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A systematic review of racial biases in healthcare workers and healthcare disparities

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ABSTRACT

United States health care may exhibit note worthy racial disparities as a result of racial bias among health providers. Racial bias is an issue in the United States that can have a substantial impact on the lives of individuals of racial minority. The primary objective of this study is to investigate the number of articles that occur in the social work literature regarding disparities in healthcare related to racial bias. A Cochrane Systematic Literature Review (SLR) was used to identify existing professional social work literature on the existence of racial bias in health disparities pertaining to the social work field. Results indicated that manyhealthcare providers exhibit racial bias in their practice. This bias was found to be implicit rather than explicit bias. While explicit bias was present in professionals who express racist ideologies, they imply a minimal portion of the population when compared to professionals who unknowingly present implicit bias. Future interventions will need to focus on training healthcare professionals and future healthcare professionals the importance of addressing racial bias, especially in the form of implicit bias. Alerting medical school and social work educators to the findings may be the first step necessary to begin removing racial bias from healthcare.

KEY WORDS: Healthcare; Disparities; Racial bias; Social work.

ABBREVIATIONS: SLR: Systematic Literature Review; AHRQ: Agency for Healthcare Research and Quality; NHDR: National Healthcare Disparities Report; NHQR: National Healthcare Quality Report.

INTRODUCTION

Professional literature on prevalent culture and healthcare distribution in the United States appears to attribute racial bias among healthcare providers as one possible contribution to racial disparities. Individuals of ethnic minority may experience racial bias in healthcare settings, which may have negativelyimpacted minorities. Some researchers believe that racial bias mayguide healthcare professionals to make medical decisions solely based on the patient's race.[1] For this reason, it is important to understand the professional literature to identify appropriate, purposeful interventions. The results of this study may direct medical professions and healthcare workers to possible interventions that may reduce negative perceptions towards minorities and thereby improve medical care. This awareness may mitigate health disparities in the U.S., at least by healthcare workers, and perhapscreate a more just system of healthcare for all who are served.

LITERATURE REVIEW

Racial Bias

According to Blair, Havranek et al bias can be defined as "the negative evaluation of one group and its members relative to another."[2] Bias itself can be divided into two different categories: explicit and implicit bias.[2-4] Explicit bias entails that the person is aware of the assessment, believes that assessment is true and has the time and motivation to act on it in the current situation.[2] In simple terms, this means that the person will have a preconceived belief about another person's race and act in accordance to that belief by expressing racial bias towards them. Conversely, implicit bias operates in an unintentional and unconscious manner. The individual develops an unconscious racial bias and reacts based on inward held anxieties towards racial minorities without even realizing they acted in that fashion. The implicit biases that contribute to many of the disparities in healthcare are stereotypes that have been passed on by the physician's culture and ingrained into their memory. Stereotypes are defined as a mental cognition that contains a person's knowledge, beliefs, and expectations for a group of people.[5] While physicians could act overtly in stereotyping, the majority are influenced without their own knowledge. Multiple studies have shown explicit bias to be virtually non-existent in healthcare today, and therefore will not be an extensive issue in this review of the literature.[2,6]

Several studies state that implicit racial bias is a leading cause of healthcare disparities.[7-9] Health disparities refer to differences in healthcare by race or ethnicity. Another term associated with "health disparities" is "health inequities," which is said to refer to differences in healthcare related to social class.[10] While "inequities" would cover a portion of the ethnic minority population, it does not cover all. Therefore, the term "disparities" is a proper fit for this study. Healthcare disparities can be classified as either acceptable or unacceptable, but it depends of the source of the disparity. For example, if disparity occurs because of a difference in patient preference in how the doctor works with them, it is acceptable. It becomes unacceptable when people with equal access to healthcare are treated differently as a result of race or ethnicity. Some examples of health disparities impacting racial bias mentioned by Dovidio et al include that African-American women with osteoporosis were less likely to receive testing and appropriate medication and that African-American prostate cancer patients were more likely to have delayed active treatments and were found to wait longer for medical monitoring.[8] Several other studies indicate that the level of implicit bias held by the physicians affected whether they would prescribe the necessary drug treatments to their ethnic minority patients.[8,11] It has also been found that because of implicit bias physicians often view African-American patients as uncooperative and less compliant.[3,8] This is likely a result of unconscious perceptions made based on learned stereotypes that African-Americans are less intelligent than Caucasian patients. This appears to occur no matter the patients age, gender, degree of income, or level of education.[6,7] While these actions may seem like conscious choices made by the physicians, they are actions of unconscious bias.

Healthcare Provider Bias

Healthcare provider biases are a major factor that determines racial disparities in providing care and the resulting outcomes.[12] However, implicit racial bias not only impacts a physician's behavior toward an ethnic minority patient, but also on how the ethnic minority patient feels about the interaction with the provider.[5] Another term associated with implicit bias is "Personally-mediated bias", also referred to as racial bias. It is a subcategory of institutionalized bias in which has two factors to take in consideration: (1) the subconscious mind and (2) the potency of the impact the unconscious thoughts towards prejudice and discrimination. This constitutes that those factors interpret a negative conception, which conceives disrespect and deliverance of poor service to those that are at disadvantaged.[13,14] Therefore, whether we use the terminology of implicit bias or person-mediated bias, healthcare providers are likely to make rushed medical judgments and decisions based on an individual's ethnicity due the pressures of being a provider which entails limit on time, quick decision making, and limited resources.[13]

Minority Group Contributions

According to the analysis completed by the Kaiser Family Foundation collected from the 2016 U.S. Census Bureau's Current Population Survey, there are approximately 39% of ethnic minorities residing in America.[15] Cambridge English Dictionary defines "Ethnic Minority" as "a group of people of a particular race or nationality living in a country or area where most people are from a different race ornationality."[16] To be connected in an ethnic minority group means those individuals share cultural experiences that consist of language, cuisine, artistic expression, traditions, and a community that is unique to their people. Together, many different ethnic groups of color amalgamate the United States to create a nation of diversity and culture. Throughout history, ethnic minorities have influenced the construction of monuments, the evolution of federal policy, creation of pop culture, and the development of the healthcare system. There may be a number of positive factors ethnic groups bring to the U.S., and yet may be diluted by marginalization created by racial biases and discrimination. This paper explores the possibility of the role healthcare worker bias as one of the factors creating disparities.

Racial Disparities in society

Racism has been defined as a belief that there are inherent differences among those of different racial groups, which help determine one's cultural or personal achievement.[17] The concept of racism is a common phenomenon that has been around for decades and fought against. Political influences, for example, Martin Luther King and other ethnic community members have risked their lives for equal social justice. In recent years, greater awareness of civil rights has now become an implicit act. In the United States, 84% of the African-American population reports that racism is still an existing problem.[12] This suggests one of the many concerns of minority groups, access to quality healthcare services.

Distribution of equal treatment has been a growing area of con-

cern as racial minorities experience a decreased quality of care as a result of receiving mediocre healthcare services.[18] During the 1990s, a presented topic that conveyed feelings of negativity, mistrust, hostility, and change of subject was how racial bias may influence a health professional's delivery of medical services.[12] Racial inequalities have existed in several forms in which prejudice and discrimination have played continuing roles in society for many decades.

In 1999, Congress reauthorized the legislation from the Healthcare Research and Quality Care Act to the Agency for Healthcare Research and Quality (AHRQ). This agency proposed to congress the first annual National Healthcare Disparities Report (NHDR) in December 2003. Information gathered in the report presents an overview of state of racial, ethnic, and socioeconomic disparities in access and quality of care in America. The AHRQ created two different annual reports in which was the NHDR and the National Healthcare Quality Report (NHQR). The NHDR measures access of care and the barriers that are associated with them: entry, structural, cultural, healthcare use, and healthcare cost. The framework also measures the quality of care by the provider: effectiveness, safety, timeliness, and patient-centeredness.[19] The consideration of congress undertaking a task recognizing healthcare disparities uncovers the importance of the connection between racial bias and access to quality healthcare.

Racial Disparities in Healthcare

Healthcare professionals from various disciplines have their own code of ethics to follow but share a commonality to commit to principles of equity, fairness, and distributive justice. Institutionalized racism, a discrepancy to consider, has a sufficient amount of evidence that has been revealed. It refers to a "set of organizational practices that create unequal outcomes between groups on the basis of their race or ethnicity".[12] Studies have shown that ethnic minorities are underrepresented in the field of medicine, especially as physicians.[1] In the last decade, there have been policy changes and community efforts (either public or private) to address institutional racism in healthcare.[12] There are two categories that construct racism holistically in deliverance of healthcare in the United States, which are institutionalized racism by the healthcare system and personally-mediated racism by the healthcare provider.[13]

The purpose of this SLR is to identify professional data that address racial biases and its correlation to receiving quality healthcare services by utilizing the Cochrane Review. Healthcare is a service that is provided to individuals to maintain a healthy lifestyle and prevent damaging effects to the body, Ethnic minorities may be disadvantaged to receive equal healthcare in comparison to their Caucasian counterparts. This SLR is intended to provide social workers with the necessary information to identify and alleviate health disparities in order to improve policy and change healthcare services delivered to ethnic minorities.

METHODS

A Cochrane systematic literature review (SLR) was utilized to identify existing professional literature on the influence of racial bias on healthcare disparities pertaining to the social work discipline and to identify any themes among those articles. The Cochrane method was used because it aims to identify the best evidence-based studies conducted in the healthcare field using the specific key words. The goal of a Cochrane SLR is to simplify the research process by searching multiple databases to negate selective bias.[20] The researchers selected seven databases: Alt HealthWatch, EconLit, Education Research Complete, PsychARTICLES, PsychINFO, SocINDEX, and Social Work Abstracts. Additional limiters were selected to concisely create systematic literature review (SLR) as follows: (1) scholarly and peer-reviewed articles that have been written within the last 10 years (2007-2017), (2) used Racial Bias, Healthcare, Disparities, and Social Work as keywords. Researchers opted to use the five steps in the Cochrane Method to guide their SRL.

Step 1: Framing Questions for Review

The researchers selected the search engines (Social Work Abstracts, Alt Healthwatch, Econlit, Education Research Complete, PsycARTICLES, PsycINFO, and SocINDEX with Full Text) for their relevance to the four keywords, *Racial Bias, Healthcare, Disparities,* and *Social Work*. Utilizing each step of the Cochrane review enabled appropriate articles to be found that would reveal relevant results and facilitate discussions pertaining to the correlation among healthcare services and racial bias.

Step 2: Identifying Relevant Work

Following the initial search, the authors strategically reduced the yield by limiting the research to scholarly peer review articles from the last 10 years (2007-2017). This process is documented in Tables 1 and 2. In most cases, articles published prior to 2006 were eliminated in effort to avoid time-dependent biases; however, two exceptions to this limitation were made based on the data analyzed. In one case, an article published by Gee and Walsemann,[21] was eliminated because the findings were based on data from the early 1980s. In another case, a study originally published in 2003 but reprinted in 2008 was included due to the relevance of the findings (Table 3).[22] The remaining articles underwent a thorough literature review process to assess for face validity, or an analysis of the relevance of the content to the proposed research question. To examine the presence of racial bias, or racism, articles relating to healthcare, available healthcare options, and pursuit of healthcare by racial minorities were included in this study (Table 3).

Step 3: Assessing the Quality of Studies

The authors reviewed the articles remaining after applying the limiters outlined in Table 1. These articles were selected from

Years	Key words	Limiters	Number of Articles
1999-2017	Racial Bias, Healthcare, Disparities, Social Work	None	N = 30
1999-2017	Racial Bias, Healthcare, Disparities, Social Work	Scholarly Review	n = 29
2007-2017	Racial Bias, Healthcare, Disparities, Social Work	Last 10 years	n = 24
2007-2017	Racial Bias, Healthcare, Disparities, Social Work	Face Validity	n = 17
		See Table 3 for exclusions	n=17

Engine searches: Social Work Abstracts, Alt HealthWatch, EconLit, Education Research Complete, PsycARTICLES, PsycINFO, SocINDEX with Full Text

Table 1: Synthesis of keywords for SLR.

Study	Reason for Exclusion
Bhattacharya[29]	Focuses only on the Arkansas Delta.
Dettlaff et al[30]	Examines racial bias as an influencing factor in the overrepresentation of black children in the welfare system. Not directly related to the topic.
Gee et al[31]	Data used for study was collected between 1979 and 1983.
Kegler et al[32]	Not focused on racism as a creating sources of health disparities.
McAllister et al[33]	States that disparities in school readiness is a type of health disparity, however we are seeking info on direct impact of racial bias, within the healthcare system or society, on the health outcomes of racial minorities and the healthcare available to them.
Noël et al[34]	This article focused solely on depression, not the overall healthcare of minorities.
Wolff[35]	Article only briefly mentions racism in reference to a partnership the author made with a program that seeks to address racism.

Table 2: Literature review exclusion matrix for references.

Author/Date	Type of Study	Purpose	General Comments	Strengths & Limitations
Acevedo-Garciaz et al[9]	Literature Review	Discuss how perceived interpersonal discrimination and segregation effect children's health.	The population of minority children is growing at high rates – from 26% in 1980 to 47% in 2011. Minority children are highly segregated – 81.6% of African American children lived in large metropolitan areas in 2010 with 77.8% of them living in areas with high levels of school segregation. Hispanics were 32.6% and 54.2%. Discrimination affects children negatively in four domains: stress, cognitive and socio-emotional development, health behaviors and ethnic identity. There are birth disparities between African Americans and Caucasian Americans. Interpersonal discrimination affects children's mental health. Perceived discrimination and segregation affect a child's health via birth outcomes and during later stages of their development	The searching criteria for their literature review was very precise in order to capture the population they were targeting.
Barnes GL	Qualitative	Examine personal perception of the cause of racial disparities in birth outcomes	Black women are experiencing higher rates of infant mortality even in instances of good and early prenatal care. Participants attributed this to the regard given to them by healthcare providers. The perception, suspicion, or expectation of prejudice or racism from their providers is a significant cause of stress which negatively impacts pregnancy.	Very small sample with results based on open responses.

Browne et al[23]	Qualitative	Investigate community perception and understanding of racialized health disparities	There is a lack of understanding of what health disparities are and an overall disbelief that they are a reality. Education providing a framework to guide student's examination of health disparities is needed to clearly illustrate the issue.	Quasi-experimental, not well representative of the entire American population studies group of social work students from same area, they are learning and not very experienced.
Burk J et al	Qualitative	Discuss race relations within the US military.	Racial minorities are less likely to receive high quality healthcare because of: Underlying clinical conditions, patient ability to pay for care, patient preferences and the conduct of medical providers (gatekeepers to the system). Providers seem to give or withhold care depending on the minority status under a variety of conditions: Less likely to receive adequate pain assessment and treatment, black and low income less likely to undergo diagnostic tests, even if Medicare would pay, blacks are less likely to receive kidney transplants, however a large portion in the population need them compared to whites and psychiatrist are more likely to prescribe antipsychotics and order involuntary hospitalizations of minorities	It focused on major areas of the military in which there was a lot of research to dissect. A possible limitation is that it did not cover areas where there was a limited amount of research which could be excluded some vital information about racism in the military.
Copeland et al	Literature Review	How to improve mental health among African American women	Perceived racism effects whether a person will seek mental health services. Overall racism negatively effects both physical and mental health outcomes	Provides good review of the outcomes of perceived racism.
Dominguez et al	Qualitative	Effects of the perception of racism on birth outcomes	Compared foreign born black women to US born black women in America. US born black women are more likely to perceive racism and therefore have more negative health and birth outcomes. Children of foreign born black women grow up to have the same perception of racism as the US born black women.	Provides a good comparison group by including Caribbean and African black women in foreign group. Examines a small sample. Needs further examination.
Fagan et al	Quantitative	Summarize the literature and describes the known disparities that exist along the tobacco disease continuum for minority racial and ethnic groups, those living in poverty, those with low education and blue-collar and service workers.	Black people start smoking later and smoke less than white people yet they die more from tobacco related diseases. National reports suggest that increasing racial/ethnic diversity among health professionals is important as it may help improve access to care for racial and ethnic minorities.	Broke down their data into more ethnic groups outside of Whites and Blacks. Described many of the frequent key terms in the article.

Hall et al[3]	Systematic Review	To investigate the extent to which implicit racial/ethnic bias exists among healthcare professionals and examined the relationships between healthcare professionals' implicit attitudes about racial/ethnic groups and healthcare outcomes.	Implicit bias was significantly related to patient---provider interactions, treatment decisions, treatment adherence, and patient health outcomes. Disparities in healthcare for minorities range from higher infant death mortality rates to premature death due to heart disease and stroke. Implicit biases are displayed in subtle ways such as making minorities wait longer for assessments and treatments, getting less one-on-one time and collaboration with their doctors, being approached in a more dominant and condescending fashion by their doctors, not being given interpreters and getting less thorough diagnostic work done. Implicit biases come out when one is under pressure, too busy or distracted. Thirteen studies reported that healthcare professionals were more likely to associate Black Americans with negative words compared with White Americans. Results of this review suggest that implicit bias against Black, Hispanic/Latino/Latina, and dark-skinned individuals is present among many healthcare providers of different specialties, levels of training, and levels of experience.	Did a great job defining key terms in the article.
Hatcher et al[28]	Literature Review	Explore the need for African-centered approached in the development of mental health interventions for black youth	Mental health is poorly accessed in the African American community. They are less likely to seek or respond to mainstream mental health interventions. Interventions should focus on principles relative to the African American community such as liberation and empowerment. The principles of Kwanzaa can provide a framework for development of future interventions.	Explores the problem and provides a logical solution that can be a source for further examination.
Katz AD, et al.	Brief Report	Examines multiple potential predictors of anti-Black bias among counselors.	The found that measures of both self-reported and automatic prejudice support, but do not supplant, self-report measures of multicultural counseling competence as predictors of biased clinical expectancies.	They received a good response from the racial population they were researching (Whites – 83.8%). They had more females respond (82.7%) than males which could have skewed the results.
Kolivoski et al[24]	Qualitative	Discusses the need for Social workers to learn Critical Race Theory (CRT) and to use it to work more effectively with minorities.	Overt racism has reduced over the years only to give rise to covert and institutional racism which gives birth to racial inequality. CRT is not embraced by all social work educators, researchers or practitioners. CRT looks at civil rights through the lens of economics, history, context, group and self-interest, feelings, and the unconscious.	Does an excellent job showing how CRT could enhance social work practice when deal with minorities. Does not dissect why this why this model is not embraced by all in the social work field.
Krieger[28]	Brief Report	Explore the influence of racism on health	Both health outcomes and healthcare are directly influenced by racism.	Uses examples of African American, Native American, and Latino American health disparities to support study.

Levine et al[25]	Qualitative	Discuss how non-verbal communication effects the doctor-patient relationship.	Members of racial minority groups report considerably more dissatisfaction with their healthcare than White patients including less trust and satisfaction in their doctors. Some things that affect white doctor's biased nonverbal behavior include: stereotypes within society and concerns about appearing prejudiced. When patients feel as if the doctor is more engaged with them it increases the amount of information they are willing to share with the doctor, they respond better to what the doctor says or diagnoses and they leave with a better understanding of what is going on with them. Doctor's non-verbal behavior effects the patient's overall health. Majority group members (Whites here in America) have a harder time reading the emotional expressions of minority group members. Having a lack of knowledge regarding the way some cultures communicate non-verbally can lead doctors to draw inaccurate conclusions from how their patients are acting. Doctors who are more sensitive to their patient's non-verbal cues have clients who like them more and have better health outcomes.	Does a great job exploring White doctor's inability to interpret racial minority groups non verbal's and the effect that has on healthcare (which no other article in our systematic review did). Does a great job explaining possible solutions to the disparities brought on by racial differences. Focuses more on African Americans rather than including multiple racial minority groups.
Ryn et al[4]	Editorial	To explore the effect unconscious biases has on disparities in medicine.	Decision making is most likely effected by explicit attitudes when there is time for one to think out their decisions, access their cognitive resources, be motivated and have the opportunity to consider the pros and cons of their actions. On the other hand, implicit attitudes most likely predict behavior when there is not a lot of conscious control.	It discussed a study which had a counter argument to their point. It went on to dissect the results of that study and gave well thought out and researched answers as to why that study was flawed.
Sabin et al[14]	Qualitative	To determine whether or not implicit racial bias exists among Pediatricians, as implicit and explicit measures would differ and implicit measures may be related to quality of care.	Modern racism is subtler and unintentional, yet is does exist. There is evidence of implicit attitudes and stereotypes that favor whites. Their study showed less showed less implicit preference for whites compared with the majority of large numbers of IAT test takers. Some physicians hold strong implicit associations for black patients as being "less cooperative" and demonstrated that this implicit bias was related to quality of care. White children are hospitalized more than African American or Hispanic Americans.	They had large participation from the dominant race in America (Whites) of 82%. A potential limitation is that they had more females respond (65%) then males (35%).

Samuel	Qualitative	Examine the beliefs about mental health and therapy among African American males	Most perceive environmental conflict and a cause of mental health problems. African Americans are more likely to live in hostile environments and are more likely to experience high levels of stress and depression. They tend to go undiagnosed due to belief that they should get over there problems or take them to a loved one or God. They are less likely to seek help due to stigma and lack of perceived acceptance or understanding from therapists	Followed a small sample of black males aged 15-17. Not representative of the African American community or of Americans in general.
Toche-Manley et al	Qualitative	This article focuses on ways to improve case planning in child welfare when dealing with minority children.	Youth in the child welfare system are at a higher risk for mental health disorders with 40% of those ages 6-17 years old meeting the criteria for one or more DSM diagnoses. Minority youth have limited access to behavioral health services. Minority youth's teacher's racial biases effect the way in which they evaluate the youth's behavior which impacts the services they youth would receive.	The assessments were fitted for the age of the participants. Self-repots can be skewed as they are subjective.

Table 3. Synthesis of key articles in the SLR.

the initial data set. Following thorough literature review for face validity, or relevance to the research question, the authors had compiled a viable data set. Quality of the study was determined based on the stipulations of the Cochrane method. The data were limited to scholarly peer-reviewed articles published between 2007-2017, relating to racial bias and healthcare in regards to the social work field (Table 1).

Step 4: Summarizing the Evidence

As shown in table 2, there is a deficit in the research on racial bias and healthcare. Following a test of face validity, articles (n=17) were identified as relevant to the study demonstrating a need for more research in this area. Relevant articles are summarized in Table1 to provide an overview of key findings. Although the research is limited, common themes were illustrated throughout the literature.

Step 5: Interpreting the Findings

The authors documented these themes and related key points on literature review sheets. These were succinctly organized, which was used to derive the findings for this study. Articles came primarily from social science publications. The authors attempted to reduce bias towards social work by searching several databases including psychology, health, economy, and education. These articles were not limited to the United States or by language in attempts to provide a larger dataset.

RESULTS

Framing Questions for Review

Upon completion of the SLR, 17 articles met the criteria to be included in this review: 16 peer reviewed articles and one editorial (Table 3). Findings may provide evidence that racial bias influences healthcare. Common themes found throughout suggest that racism negatively influences the health outcomes of minorities, as well as the type of healthcare options and services provided to them. One theme identified among the articles was the year of publication, as a bulk of the studies came from 2007 and 2014; five studies published in 2007 and four studies published in 2014. The remainder of the articles were dispersed evenly with the exception of 2010 and 2016 in which no published articles were found. Another theme found among the articles was the disciplines publishing the articles. Over half of the articles (n=9) were published in either a social science or medical journal. Three articles were published in social work journals. The residuum came from psychological, sociology or general publications.

Identifying Relevant Work

As shown in table 1 the initial search in the university's collection of online databases yielded 30 articles. When the limiters were implemented, there were 24 remaining articles. After the research team conducted a face validity using literature reviews sheets, the research team eliminated seven articles that did not fit the parameters of the study (n=17) (Table 2).

Assessing the Quality of Studies

The 17 articles that fit the specific criteria were examined based on the type of study, which was the purpose for the study and the studies strengths and limitations. First, the type of study was examined to ensure that it was scientifically relevant. Second, the purpose of the study was analyzed to confirm that the articles content was relevant to the study. Lastly, the authors inspected

the strengths and limitations of each article to safeguard against errors and biases.

Summarizing the Evidence

With a yield of 17 articles during the SLR, it is likely further research is required on racial disparities in healthcare. Only three articles were published in social work journals. The majority of the articles resulting from the SLR were published in the years 2007 and 2014, which supports a gap in current research that needs to be explored.

Interpreting the Findings

As evidenced in Table 3, a recurring theme throughout the articles under investigation was that Caucasian physicians tend to operate with an implicit/unconscious racial bias. Hall et al described implicit attitudes as "thoughts and feelings that often exist outside of conscious awareness and thus are difficult to consciously acknowledge and control".[3] This subtle bias may lead to the possibility that ethnic minorities receive poor quality healthcare and sometimes none atall. This unconscious bias may also occur among those who claim to have no explicit/conscious racial biases. Many articles seem to illustrate that this occurs because implicit bias plays on the deep-seated stereotypes one is exposed to throughout life.[3,4,24,25] When physician's minds are taxed and pressed for time it is harder for them to manage their unconscious thoughts towards ethnic minorities, and it impacts the care they provide. These articles appear to support that implicit bias impacts everything from physician-patient communication to final treatment plans.

DISCUSSION

Summary of Findings

After conducting the SLR using nine databases, four key words, and a face validity check, the research team identified 17 articles that fit the criteria established with the Cochrane Model. There were two major themes found among the articles including: (1) years of publication and (2) publishing discipline. The researchers attempted to reduce the risk of bias towards social work by searching multiple databases including many disciplines such as psychology, health, economy, and education. Further, they expanded the search outside of the United States in order to precisely grasp an understanding what was being published on this subject.

Interpretation of Findings

The articles included in this SLR illustrate that the medical field has a vested interest as disparities in healthcare cause a gap between the patients and themselves. However, it has also been shown that other disciplines such as social work, psychological, sociology believe this issue to be pertinent (Table 3). These articles also omit that more research is required to consider why more articles were published between 2007 and 2014, when compared to none in 2017. Was there an increase in minority's access to healthcare, which increased the number of people experiencing these biases? Along with the recurrent theme of implicit bias on behalf of Caucasian physicians, the articles of this SLR attest that although society has come a long way from overt racist acts in healthcare such as denial of services and segregated medical facilities, there is still research to be done on racial disparities in healthcare.

LIMITATIONS

Methodological limitations may have occurred in our study by the inclusion of the keyword phrase "social work" (Table 1) as this may have limited the range of studies the authors had access to. With the inclusion of this keyword phrase the amount of perspectives to review on this issue were decreased significantly. However, this was an unexpected limitation as instructions indicated a social work perspective must be taken. Attempts were made to minimize this limitation by including other disciplines in the databases used to search for articles such as psychological, health, economic, and educational databases. With a wide range of databases searched, this SLR has been successful in overcoming the limitation related to the phrase "social work."

Application to Social Work Policy and Practice

Concerns arise when contemplating if anything can be done to subdue an unconscious process like implicit bias. Fortunately, research has demonstrated that implicit bias can respond to changes made in situational cases and social norms. Other possibilities include strengthening patient's defenses against bias or altering the system to mitigate potential bias. The physician-patient relationship is the most central aspect of healthcare, which intensifies the importance for addressing implicit racial bias among physicians.

The results of the current study discovered 17 articles, some of whichseem to indicate racial biases negatively influence health outcomes of minority ethnic groups, encouraging increasing health disparities. According to Cooper et al perhaps, healthcare providers may unconsciously reflect these biases during practice as implicit bias.[7] This suggests the presence of unaddressed stereotypical beliefs within healthcare professionals, pointing to a potentially severe lack of awareness and deficit in cross-cultural understanding.

Lack of education and awareness is a recurrent theme within the professional literature available on this issue. In a study of a group of social work students, there was an overwhelming misunderstanding of what a health disparity is. Furthermore, it seems that Americans generally do not consider health disparities to be an actual phenomenon.[23] This lack of belief directly reflects a lack of understanding of cross cultural experiences and is often reflected in negative and charged comments, suggesting that members of ethnic minority groups are unhealthy because

they are lazy or choose to ignore their health. These types of beliefs ignore the fact that people's environments impose difficulty in receiving healthcare, but also provide a reason for discriminatory judgment to be passed on them by healthcare providers, thus creating health disparities. This is congruent with the ideas presented by Krieger in a 2008 report, which states that discriminatory judgments impose limitations on the lives of minorities.[22] Even in the current political climate where an African American became the president of the US there are political atmospheres that block the discussion on ethnic and racial disparities in healthcare. Studies have shown that people believe that with the election of an African American president there is no need to address the disparities any longer, some even say it "solved all our problems," perhaps referring to racial divides.[26] It is the justification of discriminatory behavior, examined in this study, that allows society to perpetuate disparities within healthcare.[27] Discriminatory judgment may also persist due to ignorance about the experiences of other races or lack of interactions with other races.[12] Promotion of cross-cultural education may enlighten healthcare providers to the experiences and perspectives of minorities. A study conducted by Hatcher, King et al explores the importance of the application of cross-cultural understanding to mental health interventions approaches within the African American community.[28] It stated that to improve reception of mental healthcare, therapists should use interventions emphasizing themes that resonate with African American patients, such as liberation and unity. While this article only describes a cross-cultural understanding in relation to African Americans in mental healthcare, it can be expanded to include other racial minorities in general healthcare. When a healthcare provider does not have an understanding of the racial minority populations they work with, there could be a decreased receptiveness to treatment by the patient. By increasing cultural knowledge healthcare providers could increase receptiveness therein decreasing displayed implicit biases.

As social workers, it is imperative that we promote cross-cultural education within allied health programs to foster greater understanding of diverse racial groups and to encourage open and honest conversation and exploration of racial prejudices. Furthermore, we should encourage the implementation of early intervention during the education of future healthcare providers emphasizing the bi-relational impact of racial biases on healthcare to promote effective self-management of biases during practice.

For these reasons, it is important to continue research on the subject of racial disparities in healthcare. While research has revealed racial disparities in healthcare as a major issue that potentially impacts millions of patients, it has not yet demonstrated a clear reason for the disparities. Implicit bias appears to be the most widely discussed culprit for racial bias in healthcare, however it is difficult to definitively prove if a person's bias truly arises from an unconscious cognition. Other proposed causes may be just as subjective. So perhaps, instead of putting heavy focus on determining the causes of this issue we should move forward educating medical professional and social workers on the biases that occur in the interactions between themselves and racial minority patients. By refocusing the goals of current research on racial disparities in healthcare, racial minority patients could one day be treated as equals, and never again have to worry if they will get the medical treatments necessary to keep them healthy and alive.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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