Mandated Implicit Bias Training for Health Professionals—A Step Toward Equity in Health Care

Lisa A. Cooper, MD, MPH; Somnath Saha, MD, MPH; Michelle van Ryn, PhD, MPH

Almost 30 years ago, an Institute of Medicine report documented racial disparities in health care and suggested that many disparities might be due to clinician bias (or prejudice) against patients from racially and ethnically minoritized groups and stereotypes about the behavior or health of patients in these groups. Although most clinicians report egalitarian beliefs, bias against racial minority and other socially disadvantaged groups is typically unconscious and reflects implicit, rather than explicit, attitudes. Studies over the past 20 years document that clinicians’ implicit biases affect their interpersonal interactions and clinical decision-making and are an important contributor to racial inequities in care throughout the clinical continuum, from screening through end-of-life care.

Training programs have arisen to address the negative effects of implicit bias, and California, Maryland, Michigan, Minnesota, and Washington recently passed legislation mandating implicit bias training for at least some categories of health professionals. Other states have bills in various stages of the legislative process. Legally mandating such training sends a powerful message: that equity in health and health care matters; that those negatively affected by bias are important and deserve respect, care, and dignity; and that health care organizations and personnel are accountable for ensuring equitable care.

Training mandates help bring conversations about inequity and bias into the mainstream. As such, the current laws are an important step in the right direction. However, substantial gaps and opportunities remain for strengthening the effect of this legislation to ensure that the time and resources required for widespread training are being used to achieve the goals of reducing bias and promoting equitable care.

Focusing Training on Specific Clinical Areas and Populations

Tragic racial inequities in maternal and infant morbidity and mortality helped catalyze many of the current laws mandating implicit bias training, so it is no surprise that equity of perinatal care is the most consistent focus of training across states. Other states have created policies requiring general implicit bias training for all health professionals.

Although there may be logistical advantages to a one-size-fits-all approach to such training, they are likely outweighed by the benefits of training tailored to specific clinical areas and populations. Because implicit bias operates differently across stigmatized groups (eg, Black women vs transgender men), a generic focus may dilute the effects of implicit bias training. By focusing on specific clinical issues and populations, programs can target areas where inequities are most concerning or where bias is most prevalent. Targeted training also makes it easier for evaluators to test the effectiveness of training mandates by measuring changes in specific quality or outcome metrics across specific populations. In addition, training that targets clinical topics and populations relevant to the clinicians engaged in the training will increase salience and buy-in. We therefore recommend that states develop portfolios of training options focused on specific health problems and populations and define the types of implicit biases (and stereotypes) to be addressed.
Advancing the Evidence Base on Effective Elements of Implicit Bias Training

Some state legislation requires implicit bias training to be based on empirical evidence and approved by an accrediting organization. However, the evidence for the effectiveness of implicit bias training is nascent, and reducing biases and their effects is not a simple endeavor. Recent literature reviews suggest that many interventions have no effect or may even worsen implicit biases which, paradoxically, tends to occur when people are told to avoid stereotyping.\

Many programs use the Implicit Association Test (IAT) as a precursor to enhance understanding about how cognitive processes work and to promote self-awareness of learners’ own implicit biases. However, poorly guided use of the IAT may lead to greater interracial anxiety among individuals discovering their own biases for the first time or among those discounting IAT results because they do not match their explicit egalitarian values. Due to controversies in the existing evidence, current training programs vary in their learning objectives, content areas, frequency or length of training, and methods to achieve their stated objectives—and as a result, vary widely in their effectiveness. In addition to being wasteful, ineffective training may also be harmful if it gives learners and institutions a false sense of confidence in training that has had no benefit.

Evidence suggests that training based on social psychology that includes specific curricular elements—perspective taking, building partnerships (or shared in-group identities), and emotional regulation (eg, mindfulness-based stress reduction)—tends to be most effective, and these elements should be incorporated into approved training programs. Given that evidence is evolving, however, we also recommend that states assemble expert panels or governance boards to develop quality standards and outcome measures for these programs (eg, clinician behaviors, quality of care measures, patient-reported experiences, and health outcomes) and oversee their evaluation (including assessment of the durability of intervention effects). Such evaluations can take advantage of the natural experiment offered by state training mandates, to further the evidence base about what constitutes effective vs ineffective training.

Establishing Qualifications for Trainers

Governance boards (working with experts) serving as credentialing organizations also should specify minimum qualifications of the training developers, trainers, and facilitators. Most mandated training policies do not specify required qualifications for implicit bias trainers, and it is not clear whether most of the implicit bias courses currently offered are led by people with the background, training, or experiences needed to handle emotionally charged and complex issues that arise during such training. Ineffective training wastes resources and time, crowding out effective approaches. Diversity, equity, and inclusion programs (including antibias training) often backfire by increasing anxiety and avoidance among participants; however, enhancing participant engagement in solutions, increasing intergroup contact, and promoting social accountability can help to overcome these barriers. Trainers should be knowledgeable about the potential unintended consequences of such training and how to prevent it.

Funding Mandated Training

Inequities in access to training may be an issue for organizations with fewer resources, many of which serve patients in groups at greatest risk of experiencing bias in health care. Current policies do not address the potential financial barriers that health professionals in organizations with fewer resources, and those who are frontline workers, may face in meeting the training requirement. Fortunately, some state governments and nonprofit philanthropies have provided funding for programs. Other states with mandated implicit bias training for health care personnel should provide
funding for developing programs as well as free or low-cost access for health personnel in certain categories.

Mandated implicit bias training for health professionals sends a powerful message about the importance of equity in US society, respect for persons regardless of background or social circumstances, and accountability of health care organizations and personnel for advancing equity. To strengthen the effects of legislative mandates, health system leaders and policy makers should focus this training on high-priority clinical areas and populations, collaborate with researchers and educators to enhance the evidence base on its effectiveness and establish qualifications for trainers, and cover the costs of training for practices and systems with limited resources. Implicit bias training for health professionals is 1 step forward on the long journey to equity in health care. This training must be accompanied by broader structural changes\textsuperscript{2,10} to address discrimination—within and outside health care—if society is to realize the vision of equity in health and health care.

ARTICLE INFORMATION
Published: August 11, 2022. doi:10.1001/jamahealthforum.2022.3250
Open Access: This is an open access article distributed under the terms of the CC-BY License. © 2022 Cooper LA et al. JAMA Health Forum.

Corresponding Author: Lisa A. Cooper, MD, MPH, Johns Hopkins University School of Medicine, 733 N Broadway, Baltimore, MD 21205 (lisa.cooper@jhmi.edu).

Author Affiliations: Johns Hopkins Center for Health Equity, Johns Hopkins University, Baltimore, Maryland (Cooper, Saha); Division of General Internal Medicine, Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland (Cooper, Saha); Institute for Equity and Inclusion Sciences, Diversity Science, Clackamas, Oregon (van Ryn).

Conflict of Interest Disclosures: None reported.

REFERENCES