UNIVERSITY of MARYLAND MEDICAL SYSTEM

Public Health - Implicit Bias Training and the Office of Minority Health
House Bill 28
Before the House Health and Government Operations Committee
January 26, 2021

POSITION: SUPPORT

The University of Maryland Medical System ("UMMS") supports House Bill 28. This bill would (1) require the Office of Minority Health ("Office") to publish health data that includes race and ethnicity information semi-annually, (2) require additional state funding for the Office beginning in fiscal year 2023, (3) direct the Office to seek supplemental funding from federal and special funding sources and report those efforts and results annually to the legislature, (4) define "implicit bias", (5) directs the Cultural and Linguistic Health Care Professional Competency Program to "identify and approve implicit bias training programs for health occupation licensure and certification..." from amongst training programs that are recognized by Maryland health occupation boards or accredited by the Accreditation Council for Continuing Medical Education and (6) require an applicant for license or certificate renewal by a health occupation board to attest to completion of an approved implicit bias training program.

This bill is important to the equitable dispensation of health care. It is a stark, unfortunate reality that everyone has implicit biases and they show up in all contexts. This is even true for people who do not consciously believe they are guided by negative thoughts about one demographic group over another. According researchers Samuel L. Gaertner, PhD, of the University of Delaware, and John F. Dovidio, PhD, "people may hold negative nonconscious or automatic feelings and beliefs about others that can differ from their conscious attitudes... When there's a conflict between a person's explicit and implicit attitudes—when people say they're not prejudiced but give subtle signals that they are...". In health care, unconscious biases manifest in a number of ways, including patient and provider communication, (e.g. providers may dominate the conversation, listen less to the patient, frame the conversation in exclusionary terms, avoid eye contact), or in the way care is delivered including the delivery of pain medication and specific treatments. All of these circumstances obviously can impact health care outcomes in very negative ways.

These concerns were borne out in the 2003 "Unequal Treatment" report from the Institute of Medicine (IoM). The report concluded that notwithstanding controls for insurance and family income and the like, on balance racial and ethnic minorities received inferior health care more often than non-minorities, and that both explicit and implicit bias were likely at play.

Significant health disparities exist in our communities from life expectancy to differential disease morbidities. Yet we know implicit biases in health care typically impact minority and vulnerable populations the most. No patient should receive a lower standard of care because of immutable characteristics like race, age, sexual orientation, or the like. Creating awareness of the existence of implicit social biases can enable our collective community to work to overcome prejudice, social stereotypes, and discrimination, whether intentional or not, and prejudice and working to dampen down the disparate health outcomes.

There has never been a more opportune time to tackle these issues then now-- when our country is confronting the racial injustice issues made clear during the summer of 2020 and as we are grappling with the disparate impact of COVID-19 on minority populations due in large part on long-standing health disparities. UMMS is doubling down on efforts to ensure equitable care and believe this should be the same throughout the health care industry. For these reasons, we urge this Committee to give HB 28 a favorable report.

Respectfully submitted,
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