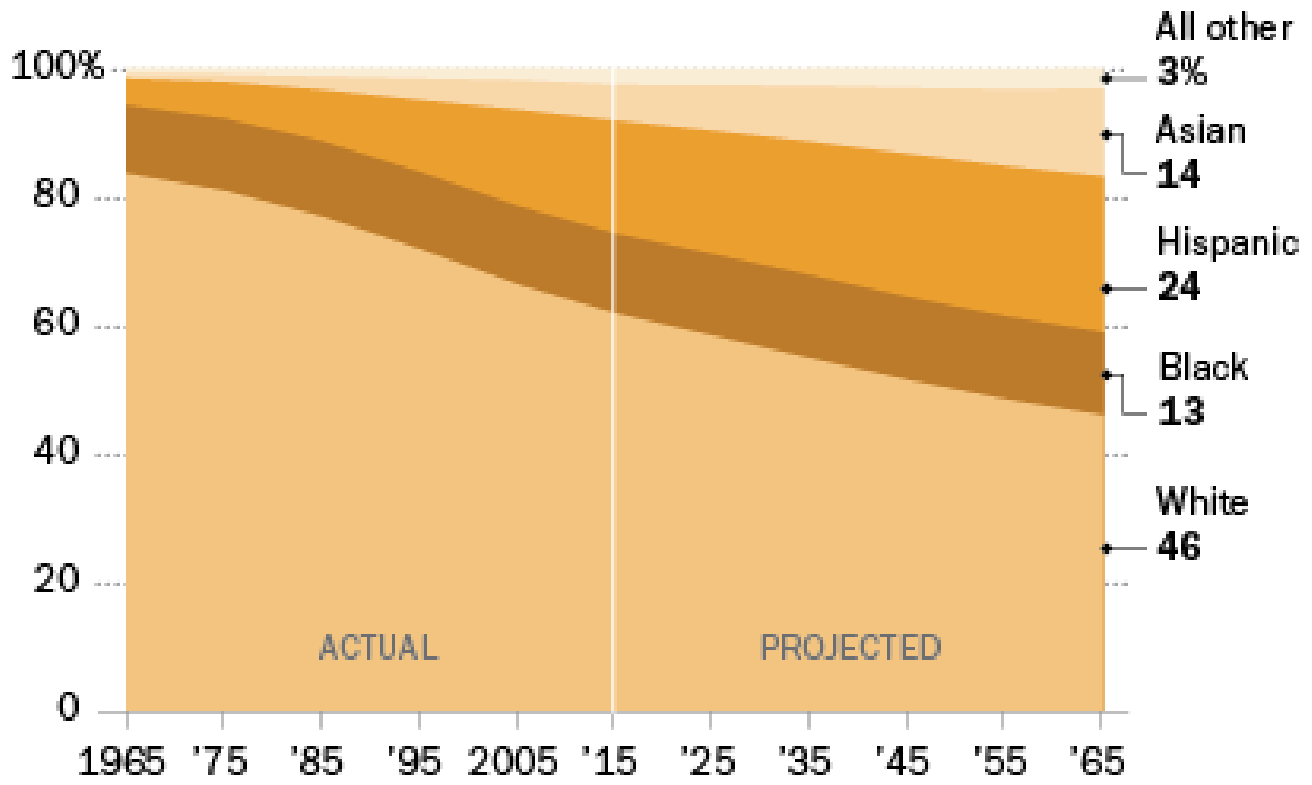
Roger Harrison, Ph.D.

Nemours Children's Health

Wilmington, DE

The changing face of America, 1965–2065

% of the total population



Note: Whites, blacks and Asians include only single-race non-Hispanics; Asians include Pacific Islanders. Hispanics can be of any race.
Source: Pew Research Center 2015 report, "Modern Immigration Wave Brings 59 Million to US, Driving Population Growth and Change Through 2065"

PEW RESEARCH CENTER

Growth by race in US, 2014 to 2060

Non-Hispanic whites are the only group that will see a decline in proportion of the population, from 62.2 percent in 2014 to 43.6 percent in 2060.

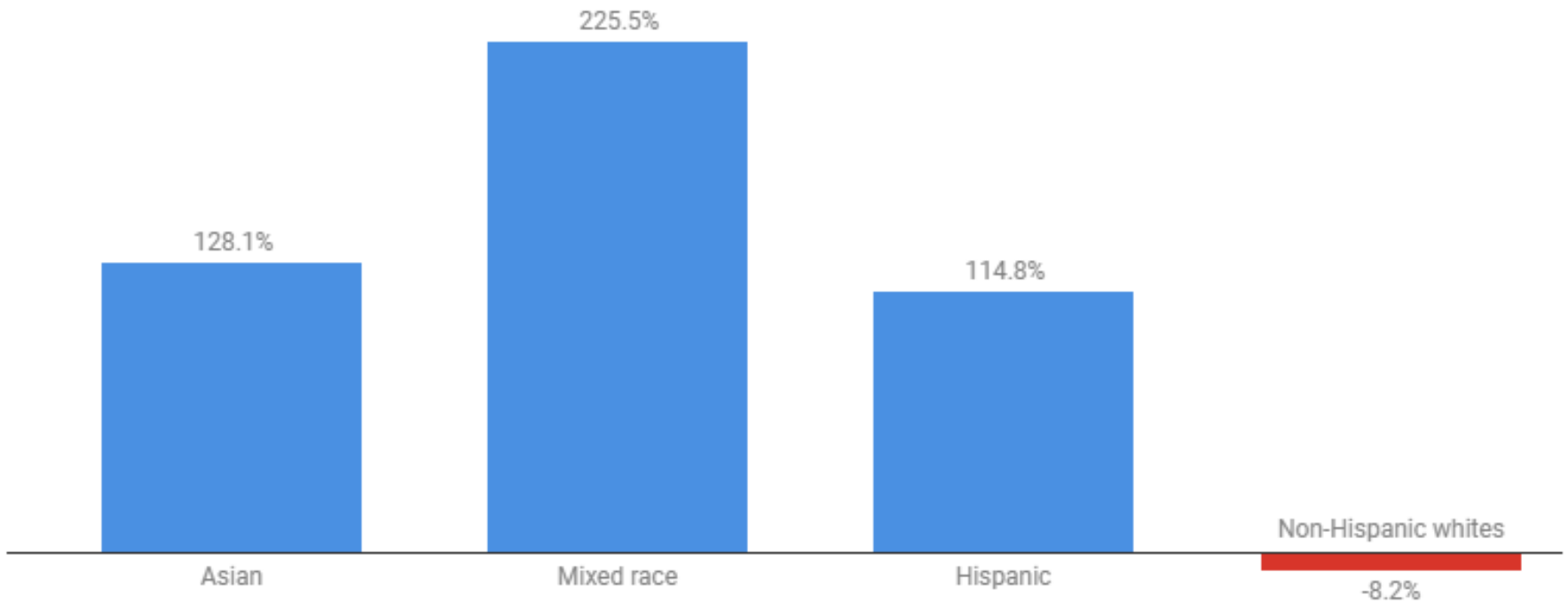
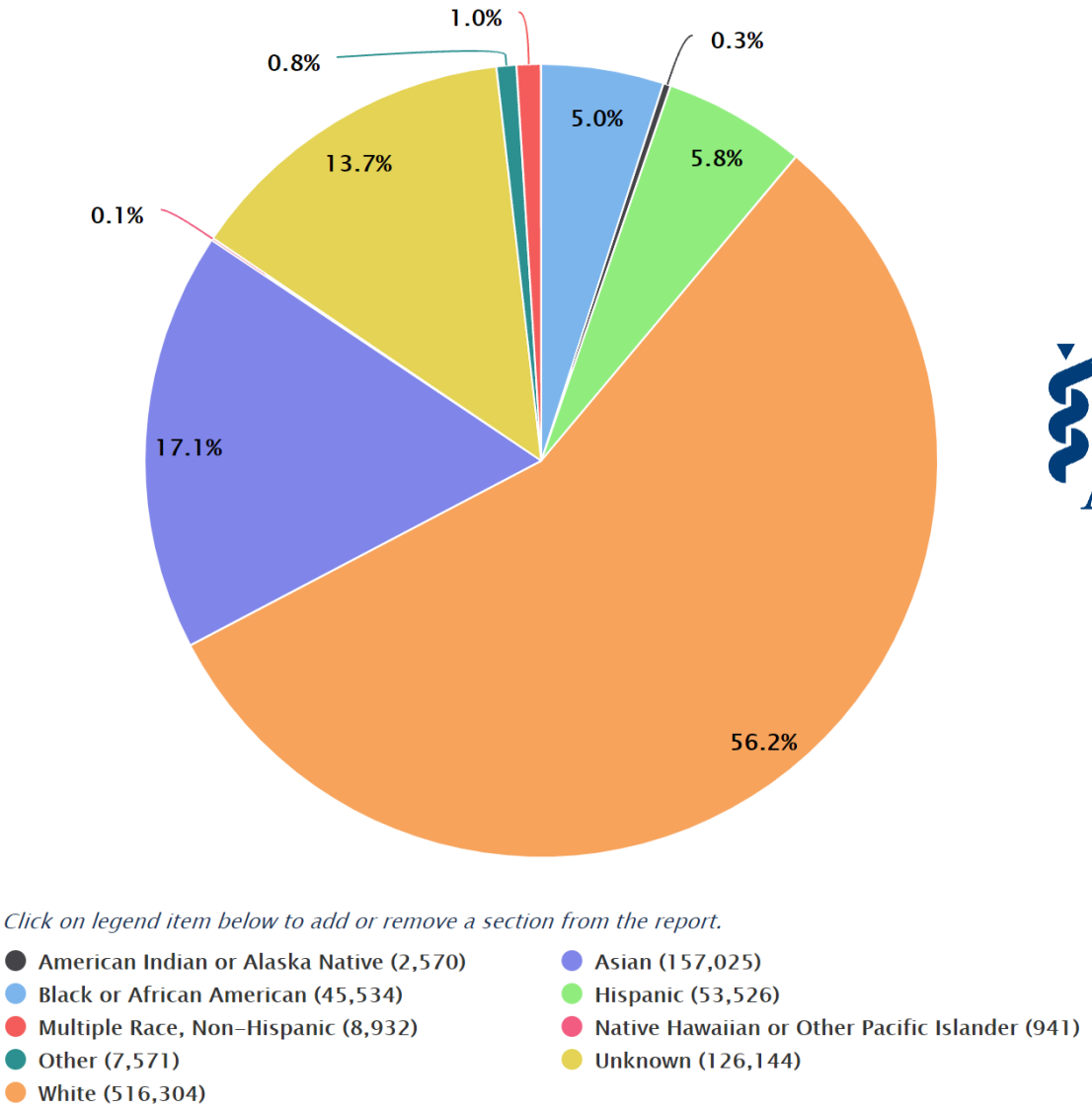


Chart: The Conversation, CC-BY-ND • Source: US Census • Get the data

Physician Workforce Demographics

Figure 18. Percentage of all active physicians by race/ethnicity, 2018.



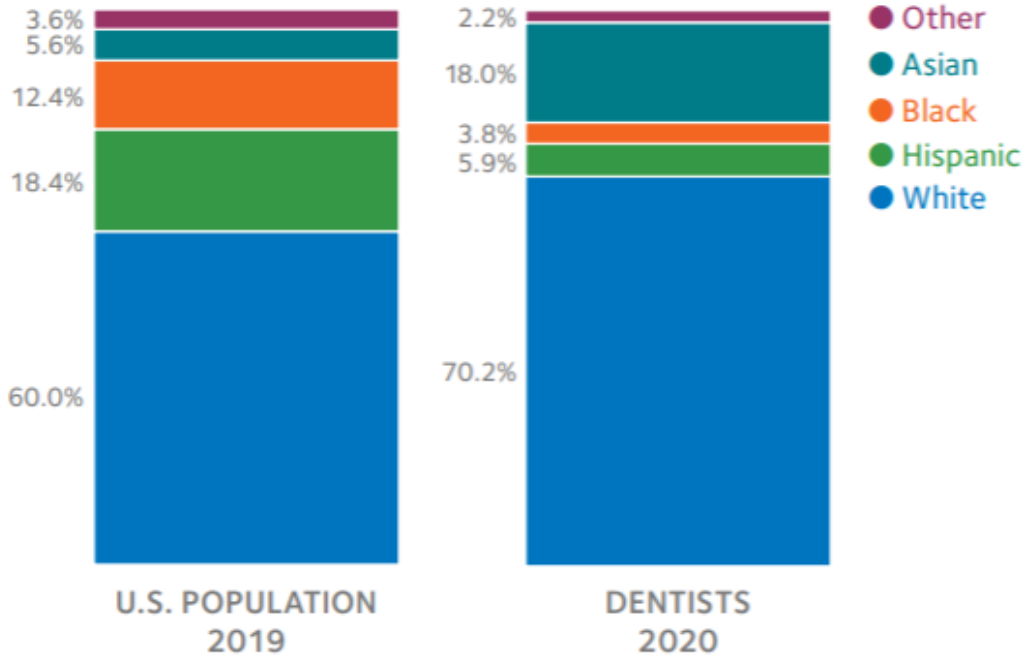
18 shows the percentage of active physicians by race and ethnicity as of July 1, 2019.

Source: Race and ethnicity are obtained from a variety of sources including DBS, ERAS, APP, MCAT, SMDEP, GQ, MSQ, PMQ, FACULTY, GME, STUDENT with priority given to the most recent self-reported source.

Dentist Workforce Demographics

ETHNIC AND RACIAL DIVERSITY AMONG DENTISTS DOES NOT MIRROR THAT OF THE U.S. POPULATION

In terms of race and ethnicity, white and Asian dentists are proportionally more represented in the profession when compared to the U.S. population. Hispanic and Black dentists, as well as dentists who identify themselves as another race or ethnicity, are proportionally less represented in the profession when compared to the U.S. population.



HPI Health Policy Institute

ADA American Dental Association®

Advanced Nursing Workforce Demographics

Racial and Ethnic Breakdown of APRNs

	U.S.	NPS & NMS	CSNS	NAS
White	73.3%	85.7%	85%	87%
Latinx	17.3%*	3.4%**	2.8%	–
Black	12.6%	6.6%	4.2%	7%
Asian	5.2%	5.8%	3.3%	4%
Multi-ethnic	3.1%	1.2%	1.4%	1%
Native American	0.8%	0.2%	0.3%	–
Other	4.8%	0.6%	–	1%

Physician Assistant Workforce Demographics

CERTIFIED PHYSICIAN ASSISTANT STATISTICS BY RACE

The most common ethnicity among certified physician assistants is White, which makes up 71.0% of all certified physician assistants. Comparatively, there are 10.9% of the Asian ethnicity and 10.5% of the Hispanic or Latino ethnicity.

ZIPPIA
THE CAREER EXPERT

Job Title

- White, **71.0%**
- Asian, **10.9%**
- Hispanic or Latino, **10.5%**
- Black or African American, **5.2%**
- Unknown, **1.8%**
- American Indian and Alaska Native, **0.6%**

Volume I:
Executive Summary

Report of the Secretary's Task Force on

Black & Minority Health

Margaret M. Heckler
Secretary

U.S. Department of Health and
Human Services

August 1985

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Task Force on
Black and Minority Health

National Institutes of Health
Bethesda, Maryland 20205
(301) 496-6177

The Honorable Margaret M. Heckler
Secretary, Department of Health
and Human Services
Washington, D.C. 20201

Dear Madam Secretary:

On behalf of the Task Force on Black and Minority Health, I am pleased to submit the report and recommendations of the Task Force for your review and consideration. The report consists of an executive summary volume presenting our major findings and recommendations, and additional volumes containing extensive background information and analyses supporting and extending the executive summary. These will be extremely useful to those who wish to become familiar in greater depth with selected aspects of the issues we have analyzed.

I believe this report is a landmark effort in analyzing and synthesizing the present state of knowledge of the major factors that contribute to the health status of Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans. It represents the first time the Department of Health and Human Services (DHHS) has consolidated minority health issues into one report. This report should serve not only as a standard resource for departmentwide strategy, but as the generating force for an accelerated national assault on the persistent health disparities which led you to establish the Task Force a little more than a year ago.

It would be a disservice to the Task Force members, staff and consultants who worked so diligently on this project during the past year, to understate the complexity of the task we undertook. The issues identified during our deliberations and presented in this report are of major importance, but must not be regarded as the final word on the subject. Just as individual well-being is not static, the health needs of minority populations are changing. They are influenced by a diverse set of factors of which disease is but one aspect. The report, then, must continue to be updated and revised as new data and information become available.

In accordance with your charge, we have examined the impact of a broad range of behavioral, societal, and health care issues on the current departmental program areas. Our recommendations are consistent with the objectives for the Nation in disease prevention and health promotion for the year 1990. The six topics we have identified as priority areas merit intensive action and study in themselves, as do various issues such as nutrition and development of health professionals that cut across all health problem areas. We encourage the Department to continue to take the lead in implementing such activities.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

In January 1984--ten months after becoming Secretary of Health and Human Services--I sent Health, United States, 1983 to the Congress. It was the annual report card on the health status of the American people.

That report--like its predecessors--documented significant progress: Americans were living longer, infant mortality had continued to decline--the overall American health picture showed almost uniform improvement.

But, and that "but" signaled a sad and significant fact; there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole.

That disparity has existed ever since accurate federal record keeping began--more than a generation ago. And although our health charts do itemize steady gains in the health status of minority Americans, the stubborn disparity remained--an affront both to our ideals and to the ongoing genius of American medicine.

I felt--passionately--that it was time to decipher the message inherent in that disparity. In order to unravel the complex picture provided by our data and experience, I established a Secretarial Task Force whose broad assignment was the comprehensive investigation of the health problems of Blacks, Native Americans, Hispanics and Asian/Pacific Islanders.

The Task Force under the insightful direction of the distinguished Thomas E. Malone, Ph.D., Deputy Director of the National Institutes of Health and with the invaluable contribution of experts from throughout the department, has met its challenge. Brilliantly. First: by a review of departmental programs to determine how the health problems of minorities have been addressed; followed by a careful analysis of the range of health care resources and information available; and then--by a critique of the health status of Blacks, Native Americans, Hispanics and Asian/Pacific Islanders. The Task Force was further charged with finding ways for our department to exert leadership, influence and initiative to close the existing gap. The report is comprehensive. Its analysis is thoughtful. Its thrust is masterful. It sets the framework for meeting the challenge--for improving the health of minorities.

It can--it should--mark the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of ever improving health.

Margaret M. Heckler

Margaret M. Heckler
Secretary

MAY 2017

CDC Vitalsigns™

African American Health

Creating equal opportunities for health

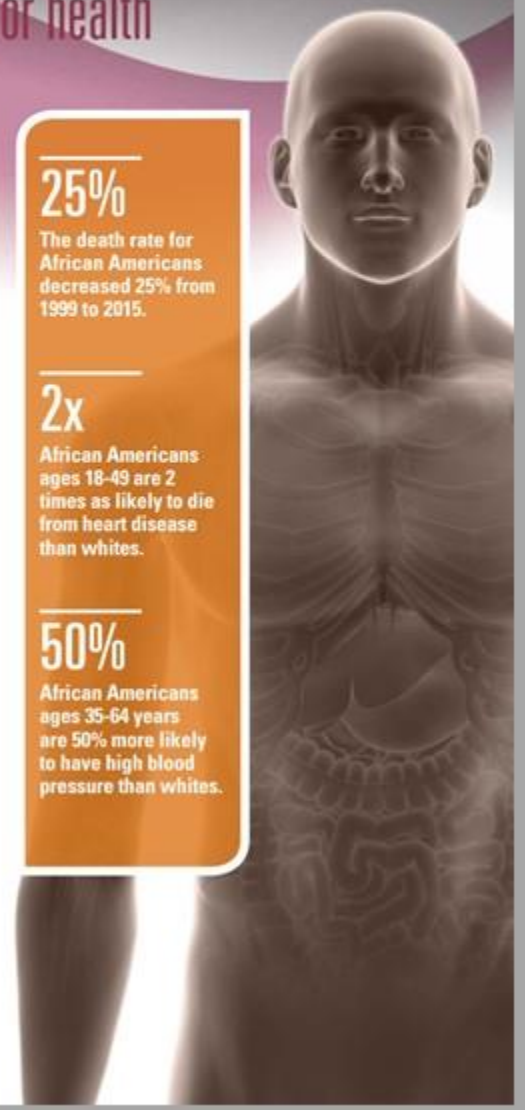
African Americans are living longer. The death rate for African Americans has declined about 25% over 17 years, primarily for those aged 65 years and older. Even with these improvements, new analysis shows that younger African Americans are living with or dying of many conditions typically found in white Americans at older ages. The difference shows up in African Americans in their 20s, 30s, and 40s for diseases and causes of death. When diseases start early, they can lead to death earlier. Chronic diseases and some of their risk factors may be silent or not diagnosed during these early years. Health differences are often due to economic and social conditions that are more common among African Americans than whites. For example, African American adults are more likely to report they cannot see a doctor because of cost. All Americans should have equal opportunities to pursue a healthy lifestyle.

Public health professionals can:

- Use proven programs to reduce disparities and barriers to create opportunities for health.
- Work with other sectors, such as faith and community organizations, education, business, transportation, and housing, to create social and economic conditions that promote health starting in childhood.
- Link more people to doctors, nurses, or community health centers to encourage regular and follow-up medical visits.
- Develop and provide trainings for healthcare professionals to understand cultural differences in how patients interact with providers and the healthcare system.

Want to learn more? www.cdc.gov/vitalsigns/aahealth

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion



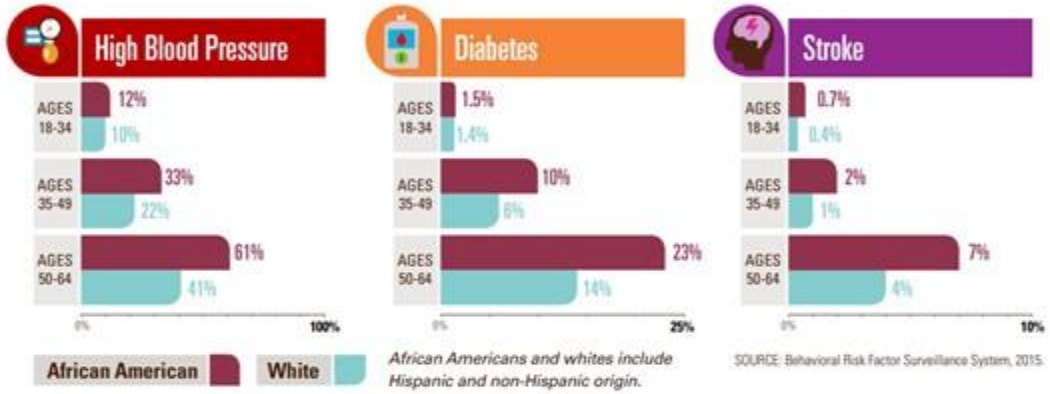
25%
The death rate for African Americans decreased 25% from 1999 to 2015.

2x
African Americans ages 18-49 are 2 times as likely to die from heart disease than whites.

50%
African Americans ages 35-64 years are 50% more likely to have high blood pressure than whites.

Problem:

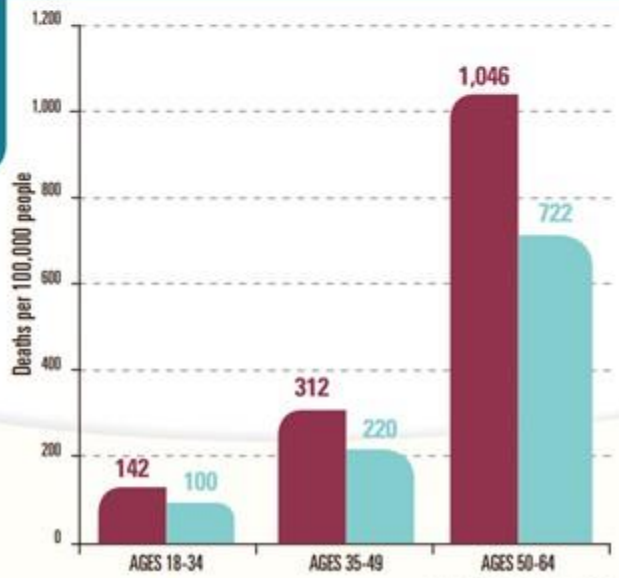
Young African Americans are living with diseases more common at older ages.



African Americans and whites include Hispanic and non-Hispanic origin.

SOURCE: Behavioral Risk Factor Surveillance System, 2015.

African Americans are more likely to die at early ages from all causes.



SOURCE: US Vital Statistics, 2015.

National Healthcare Quality and Disparities Reports

Tools for measuring healthcare quality, including the National Healthcare Quality and Disparities Reports, AHRQ Quality Indicators, and ambulatory clinical performance measures.

For the 16th year in a row, the Agency for Healthcare Research and Quality (AHRQ) has reported on healthcare quality and disparities. The *National Healthcare Quality and Disparities Report* presents trends for measures related to access to care, affordable care, care coordination, effective treatment, healthy living, patient safety, and person-centered care. The report presents, in chart form, the latest available findings on quality of and access to healthcare, as well as disparities related to race and ethnicity, income, and other social determinants of health.

DATA SPOTLIGHTS

The newest Data Spotlight (PDF, 572 KB) shows that person-centered care among Asian and Native Hawaiian/Pacific Islander home health patients needs improvement. A related infographic is also available.

Entire Data Spotlight series

RELATED CONTENT

Compendium of Federal Datasets Addressing Health Disparities

Figure 9. Overall quality of care, by state, 2015-2017

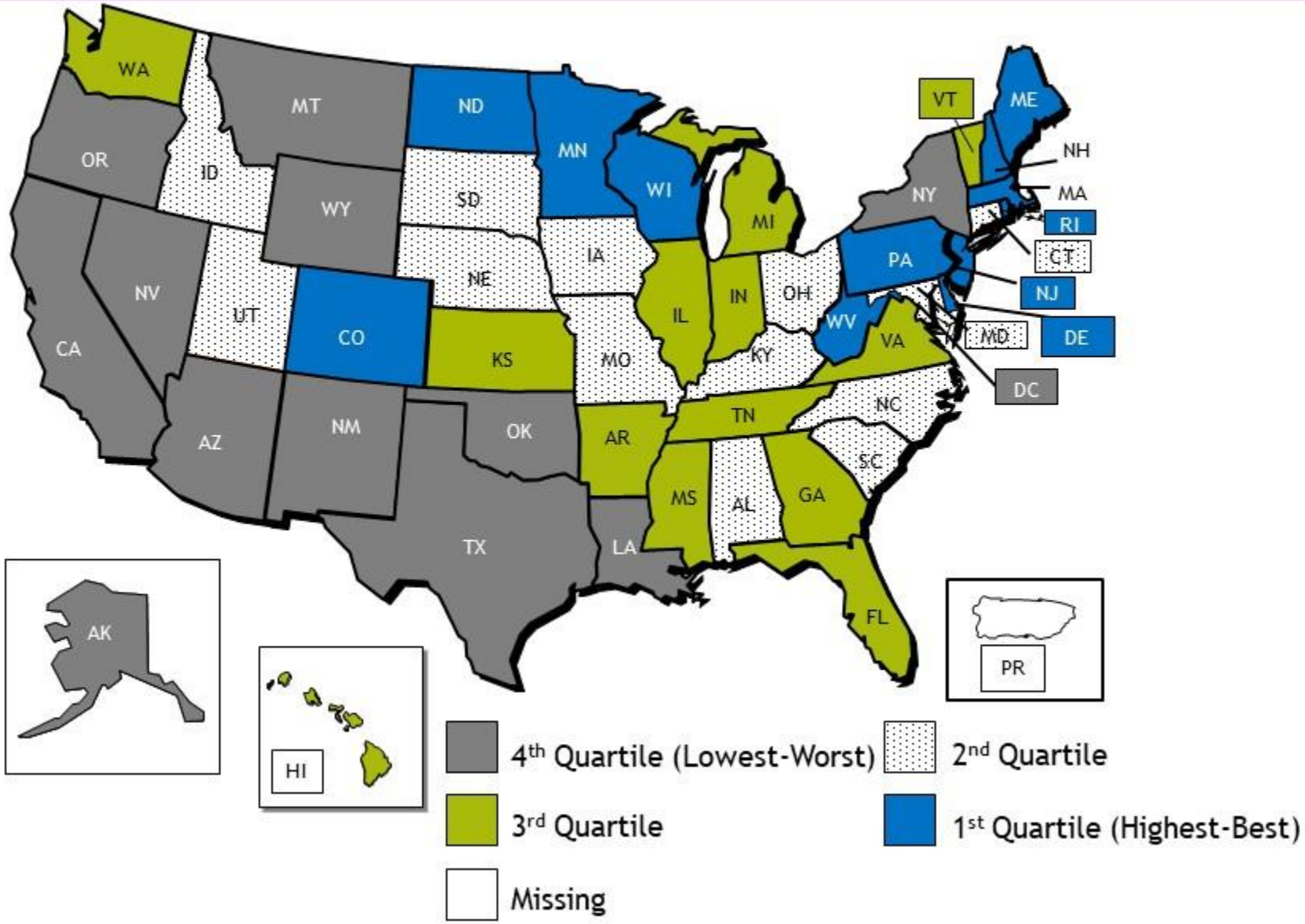
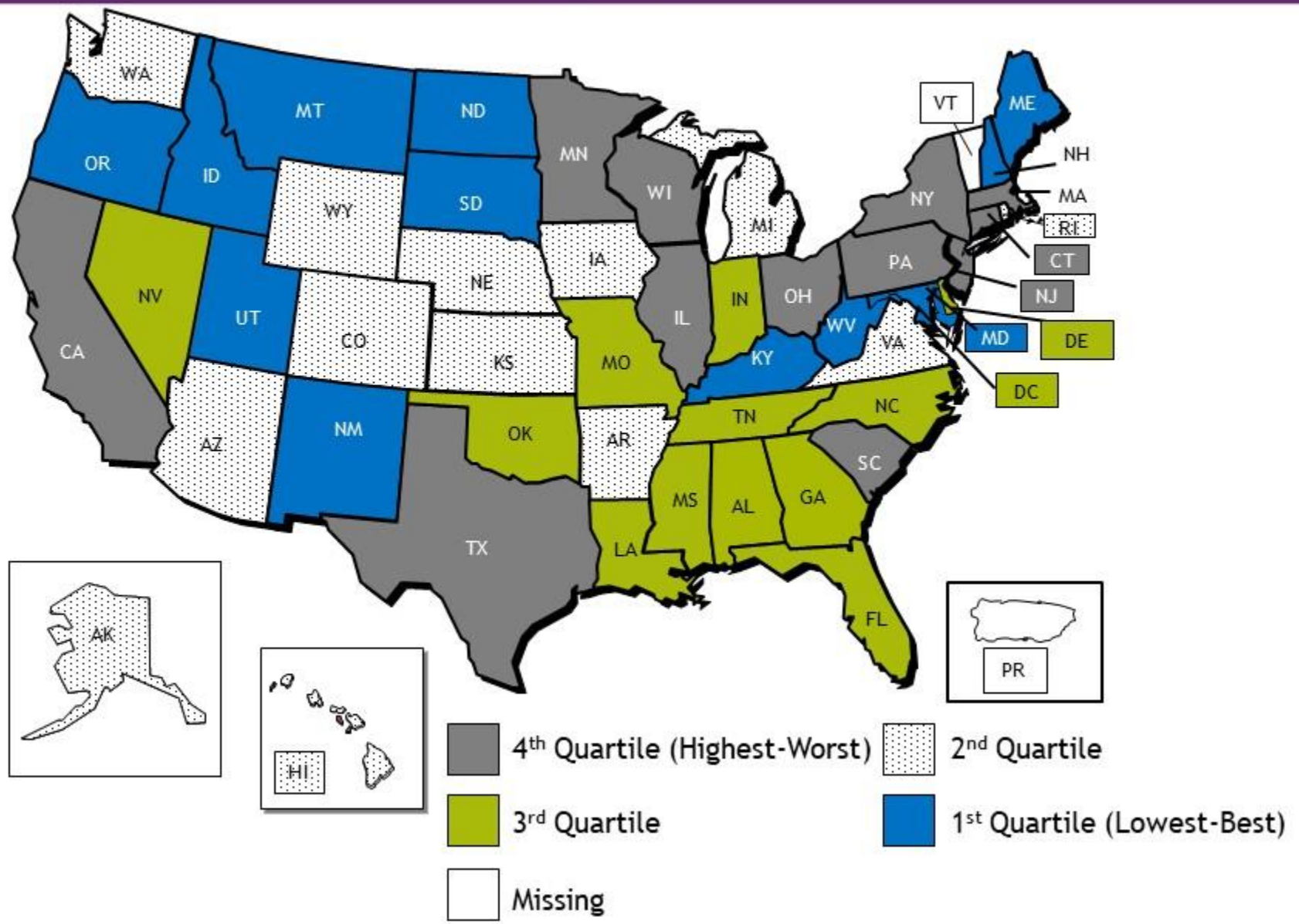


Figure 10. Average differences in quality of care for Blacks, Hispanics, and Asians compared with Whites, by state, 2015-2017



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STRUCTURAL RACISM AND HEALTH INEQUITIES:

Old Issues, New Directions[1]

Gilbert C. Gee and
School of Public Health, University of California, Los Angeles

Chandra L. Ford
School of Public Health, University of California, Los Angeles

Abstract

Racial minorities bear a disproportionate burden of morbidity and mortality. These inequities might be explained by racism, given the fact that racism has restricted the lives of racial minorities and immigrants throughout history. Recent studies have documented that individuals who report experiencing racism have greater rates of illnesses. While this body of research has been invaluable in advancing knowledge on health inequities, it still locates the experiences of racism at the individual level. Yet, the health of social groups is likely most strongly affected by structural, rather than individual, phenomena. The structural forms of racism and their relationship to health inequities remain under-studied. This article reviews several ways of conceptualizing structural racism, with a focus on social segregation, immigration policy, and intergenerational effects. Studies of disparities should more seriously consider the multiple dimensions of structural racism as fundamental causes of health disparities.

Keywords

Racism; Discrimination; Health Disparity; Race; Ethnicity; Immigrant; Social Determinants; Inequity

INTRODUCTION

Health inequities among racial minorities are pronounced, persistent, and pervasive (Sondik et al., 2010). Racism may be one cause of these inequities. Studies find that individuals who report experiencing racism exhibit worse health than people who do not report it (Williams and Mohammed, 2009). While this line of research has been invaluable in shifting the discussion from innate differences in biology or culture to social exposures, it is limited by inadequate attention to the multiple dimensions of racism, particularly structural racism. The

[1]The authors thank Kaori Fujishiro, the guest editors, and several anonymous reviewers for invaluable comments on an earlier draft of this manuscript. The authors acknowledge support from the California Center for Population Research at the University of California at Los Angeles.

Corresponding author: Gilbert C. Gee, Department of Community Health Sciences, UCLA School of Public Health, 650 Charles E.

EDITORIALS

Diagnosing and Treating Systemic Racism

Michele K. Evans, M.D., Lisa Rosenbaum, M.D., Debra Malina, Ph.D., Stephen Morrissey, Ph.D., and Eric J. Rubin, M.D., Ph.D.

For physicians, the words "I can't breathe" are a primal cry for help. As many physicians have left their comfort zones to care for patients with Covid-19–associated respiratory failure, the role of the medical profession in addressing this life-defining need has rarely been clearer. But as George Floyd's repeated cry of "I can't breathe" while he was being murdered by a Minneapolis police officer has resounded through the country, the physician's role has seemed less clear. Police brutality against black people, and the systemic racism of which it is but one lethal manifestation, is a festering public health crisis. Can the medical profession use the tools in its armamentarium to address this deep-rooted disease?

The role of the physician in times of social injustice and societal distress is difficult to navigate. Since the importation of enslaved Africans as chattel to provide the labor that built this country began, Americans have functioned within the intricate injustices that are the vestiges of that institution. Slavery has produced a legacy of racism, injustice, and brutality that runs from 1619 to the present, and that legacy infects medicine as it does all social institutions. Slaves provided economic security for physicians and clinical material that permitted the expansion of medical research, improvement of medical care, and enhancement of medical training.[1] This long and troubled history has permeated the physician–patient relationship with mistrust, reducing the potency of one of medicine's most powerful tools for healing and changing behavior.[2]

In an effort to engender trust in what they would like to see as a "postracial" society, some U.S. clinicians proclaim that they "don't see color." But color must be seen. By looking through a racially impervious lens, clinicians neglect the life experiences and historical inequities that shape patients and disease processes. They may inadvertently feed the robust structural racism that influences access to care, quality of care, and resultant health disparities. At times, we fail to make even the simplest efforts: for instance, even though Covid-19 disproportionately affects black Americans, when physicians describing its manifestations have presented images of dermatologic effects, black skin has not been included. The "Covid toes" have all been pink and white.

In the review of systems, we query patients about exposure to toxicants, but we never ask about one of the most dangerous toxicants: racism. The work of David Williams details the morbidity and risk of death related to perceived discrimination.[3] Discrimination and racism as social determinants of health act through biologic transduction pathways to promote subclinical cerebrovascular disease, accelerate aging, and impede vascular and renal function, producing disproportionate burdens of disease on black Americans and other minority populations.[4-7]

Such research is part of a growing body of literature on health and health care disparities and their manifestations at every level of care. One recent study, for instance, found racial bias baked into a commercial algorithm used to predict the needs of patients with uncontrolled illnesses. Using health spending as a proxy for gravity of illness, the algorithm ignored the fact that disparities in access result in lower spending on black patients and thus failed to identify

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

The Impact of Racism on Child and Adolescent Health

Maria Trent, MD, MPH, FAAP, FSAHM,[a] Danielle G. Dooley, MD, MPhil, FAAP,[b] Jacqueline Dougé, MD, MPH, FAAP,[c] SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON ADOLESCENCE

The American Academy of Pediatrics is committed to addressing the factors that affect child and adolescent health with a focus on issues that may leave some children more vulnerable than others. Racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. By acknowledging the role of racism in child and adolescent health, pediatricians and other pediatric health professionals will be able to proactively engage in strategies to optimize clinical care, workforce development, professional education, systems engagement, and research in a manner designed to reduce the health effects of structural, personally mediated, and internalized racism and improve the health and well-being of all children, adolescents, emerging adults, and their families.

STATEMENT OF THE PROBLEM

Racism is a "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race') that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."[1] Racism is a social determinant of health[2] that has a profound impact on the health status of children, adolescents, emerging adults, and their families.[3–8] Although progress has been made toward racial equality and equity,[9] the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear.[10] Failure to address racism will continue to undermine health equity for all children, adolescents, emerging adults, and their families.

The social environment in which children are raised shapes child and adolescent development, and pediatricians are poised to prevent and respond to environmental circumstances that undermine child health. Pediatrics as a field has yet to systematically address the influence of racism on child health outcomes and to prepare pediatricians to identify, manage, mitigate, or prevent risks and harms. Recognizing that racism has significant adverse effects on the individual who receives, commits, and observes racism,[11,12] substantial investments in dismantling structural racism are required to facilitate the societal shifts necessary for optimal development of children in the United States. The American Academy of Pediatrics (AAP) is committed to reducing the ongoing costs and burden of racism to children, the health care system, and society.[13,14]

Today's children, adolescents, and emerging adults are increasingly diverse. Strategies to address health and developmental issues across the pediatric life span that incorporate ethnicity, culture, and circumstance are critical to achieving a reduction in health disparities. Accordingly, pediatrics should be at the forefront of addressing racism as a core social determinant. The inclusion of racism is in alignment with the health equity pillar of the AAP strategic plan.[15] In a series of workshops in 2016 during national meetings of pediatricians, 3 strategic actions were identified: (1) development of a task force within the AAP to address racism and other forms of discrimination that impact the health status and outcomes of minority youth, (2) development of a policy statement on racism, and (3) integration of evidence-based anticipatory guidance about racism into *Bright Futures*.[16]

The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. This policy statement will allow pediatricians to implement recommendations in practice that will better address the factors that make some children more vulnerable than others.[13] The statement also builds on existing AAP policy recommendations associated with other social determinants of health, such as poverty, housing insecurity, child health equity, immigration status, and early childhood adversity.[9,17–19]

RACISM AS A CORE DETERMINANT OF CHILD HEALTH

Racism is a core social determinant of health that is a driver of health inequities.[20–22] The World Health Organization defines social determinants of health as "the conditions in which people are born, grow, live, work, and age." These determinants are influenced by economic, political, and social factors linked to health inequities (avoidable inequalities in health between groups of people within populations and between countries). These health inequities are not the result of individual behavior choices or genetic predisposition but are caused by economic, political, and social conditions, including racism.[23]

The impact of racism has been linked to birth disparities and mental health problems in children and adolescents.[6,24–30] The biological mechanism that emerges from chronic stress leads to increased and prolonged levels of exposure to stress hormones and oxidative stress at the cellular level. Prolonged exposure to stress hormones, such as cortisol, leads to inflammatory reactions that predispose individuals to chronic disease.[31] As an example, racial disparities in the infant mortality rate remain,[32] and the complications of low birth weight have been associated with perceived racial discrimination and maternal stress.[25,33,34]

Investments in policies to address social determinants of health, such as poverty, have yielded improvements in the health of children. The Food Stamp Program, a War on Poverty initiative first developed in the 1930s during the Great Depression and later revived in the 1960s, is linked to improvements in birth outcomes.[35] Efforts in education, housing, and child health insurance have also led to improved health outcomes for issues such as lead poisoning, injuries, asthma, cancer, neurotoxicity, cardiovascular disease, and mental health problems.[20,36,37] Expansion of child health insurance has improved health care access for children, with significant gains for African American and Hispanic children in terms of access to well-child, doctor, and dental visits.[38] Despite these improvements, it is important to recognize that children raised in African American, Hispanic, and American Indian populations continue to face higher risks of parental unemployment and to reside in families with significantly lower household net wealth relative to white children in the United States, posing barriers to equal opportunities and services that optimize health and vocational outcomes.[39–45]

Juvenile justice involvement is also a critical social determinant of health. Because racial inequity continues to shape the juvenile justice system, this area is a modern example of race being an important determinant of short- and long-term outcomes. The AAP published a statement in 2011[46] focusing on key health issues of justice-involved youth, which was recently revised to include an in-depth discussion on racial and ethnic inequalities for this population.[47] Although the overall rates of youth incarceration have decreased, African American, Hispanic, and American

[a]Division of Adolescent and Young Adult Medicine, Department of Pediatrics, School of Medicine, Johns Hopkins University, Baltimore, Maryland; [b]Division of General Pediatrics and Community Health and Child Health Advocacy Institute, Children's National Health System, Washington, District of Columbia; and [c]Medical Director, Howard County Health Department, Columbia, Maryland

Drs Trent, Dooley, and Dougé worked together as a writing team to develop the manuscript outline, conduct the literature search, develop the stated policies, incorporate perspectives and feedback from American Academy of Pediatrics leadership, and draft the final version of the manuscript; and all authors approved the final manuscript as submitted.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

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I'M NOT
RACIST!!!

Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review

William J. Hall, PhD, Mimi V. Chapman, PhD, Kent M. Lee, MS, Yesenia M. Merino, MPH, Tainayah W. Thomas, MPH, B. Keith Payne, PhD, Eugenia Eng, DrPH, Steven H. Day, MCP, and Tamera Coyne-Beasley, MD

Background. In the United States, people of color face disparities in access to health care, the quality of care received, and health outcomes. The attitudes and behaviors of health care providers have been identified as one of many factors that contribute to health disparities. Implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. These attitudes are often automatically activated and can influence human behavior without conscious volition.

Objectives. We investigated the extent to which implicit racial/ethnic bias exists among health care professionals and examined the relationships between health care professionals' implicit attitudes about racial/ethnic groups and health care outcomes.

Search Methods. To identify relevant studies, we searched 10 computerized bibliographic databases and used a reference harvesting technique.

Selection Criteria. We assessed eligibility using double independent screening based on a priori inclusion criteria. We included studies if they sampled existing health care providers or those in training to become health care providers, measured and reported results on implicit racial/ethnic bias, and were written in English.

Data Collection and Analysis. We included a total of 15 studies for review and then subjected them to double independent data extraction. Information extracted included the citation, purpose of the study, use of theory, study design, study site and location, sampling strategy, response rate, sample size and characteristics, measurement of relevant variables, analyses performed, and results and findings. We summarized study design characteristics, and categorized and then synthesized substantive findings.

Main Results. Almost all studies used cross-sectional designs, convenience sampling, US participants, and the Implicit Association Test to assess implicit bias. Low to moderate levels of implicit racial/ethnic bias were found among health care professionals in all but 1 study. These implicit bias scores are similar to those in the general population. Levels of implicit bias against Black, Hispanic/Latino/Latina, and dark-skinned people were relatively similar across these groups. Although some associations between implicit bias and health care outcomes were nonsignificant, results also showed that implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes. Implicit attitudes were more often significantly related to patient–provider interactions and health outcomes than treatment processes.

Conclusions. Most health care providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward people of color. Future studies need to employ more rigorous methods to examine the relationships between implicit bias and health care outcomes. Interventions targeting implicit attitudes among health care professionals are needed because implicit bias may contribute to health disparities for people of color. (*Am J Public Health.* 2015;105:e60–e76. doi:10.2105/AJPH.2015.302903)

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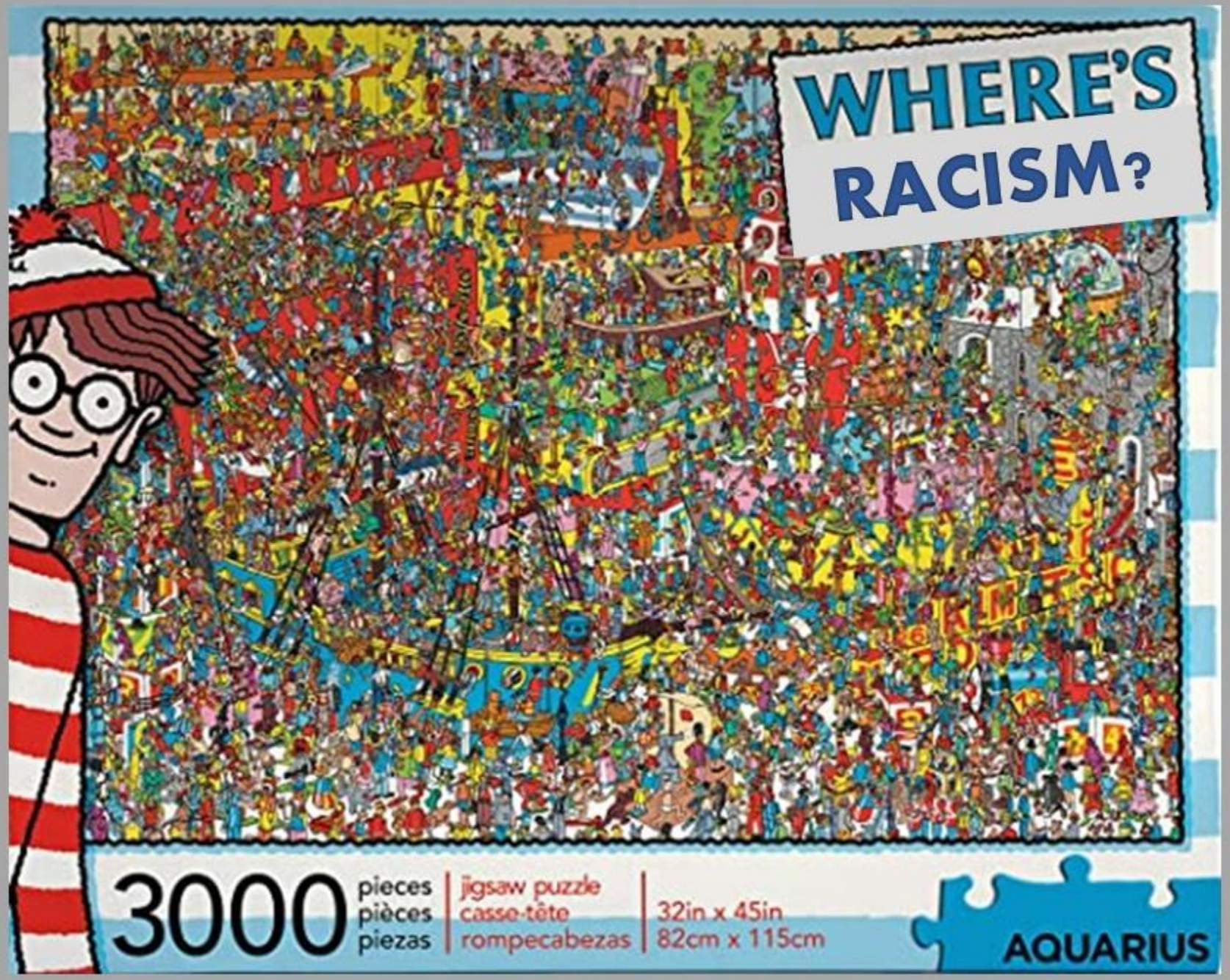
WHERE'S
RACISM?
3000
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rompecabezas
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AQUARIUS

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BMC Medical Ethics

RESEARCH ARTICLE Open Access

Implicit bias in healthcare professionals: a systematic review

Chloë FitzGerald* and Samia Hurst

Abstract

Background: Implicit biases involve associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender. This review examines the evidence that healthcare professionals display implicit biases towards patients.

Methods: PubMed, PsychINFO, PsychARTICLE and CINAHL were searched for peer-reviewed articles published between 1st March 2003 and 31st March 2013. Two reviewers assessed the eligibility of the identified papers based on precise content and quality criteria. The references of eligible papers were examined to identify further eligible studies.

Results: Forty two articles were identified as eligible. Seventeen used an implicit measure (Implicit Association Test in fifteen and subliminal priming in two), to test the biases of healthcare professionals. Twenty five articles employed a between-subjects design, using vignettes to examine the influence of patient characteristics on healthcare professionals' attitudes, diagnoses, and treatment decisions. The second method was included although it does not isolate implicit attitudes because it is recognised by psychologists who specialise in implicit cognition as a way of detecting the possible presence of implicit bias. Twenty seven studies examined racial/ethnic biases; ten other biases were investigated, including gender, age and weight. Thirty five articles found evidence of implicit bias in healthcare professionals; all the studies that investigated correlations found a significant positive relationship between level of implicit bias and lower quality of care.

Discussion: The evidence indicates that healthcare professionals exhibit the same levels of implicit bias as the wider population. The interactions between multiple patient characteristics and between healthcare professional and patient characteristics reveal the complexity of the phenomenon of implicit bias and its influence on clinician-patient interaction. The most convincing studies from our review are those that combine the IAT and a method measuring the quality of treatment in the actual world. Correlational evidence indicates that biases are likely to influence diagnosis and treatment decisions and levels of care in some circumstances and need to be further investigated. Our review also indicates that there may sometimes be a gap between the norm of impartiality and the extent to which it is embraced by healthcare professionals for some of the tested characteristics.

Conclusions: Our findings highlight the need for the healthcare profession to address the role of implicit biases in disparities in healthcare. More research in actual care settings and a greater homogeneity in methods employed to test implicit biases in healthcare is needed.

Keywords: Implicit bias, Prejudice, Stereotyping, Attitudes of health personnel, Healthcare disparities

Existence of implicit biases/stereotypes in healthcare professionals and influence on quality of care

Healthcare professionals have implicit biases

Almost all studies found evidence for implicit biases among physicians and nurses. Based on the available evidence, physicians and nurses manifest implicit biases to a similar degree as the general population. The following characteristics are at issue: race/ethnicity, gender, socioeconomic status (SES), age, mental illness, weight, having AIDS, brain injured patients perceived to have contributed to their injury,[3] intravenous drug users, disability, and social circumstances.

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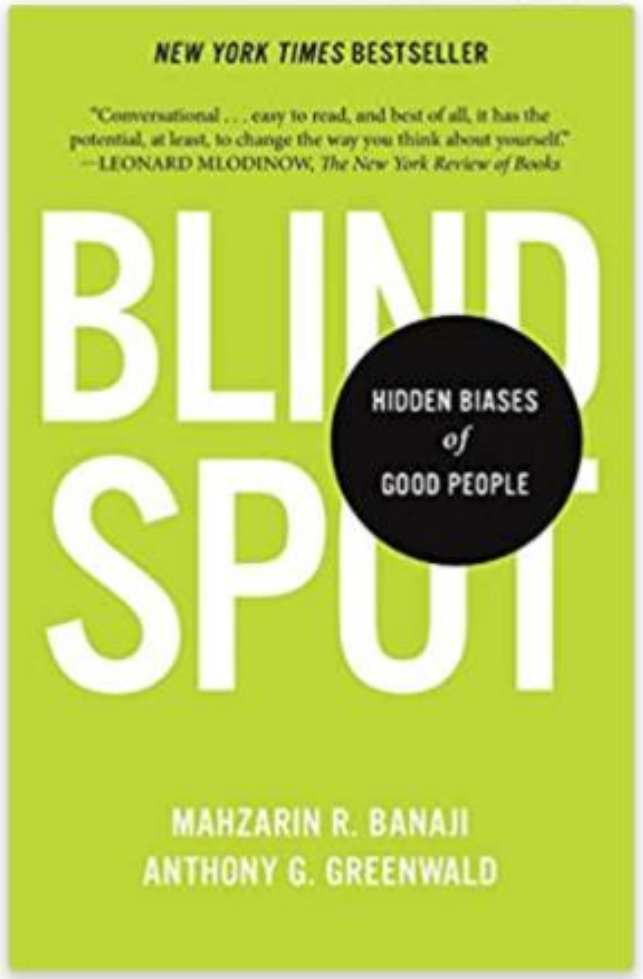
Implicit bias affects clinical judgement and behaviour

Three studies found a significant correlation between high levels of physicians' implicit bias against blacks on IAT scores and interaction that was negatively rated by black patients [23, 24, 44] and, in one study, also negatively rated by external observers [23]. Four studies examining the correlation between IAT scores and responses to clinical vignettes found a significant correlation between high levels of pro-white implicit bias and treatment responses that favoured patients specified as white [42, 45–47]. In one study, implicit prejudice of nurses towards injecting drug users significantly mediated the relationship between job stress and their intention to change jobs [48].

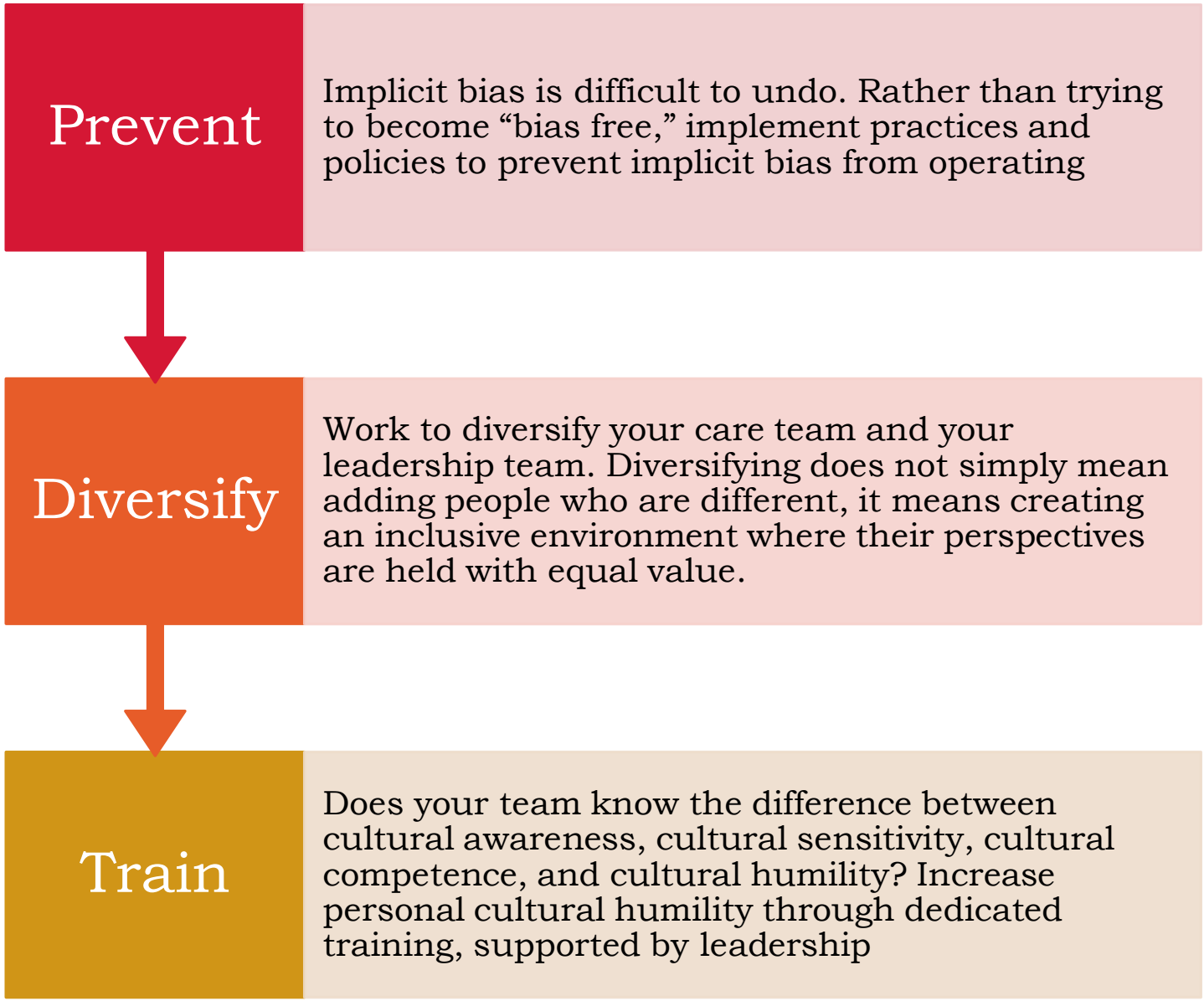
Twenty out of 25 assumption studies found that some kind of bias was evident either in the diagnosis, the treatment recommendations, the number of questions asked of the patient, the number of tests ordered, or other responses indicating bias against the characteristic of the patient under examination.

Want to learn more about implicit bias and implicit association tests?

Project Implicit
www.implicit.harvard.edu



Reducing Implicit Bias on your Care Team



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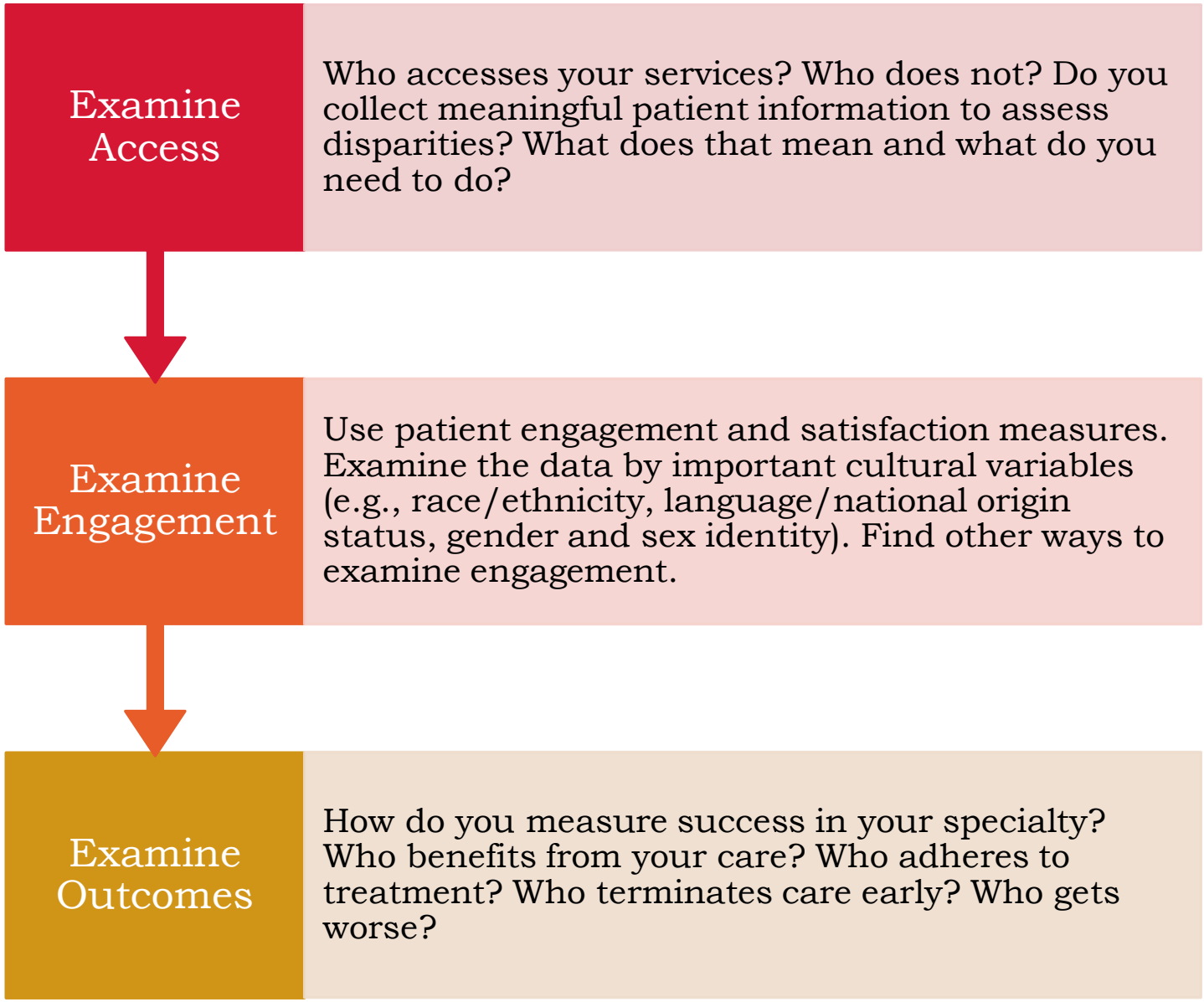

The Nemours Behavioral Health Strategy

- Acknowledge
- Train
- Plan
- Assess
- Incorporate into mission and vision
- Execute

The Nemours Behavioral Health Strategy Outcome

Year	# positions	% applicants of color ranked in highest tier (unique applicants)	% interns of color in class
2012-13	7	0%	0%
2013-14	7	0%	0%
2014-15	8	13%	0%
2015-16	8	13%	13%
2016-17	8	25%	13%
2017-18	11	36%	36%
2018-19	12	33%	25%
2019-20	12	33%	25%
2020-21	12	67%	42%
2021-22	10	90%	70%

Diversity and Equity: What's required?

- Will
- Leadership
- Data
  - *We measure what we value and value what we measure*
- Inclusion
- Accountability
- Policy