

Structural Racism and Implicit Bias in Women's Healthcare



The National Association of Nurse Practitioners in Women's Health (NPWH) is committed to addressing structural racism and implicit bias in meaningful ways that will improve women's healthcare and reduce health disparities. Structural racism encompasses the ways a society fosters racial/ethnic discrimination through intersecting and reinforcing systems. Structural racism creates differential access to opportunities by race/ethnicity and perpetuates inequities among these groups.¹⁻⁴ Implicit bias derives from an individual's learned stereotypes and prejudices that automatically and unconsciously influence affect, behavior, and cognitive processes.⁵⁻⁷ Implicit bias affects patient-clinician interactions, treatment decisions, treatment adherence, and patient outcomes.^{5,6} Implicit bias in the healthcare setting and structural racism in social, economic, and political systems are intertwined, meaning that both must be addressed to be successful in improving women's healthcare and reducing health disparities.

NPWH advocates for public and institutional policies and practices and evidence-based initiatives that promote health equity and reduce health disparities. We commit to the expanded provision of educational offerings, forums, and other resources to support nurse practitioners who provide women's healthcare in self-reflection, identifying implicit bias, and making changes in practice that mitigate the effects of bias and structural racism on health outcomes for Black, Indigenous, and people of color (BIPOC).

As an organization, NPWH is taking deliberate, concrete action to examine our policies and practices to identify and mitigate racial/ethnic bias and discrimination and to promote inclusiveness and antiracism at all levels. We believe it will take all of us both individually and collectively to bring about positive and sustainable change.

This position statement focuses on structural racism and racial/ethnic implicit bias as these affect women's health and women's healthcare. We recognize that health inequities and health disparities extend beyond race

and ethnicity to all groups of people who experience obstacles to health equity based on characteristics historically linked to discrimination and exclusion (eg, gender identity/gender expression, sexual orientation, national origin, disability status, socioeconomic status).⁸ We also recognize that simultaneous occurrence (intersectionality) of any of these characteristics has the potential to create complex experiences of bias and discrimination that multiply negative effects on health.⁹ In a truly equitable society, the distribution of society's benefits and burdens would not be skewed by any of these characteristics.¹ Recommendations regarding the elimination of structural racism and implicit bias to improve health and healthcare in this position statement are applicable to other groups of marginalized people.

Background

Structural racism is evident today across the United States. It is a feature of the social, economic, and political systems in which we all live.¹ At the structural level, the cumulative effect of racism through discrimination in housing, education, employment, earnings, media, criminal justice, and healthcare perpetuates racial/ethnic inequity.² Structural racism shapes social determinants of health, that is, the conditions in which one is born, grows, works, lives, and ages resulting in health inequities.¹⁰ The field of public health acknowledges racism as a social determinant of health.^{11,12} Pervasive structural inequities and their effect on social determinants of health are primary causes of health disparities.⁸

Racial/ethnic bias and discrimination also exist at institutional and interpersonal levels. BIPOC report experiencing widespread discrimination in areas of their lives that includes healthcare, at significantly higher levels than White people.¹³⁻¹⁶ In healthcare specifically, approximately 1 in 5 Black and Latino people have reported that they or a family member avoided going to a healthcare provider because of concerns about discrimination or poor treatment.^{13,14} In other areas of their lives, BIPOC have reported personal experiences of racial/ethnic discrimination at institutional levels (eg, employment, education, housing, police, courts) and interpersonal levels (eg, microaggressions, racial/ethnic slurs, racial/ethnic fear, violence) that are double or more than that reported by White people.¹³⁻¹⁶

Recent studies reveal that implicit racial/ethnic bias continues to be prevalent among the general population and among healthcare providers.¹⁷ In one systematic review of evidence on implicit racial/ethnic bias among healthcare providers, low-to-moderate levels of implicit bias were found, with implicit bias scores similar to those of the general population.⁵ Implicit bias may be expressed by microaggressions, in which the healthcare provider makes negative assumptions and/or insensitive/offensive comments based on race/ethnicity, nonverbal behavior, or decision-making processes based on stereotypes rather than on individual attributes. Implicit bias influences care in ways that perpetuate disparities and inequities.⁵ Healthcare providers who desire to provide equitable care may unintentionally interact with BIPOC in ways that contribute to health disparities.

The challenge of reducing implicit racial/ethnic bias lies in its nature of existing outside of conscious awareness and unintentionally being activated to influence behavior.⁵ Interventions to mitigate the effects of implicit racial/ethnic bias on patient–clinician interactions, quality of care, and health outcomes need to be multifactorial, with attention to situational cues and social norms at individual and healthcare delivery system levels.¹⁷ Research has demonstrated that implicit bias is not a fixed trait and can be changed with deliberate effort.^{6,18} Additional studies are needed to gain a better understanding of what interventions are effective in reducing implicit bias as well as mechanisms for regulating the effects of behavior that contribute to racial/ethnic inequities in healthcare.

Implications for women’s health and healthcare

In the United States, significant racial and ethnic disparities in women’s health and inequities in healthcare are prevalent and persistent. The causes are multifactorial, with structural racism and implicit bias as leading contributors. Barriers to receiving quality healthcare occur when social and structural determinants result in health inequities. A growing body of evidence links self-reports of racial/ethnic discrimination to physical and mental health status and healthcare utilization.¹⁹ Chronic stress from experiencing everyday discrimination can lead to long-term changes in physiologic and psychological responses that affect a wide range of health outcomes.¹⁵ Many aspects of women’s health are affected, with significant influence on mental, gynecologic, reproductive, and maternal health.

It is critical to understand and provide care in a manner acknowledging that it is racism and not race itself

that creates health inequities and has an influence on health.²⁰ Nevertheless, health and healthcare data are often reported as risks attributed to race as observed in the following examples:

Black, Hispanic, and American Indian/Native Alaskan people are at least 2 times more likely to not have health insurance compared with non-Hispanic White people.²¹ Women in these racial/ethnic groups are more likely to report not having a personal healthcare provider and not seeing a healthcare provider due to cost in the previous 12 months than White women.²² More American Indian/Native Alaskan, Black, and Hispanic women report late or no prenatal care compared with White women.^{21,22}

Despite similar breast cancer screening and incidence rates, Black women are 40% more likely to die from breast cancer compared with White women. Cervical cancer incidence and death rates for Black women and Hispanic women remain higher than those for White women. This is despite Black and Hispanic women having similar or higher rates of cervical cancer screening as White women.²³

Maternal health and maternal health outcomes represent one of the most significant areas of health disparity. Black women are 3 times more likely and American Indian/Native Alaskan women are 2.5 times more likely to die from pregnancy-related causes, including through the first year postpartum, than non-Hispanic White women.²⁴ The rate of preterm birth among Black women is about 50% higher than the rate of preterm birth among White women.²⁵ The mortality rate is more than twice as high for Black, Hispanic, and American Indian/Native Alaskan infants as it is for non-Hispanic White infants.²³

Structural racism and racial/ethnic bias are associated with mental health consequences including low self-esteem, depression, anxiety, and post-traumatic stress disorder in women.^{15,26–28} In particular, everyday experiences of discrimination in all aspects of life are positively associated with depression, anxiety, and psychological distress.²⁹

Inequities in women’s healthcare and disparities in women’s health outcomes are not limited to these examples. Eliminating these inequities and health disparities requires acknowledging and addressing racism and bias as major contributing factors throughout all aspects of women’s healthcare. This can only happen when there is a commitment to make significant and sustainable changes that transform how we provide care.

As of 2019, approximately 40% of the US population were members of a racial or ethnic minority group.³⁰ The 2018 American Association of Nurse Practitioner Sample Survey results indicate that only 13% of nurse practitioner

respondents described themselves as a race other than White and only 3% described themselves as Hispanic or Latino.³¹ The 2017 National Council of State Boards of Nursing National Nursing Workforce results indicated only 19% of registered nurse respondents were minorities.³²

Expanding the racial/ethnic diversity of NPs who provide care for women is important. Studies indicate that patient satisfaction, patient–clinician communication, and access to care are improved when healthcare providers share or understand the language, race, ethnicity, and other cultural characteristics of their patients.³³ BIPOC report that it is important to have a healthcare provider who shares or understands their culture at significantly higher rates than do White people. BIPOC are also significantly more likely to report never being able to see a culturally similar healthcare provider than are White people.³⁴ Academic institutions with schools of nursing have a responsibility to implement strategies to increase the number of students and graduates representing BIPOC so as to provide a pipeline of nurses and nurse practitioners that reflect the racial/ethnic diversity of the populations they serve.

Facilitating student learning so that future WHNPs and other NPs who provide women’s healthcare can develop effective strategies to mitigate racism and implicit bias in practice is also important. Faculty members need to seek opportunities to increase their own level of comfort and skills and schools of nursing need to invest in the resources required to develop more faculty leaders in this area. A deliberate, coordinated effort to address racism and implicit bias by multiple means in dynamic learning environments will effect the greatest change.^{7,18}

A concerted effort at clinician, health facility, community, and systems levels is critical to progress in the goal of reducing racial/ethnic health disparities. Every NP who provides women’s healthcare should participate in meeting this goal at one or more levels. Engaging in self-reflection regarding the potential for implicit bias and seeking educational activities that increase awareness and enhance patient–clinician interactions are important first steps in creating change. Participating in quality improvement projects that facilitate the reduction of health disparities in their communities and health facilities is important. Advocating for local, state, and federal policies that address social health determinants and reduce structural racism at community and systems levels is imperative.

NPWH leadership

NPWH is committed to addressing structural racism and implicit bias in meaningful ways that will improve

women’s healthcare and reduce health disparities. This includes providing leadership to ensure:

- Continuing education (CE) programs and other evidence-based resources on strategies for WHNPs to recognize and address racial/ethnic bias in themselves and at their healthcare facilities are available.
- CE programs and other evidence-based resources are available to assist WHNP program faculty to develop curricula that include strategies to mitigate racism and implicit bias in practice.
- Collaborative engagement with other professional organizations and academic institutions advances the development, implementation, and evaluation of best practices to increase the racial/ethnic diversity of the WHNP workforce.
- Collaborative engagement supports action-oriented groups that are presently leading work to achieve racial justice and equity in all aspects of women’s healthcare.
- Public health policies support the elimination of racism and promote health equity for all women.
- Research moves forward in all aspects of reducing health disparities for women.

NPWH makes the commitment to become an anti-racist organization. As such, we will make an active and conscious effort to identify and eliminate racial/ethnic bias and discrimination and intentionally promote racial/ethnic diversity and inclusiveness at all levels of the organization. NPWH will conduct an ongoing comprehensive review of all current and new guidelines, position statements, policies, other written materials, and CE offerings produced or directed by the organization to ensure they reflect our commitment. The organization’s 3-year strategic plan (2021–2024) will include specific, concrete actions and methods to evaluate progress toward meeting this commitment. NPWH leadership will inform the membership of planned actions and provide an annual report regarding successes and challenges to achieving these actions. ●

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