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Impacts of White Privilege and Implicit Bias on Treatment Implementation with Black Pediatric Patients

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Abstract

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Dissertation Submitted in Partial Fulfillment
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Abstract

White privilege and implicit bias are known contributing factors to the racial health inequities that exist in the treatment of Black children in U.S. hospitals. There is limited research, however, on the potential for White nurses to engage in self-examination related to either concept. The purpose of this basic qualitative inquiry was to understand how White privilege and/or implicit bias shapes the lived experiences of White nurses as they treat and interact with Black pediatric patients. The conceptual framework included a modified model comprised of Hobbs's concept of White privilege and Blair et al.'s model of influences of implicit bias in treatment interactions. A purposeful sample of 13 White pediatric nurses who worked in an urban setting in California for at least a year were interviewed. An iterative coding process yielded 29 subthemes and 10 overarching themes. One group of six participants showed self-awareness of the concepts in their lives and how they influence treatment interactions; the other seven participants showed a lack of self-awareness and understanding of the impact of these concepts. However, some respondents in the latter group grew in their understanding of how these concepts could influence their treatment of patients. Further research with different health professionals may be beneficial. This study may contribute to positive social change by increasing administrators' awareness of the need for training for health care professionals on White privilege and implicit bias. With this training, health care professionals and administrators may be able to ensure a more sensitive and equitable health delivery system that fosters trust between family members and providers and results in better outcomes for Black pediatric patients.

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Dedication

I dedicate my dissertation to my family. Most importantly, I dedicate it to each of my adopted Black children, who have varying health concerns and have experienced differing degrees of unfair treatment in hospital settings. I also dedicate it to my Black friends who have suffered the same issues. And I dedicated it to all the Black children who have experienced any level of different treatment than their White counterparts due to White privilege or racial implicit bias.

Acknowledgments

I would like to thank the members of my dissertation committee for their support and guidance throughout my journey. To Dr. Terri Rorie, I appreciate the encouragement from you to pursue my research topic despite potential difficulties. In addition, thank you for your guidance as I continued to develop my research abilities as a doctoral scholar-practitioner. I am thankful to you, Dr. Nazarene Tubman, for your support on the methodological aspects of my study. I also want to express my gratitude to Dr. Suzanne Richins for serving as my university research reviewer. There were several others who provided me with guidance and support for which I would like to express gratitude. I appreciate all of my friends and extended family members who were alongside me as my cheerleaders during this journey. Lastly, I would like to especially thank my husband, Scott Leiker, and my children, Anthony, Remi, and Myles, for their support throughout this entire process. They were my main champions, providing continual motivating words of encouragement and letting me embark on this path.

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Chapter 1: Introduction to the Study

Racial injustices have permeated U.S. society for many decades, presenting themselves in many different areas of people's lives and rippling through various types of interpersonal relationships. Assari (2018) asserted that these racial inequities affect all generations in a family, bringing stress to old and young alike. Racial injustices may foster different dynamics within familiar relationships. In the context of those relationships, racism has the potential to be displayed through actions or nonactions of one person that can harm those with whom they are interacting (Assari, 2018). Racism can be manifested in such a way that the person experiencing it and acting on it is unaware of it.

White privilege is a factor in individuals' experiences of racism. White privilege is an unspoken systemic privilege that individuals harbor and that has been perpetuated by U.S. society (Hobbs, 2018). Jackson (2009) found that a way White privilege can occur is when someone who is White-passing (perceived by others as White) is afforded certain privileges and uses them to put themselves in a position of power over someone else with a different skin color. Another way White privilege can take shape in a person is through an experience of implicit bias. Implicit bias occurs when someone forms a conclusion about another person or provides them with a stereotypical label due to a difference of skin color (Hobbs, 2018). In this study, I explored how each of these subjective experiences of White privilege and implicit bias can contribute to the racial inequities that have been documented the U.S. health care system, specifically for Black pediatric patients.

Research indicates that racial injustices lead to health outcome inequities, including morbidity and mortality rates, between White and Black Americans (Churchwell et al., 2020). The extensiveness of these existing disparities was brought to light during the first years of the COVID-19 pandemic. Researchers found evidence of unequal treatment of Black patients leading to poorer health outcomes (Yearby & Mohapatra, 2021). In an environment marked by higher contagion and mortality rates caused by COVID-19 and increased acknowledgment among Americans of these health inequalities, such as, there was a need to further investigate what contributes to the disparities.

Specifically, there was the need to explore the ways in which health care providers, whether aware or unaware, contribute to the problem of race-related health inequities. Even though researchers have examined this issue, there was little literature on specific ways White privilege and/or implicit bias shapes the lived experiences of White nurses and treatment implementation and interactions with Black pediatric patients. The results of this investigation indicate that White privilege and bias contribute to treatment decision-making processes; the study provides a basis for health care entities to address this issue. The study may foster positive social change. The interview process increased the participating White pediatric nurses' awareness of their decision-making processes in their treatment and interactions with their Black patients. Additionally, involvement in the study increased participants' understanding of how they may personally be helping to perpetuate racial health inequities among the children they serve. This increased awareness may result in Black pediatric patients being treated more fairly from the onset.

Furthermore, the results may encourage public hospital leaders to improve policies and implement more staff training on the potential influences of White privilege and implicit bias in treatment of Black pediatric patients. New implementation standards for treating patients may be designed and implemented as a result.

In Chapter 1, I provide an overview of the study. The chapter begins with background information about racial health inequities in pediatric health outcomes and how White privilege and implicit bias in nurses can contribute to these outcomes. The problem statement, the purpose of the study, and the research questions (RQs) are presented in this chapter. The conceptual framework and model will be discussed as well as the rationale for the chosen research design. Key definitions and a list of important and relevant assumptions to the research will be stated. I will also discuss the scope and delimitations, limitations, and significance of the study.

Background

Racial health inequities have been shown to affect the lives of U.S. Black children by increasing their risk for illness and hospitalization (Cofer, 2021). Minority pediatric patients are often unfairly treated resulting in disparities in health equity. The recent COVID-19 pandemic brought significant racial disparities in the treatment of hospitalized patients to the forefront of public attention (Centers for Disease Control and Prevention [CDC], 2021b). Yearby and Mohapatra (2021) highlighted that racial minority patients, including pediatric ones, receive poorer quality of care and are disproportionately affected by severe illness. Pediatric patients of color are at greater risks for poor health and mortality in hospital settings. In a study conducted with children who had inpatient operations performed within a 5-year period, Black children who had not presented with any other health issues were found to be at a higher risk than their White counterparts for postoperative complications and death (Nafiu et al., 2020). Research studies that will be further explored in Chapter 2 provide evidence of the existence of racial inequities in the treatment of Black pediatric patients.

Various studies have shown a connection between racial health inequities and treatment influenced by provider bias and/or White privilege. Alang et al. (2021) argued that to combat the racism integrated within the structures of the U.S. health care system, stakeholders must tackle the White privilege that exists. Some health care workers have begun to explore the concept of White privilege and how it may affect their treatment of patients; however, there is a recognized need for more workers to engage in such self-examination (Alexis et al., 2019). Personal biases are also credited within the research for contributing to disparities in health outcomes. Trent et al. (2019), through an exploration of the role of racism in the disparities of pediatric health outcomes, found that there is a dire need for pediatricians to examine their own biases that contribute to these inequalities. Lang et al. (2016) explored implicit bias within the context of ethical standards and systemic oppression in relationship to the causing of harm in the treatment of patients. They found that implicit bias causes harm and asserted that health care workers must examine and critically evaluate their own role in the perpetuation of implicit racial bias in the implementation of care and treatment. In reviewing the literature, I found limited research on the specific role White privilege or implicit bias among providers has in treatment disparities.

Several researchers have expressed the need to address the problem of racial equity in health care. Mateo and Williams (2020) argued that to have implementation of care and treatment that is equal and effective for all patients, it is crucial that each health care professional take individual responsibility to address any possible discrimination and harmful bias. Williams and Cooper (2019) additionally identified the need for more research to be conducted on identifying new ways to support the reduction of health inequities through the building of empathy and support, as well as the capacity within the providers for self-examination and reflection. This study specifically delved into whether providers engaged in this type of self-examination and reflection on their own. Furthermore, I sought to determine whether they did so in their treatment decision-making processes and interactions with patients.

The current literature clarifies the effects of White privilege and bias on health outcomes related to racial health inequities and support the need for further investigation. There was a gap in the literature provider-based bias or experiences of White privilege in treatment decision-making processes and interactions with patients. The authors' findings collectively suggest that contributions to racial health inequities arising from the provider's involvement in implicit bias and White privilege need to be further explored. I addressed this gap in the literature with a specific focus on the treatment of Black pediatric patients.

Problem Statement

There was a need to further explore the ways in which health care professionals, whether aware or not, contribute to the problem of the health inequities that exist among

White and Black Americans. Researchers have found disparities in the treatment outcomes of Black pediatric patients (Nafiu et al., 2020; Yearby & Mohapatra, 2021). Asonye et al. (2020) documented that racism and implicit bias function to preserve disparities in the health care system. Their research demonstrated the necessity for more exploration into contributing factors of racial health disparities to meet the need for creating greater and lasting change. Bailey et al. (2017) showed how racial bias among providers gives rise to adverse health effects due to patients receiving inadequate access to quality health care or receiving substandard treatment. In addition, in one study, health care providers were unaware of their racial bias and how this could contribute to different treatment of patients from racial minority groups and unintentionally cause inequities in health outcomes (Van Ryn, 2016). Furthermore, Vanidestine (2018), through the exploration of policy initiatives addressing racial and ethnic health disparities, discovered that initiatives rarely include contributions of racism or Whiteness; based on the results, Vanidestine stressed the need to focus on individual responsibility as a cause for these disparities.

Researchers have examined the issue of racial disparities in health outcomes among pediatric patients in various ways. However, a gap in the literature and knowledge was found regarding specific representations of White privilege and implicit bias in the lived experiences of White nurse's and their implementation of treatment decisions and interactions with Black pediatric patients, within urban public hospital settings. In this research, I explored the self-examination of White privilege and implicit bias among self-identified White nurses. The study findings may provide a means of understanding the lack of substantial change over time in mitigating racial health inequities and the contributions of individual health providers.

Ample research indicated racial health disparities between White and Black pediatric patients in hospital settings, as well as the influence of White privilege and implicit bias on the disparities. However, there was inadequate attention given to how White health care workers' subjective experiences of White privilege and bias impact the treatment of and interactions with Black patients. Particularly, there was not enough specific insight into how these concepts affect the lived experiences of White nurses and how they implement treatment decision-making processes and interactions with Black pediatric patients, discovered through a self-examination process. The revelations from this study highlight the need for self-identified White nurses and other health care professionals to examine themselves at a deeper level. With greater understanding of White privilege and/or implicit bias and its contribution to ongoing racial health inequities, White nurses may be able to change their beliefs and practices, which may potentially promote deeper change from within. Additionally, the results from this study may support public health policy changes within hospitals. This may happen through the incorporation of new trainings and the implementation of new standards to address the underlying need to bring more attention and awareness to the issue of pediatric racial health disparities in an effective way.

Purpose of the Study

One research design approach that researchers use to qualitatively explore a topic is conducting a basic qualitative study. A basic qualitative study is one that that includes nonnumerical data collection (specifically, interviews) to explore participants' perceptions, conceptions, and/or experiences (Creswell & Creswell, 2018). Researchers who use this design desire to gain valuable insights and bring understanding to the topic being studied. Through a basic qualitative approach, I discovered how influences of White privilege and implicit bias shape and impact nurses as they implement treatment decision-making processes and interactions with Black pediatric patients. Using this inquisitive approach, I explored and gained an in-depth understanding of how these concepts influence nurses' lived experiences, through a self-examination process. Applying a qualitative inquiry perspective to this research helped to promote recognition and understanding of the data through an interpretive understanding of participants' lived experiences. It also helped to bring a deeper perspective and meaning to the influences of perceptions of social reality on the construction of White privilege and implicit bias within the context of application to nurses' natural work settings. Experiences from the context of each participating nurse's own personal histories and social and relational dynamics contributed to the study.

I used a basic qualitative inquiry methodology because it allowed me to focus on obtaining rich and meaningful responses through in-depth quality interviews with participants (Creswell & Creswell, 2018). I used a purposeful sampling size of 13 self-identified White nurses from urban public hospital settings within California to provide the best representative sample. I hope that the results of this study will broaden cognizance and appreciation of the influences of White privilege and racial bias on racial health inequities. Specifically, there is the potential for the results to influence White nurses as they make decisions and interact with Black pediatric patients and their families and help them to change any dynamics that may contribute to disparities in treatment.

Research Questions

RQ1: Does White privilege and/or implicit bias impact and shape the lived experiences of self-identified White nurses in the way they implement treatment decision-making processes and interactions with Black pediatric patients in urban public hospital settings within California?

RQ2: Does bringing attention to personal awareness or unawareness of White privilege and/or implicit bias play a role in decision-making processes and treatment interactions with Black pediatric patients?

RQ3: Does utilizing a personal self-examination process of the impacts of White privilege and implicit bias bring more awareness and attention to how these concepts impact treatment decision-making processes and interactions and shape the way White nurses plan to work with Black pediatric patients moving forward?

Conceptual Framework

For this research study, I drew from Hobbs's (2018) conceptual framework of White privilege and Blair et al.'s (2011) conceptual model of the influences of implicit bias to ground the study. White privilege and implicit bias were the key concepts I used for the study's conceptual framework. Hobbs presented a conceptual framework of White privilege that is centered on the distinguishment of those with White skin from others, in a way that places White-passing people in a position to inherently receive more privilege in society. Blair et al. developed a conceptual model of the influences of implicit bias.

Both concepts were pertinent in the present investigation and comprised the contextual framework for this research study; each has been particularly explored within the health care field in connection to the perpetuation of racial health disparities (Blair et al., 2011; Hobbs, 2018). Together, these concepts provided a context for a greater understanding of the connections between White privilege and implicit bias and how they shape the lived experiences of White nurses.

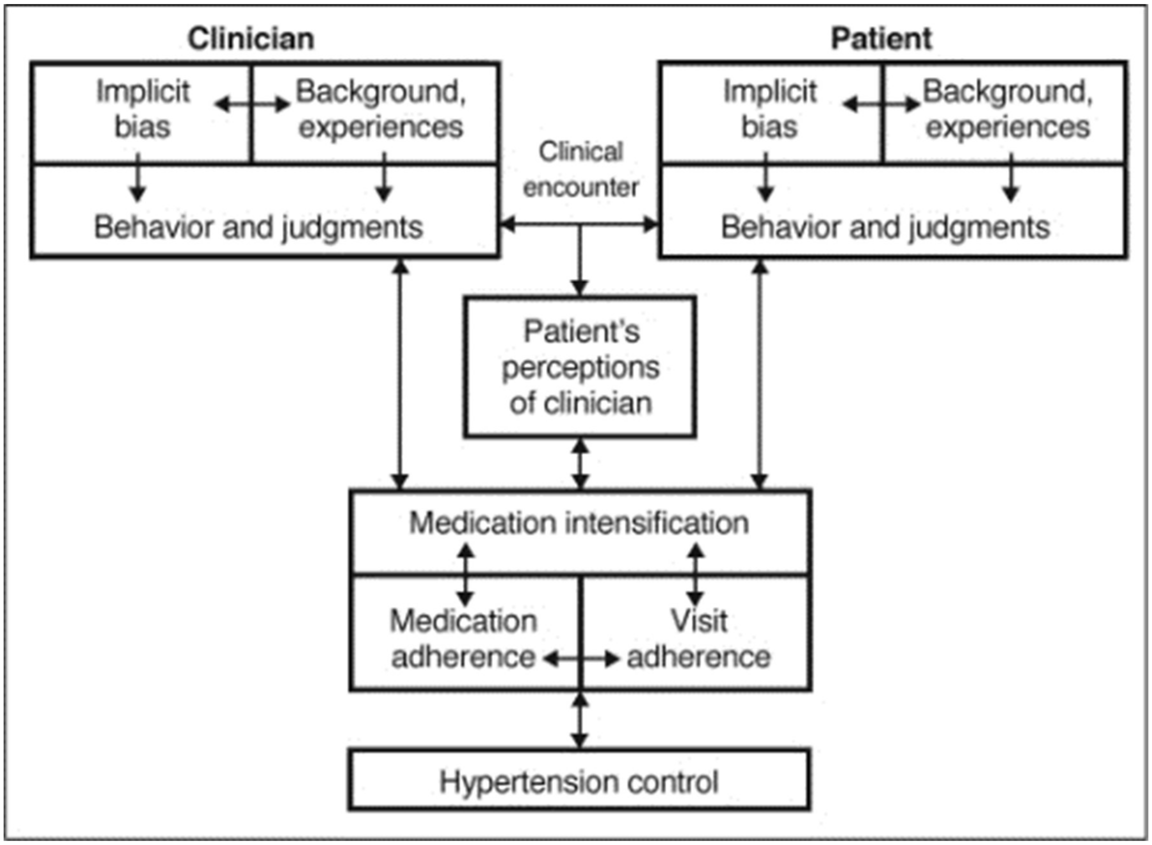
White privilege is a concept, inclusive of something that may be perceived and experienced. The key premise of White privilege is that those with White skin have more intrinsic historical and societal privileges and freedoms than people with non-White skin (Hobbs, 2018). Hobbs (2018) postulated that those who by virtue are White passing have access to privileges and opportunities such as better-quality health care and treatment than others. Whether it is apparent to White-passing people, this occurs within the structures and systems of U.S. society. White privilege also complexly interacts with systems of health care, research shows.

Hobbs's (2018) conceptual framework of White privilege because it utilized a context that promotes an understood definition of White privilege and how it connects to personal racism, whether awareness of it simultaneously exists or not. The framework also provided a reference for understanding the role it plays within the health care system and promotion of health inequities. Blair et al.'s (2011) conceptual model of the influences of implicit bias on hypertension control depicted the process of how implicit bias impacts the way a clinician relates to a patient and the related decision-making process with adult patients. The logical connection to Blair et al.'s model of implicit bias was that it provided an understanding of how background experiences influence a clinician's implicit bias and lead to behaviors and judgments in clinical decision-making and interactions with patients. The concept of implicit bias also provided a means of understanding interpersonal dynamics that exist within the model between clinicians and patients and their contributions to health inequities. Together, the concepts of White privilege and implicit bias provided a framework for understanding how a clinician's beliefs affect their treatment of Black pediatric patients in comparison with their White counterparts within hospital settings.

Blair et al.'s (2011) model of the influence of implicit bias on hypertension control describes the process of how it influences clinical decision-making and interactions with adult patients who have their own developed implicit biases and behaviors and judgments (see Figure 1). I modified Blair et al.'s conceptual model. I eliminated the patient's own developed implicit bias and behaviors and judgments due to this study's focus on pediatric patients and their lack of development in this area (see Figure 2). Blair et al. indicated that implicit bias not only directly impacts clinical decisions but may also impact treatment. Additionally, the modified model focuses more specifically on the treatment decision-making process and outcome, which aligned with the intentions of this study. Furthermore, the modified model incorporates the concept of White privilege stemming from the use of Hobbs's conceptual framework. The conceptual model for White privilege and implicit bias for this study was adapted from Blair et al.'s model and Hobbs's conceptual framework of White privilege. The original model and the adapted and modified model are depicted, respectively, in Figures 1 and 2.

Figure 1

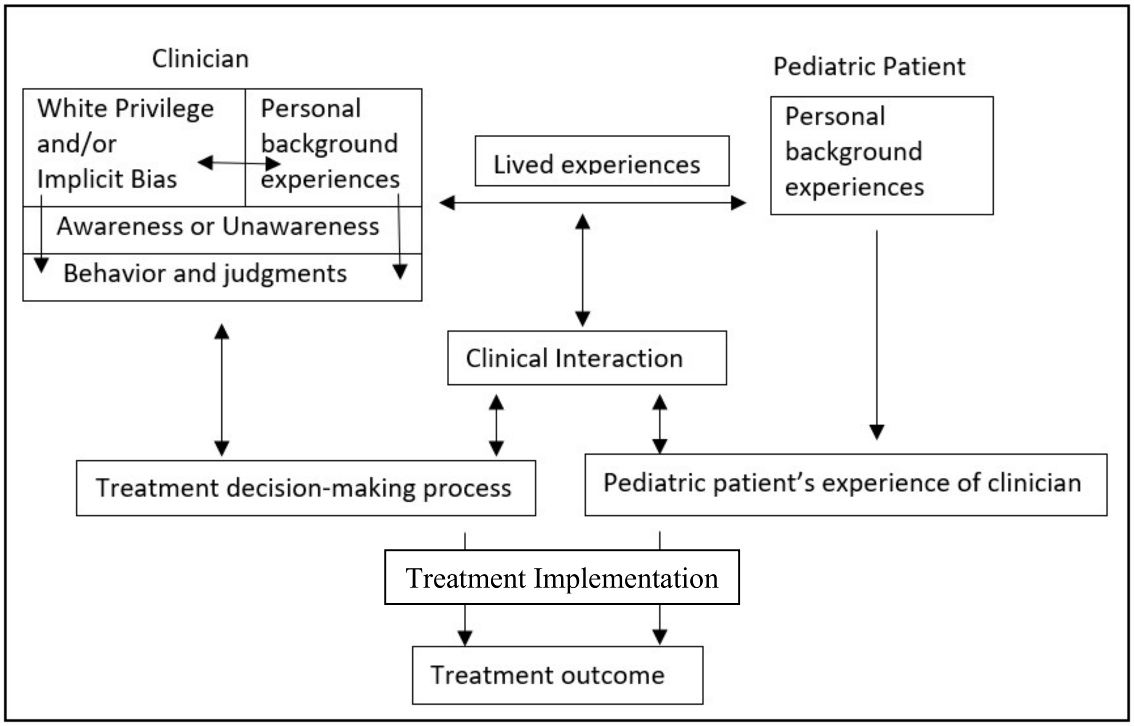
Conceptual Model of the Influence of Implicit Bias on Hypertension Control



Note. Blair et al. (2011) created a conceptual model for understanding the influence of implicit bias on hypertension control and clinical decision-making. From "Unconscious (Implicit) Bias and Health Disparities: Where Do We Go From Here?," by I. V. Blair, J. F. Steiner, and E. P. Havranek, 2011, *The Permanente Journal, 15*(2), p. 72 (https://doi.org/10.7812/TPP/11.979). Copyright 2011 by The Permanente Federation LLC. Reprinted with permission.

Figure 2

Conceptual Model of Influences of White Privilege and Implicit Bias on Treatment Decision-Making and Interactions With Pediatric Patients



Note. This model represents a modification of Blair et al.'s (2011) conceptual model, which specifically focuses on the influence of implicit bias on hypertension control. Adapted from "Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here?," by I. V. Blair, J. F. Steiner, and E. P. Havranek, 2011, *The Permanente Journal, 15*(2), p. 72 (https://doi.org/10.7812/TPP/11.979). Copyright 2011 by The Permanente Federation LLC. Adapted with permission.

As shown in Figure 2, I modified Blair et al.’s initial model to fit this study's specific focus on treatment decisions-making processes and interactions of the clinician with Black pediatric patients. The modified model stresses the impact of White privilege and implicit bias on the lived experiences of White nurses and their treatment of Black children.

Qualitative researchers use conceptual frameworks and models, inclusive of empirical findings from literature, to show relationships among key concepts and how the concepts are connected to the study phenomena (Walden University, 2021). I used the conceptual framework of White privilege and implicit bias to focus all aspects of this study. The basic qualitative inquiry approach of this study fit well within this conceptual framework because the approach could be utilized to explore each participant’s perceptions of how they viewed their own experiences of White privilege and implicit bias within the confines of treatment implementation and interactions with Black pediatric patients. To ensure proper alignment within the study, I used the concepts of White privilege and implicit bias to develop the RQs, as well as the interview and follow-up questions. Furthermore, the themes found within the data analysis process were connected to these key concepts and conveyed in the results. I discuss the study's conceptual framework in greater detail in Chapter 2.

Nature of the Study

I used a basic qualitative inquiry approach featuring one-on-one, in-depth interviews to gather the most amount of rich data possible. Qualitative interviews involve collecting data to gain insights into the perceptions or experiences of people related to a specific topic (Creswell & Creswell, 2018). Interviews were conducted privately over the online Zoom platform. The questions were targeted to gather in-depth information regarding the influences of White privilege and/or implicit bias on White nurses' lived experiences of treating Black pediatric patients. By using a basic exploratory approach, I was better able to understand how White privilege and/or implicit bias shapes the lived experiences of these nurses and how they implement treatment decision-making processes and interact with Black pediatric patients. Data were collected from a purposeful and random representative sample of 13 self-identified White pediatric nurses from California urban public hospital settings who had worked with Black patients.

To interpret the interview data, I performed coding with thematic content analysis. This basic qualitative approach was based on Aliyu et al.'s (2020) qualitative inquiry study with one-on-one, in-depth interviews to discover themes based on perspectives of clinical staff at a large urban public hospital to identify what is needed to prepare for a pandemic. The team used this approach to be provided with the best chance to explore participant's experiences and perspectives with meaningfulness. Thematic content analysis for data processing and reporting was also used. Due to the similarities in study purpose as well as target population, Aliyu et al.'s study design provided an appropriate approach and analysis for this research study. By performing in-depth, one-on-one interviews, I was able to explore participants' experiences and perspectives with meaningfulness.

Definitions

Bias: The adverse appraisal of a group and those within it, based on perceived group characteristics; bias can be expressed either directly or through subtlety (Blair et al., 2011).

Black: Per the contemporary use of the term, a collective racialized identity for individuals of African ancestry (Britton, 1999).

Equitable: Treatment that is diverse, inclusive, equal, and fair (CDC, 2021a).

Explicit bias: An overt bias that entails someone being aware of their appraisal of a group and believing that the appraisal is in some way accurate (Blair et al., 2011). Explicit bias involves the person also having a motive and planning to take related action (Blair et al., 2011).

Health disparities: The differences that exist in outcomes in health among groups of people (Ndugga & Artiga, 2021). Health disparities also encompass the causes of these differences (Ndugga & Artiga, 2021).

Health equity: A situation that occurs when all members of the population have a fair and just opportunity to be as healthy as they can be and when public health policies and programs are focused on the specific needs of the community to promote health equity (CDC, 2021a).

Health inequities: Differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment (National Center for Chronic Disease Prevention and Health Promotion, 2020).

Impact: The effect that interventions have on people, organizations, or systems to influence health (National Center for Chronic Disease Prevention and Health Promotion, 2011).

Implicit bias: A bias that operates in an unintentional or even unconscious manner and that does not require the person who perceives it to endorse it or devote attention to its expression (Blair et al., 2011).

Pediatric: The specialty of medical practice and study that concerns the physical, mental, and social health of children from birth to young adulthood; it includes a broad range of health services encompassing treatment of acute and chronic diseases (Committee on Pediatric Workforce, 2015).

Professional responsibility: Adherence to ethical principles and a sensitivity to patient populations who may differ in terms of culture and/or age, gender, or disability status; professional responsibility requires the demonstration of respect, compassion, and integrity and a commitment to excellence and accountability (Kirk, 2007).

Public hospital: In this study, a hospital that is supported by publicly accessed medical plans in California, inclusive of Medi-Cal and Medicare.

Racism: A system of structures, policies, practices, and norms that assigns value and determines opportunity based on the way people look or the color of their skin, which results in conditions that unfairly advantage some over others (CDC, 2021c). Racism negatively affects the mental and physical health of the people who experience it, which prevents them from reaching their optimum level of health (CDC, 2021c).

Self-identified White: A self-description of being racially and/or ethnically White (Tang et al., 2005).

White privilege: A privilege that White-passing people are in a position to inherently receive more of in society, compared to other individuals due to their having White skin (Hobbs, 2018).

Assumptions

It is important to include researcher assumptions in a dissertation. Assumptions are beliefs that cannot be verified about the proposed research study but are needed to design and carry out the research (Walters, 2001). Researchers seek to examine descriptions found within data without attempting to discover certain findings to prove a self-gratifying prediction (Walters, 2001). Therefore, assumptions were necessary to be able to support and conduct the research. Two assumptions I had for this study were that the Interview guide was appropriate to gain the most pertinent qualitative information possible and that it would accurately collect the information it was intended to.

Another assumption I had is that participants would answer the interview questions with responses that were directly aligned to the content of the questions. I also assumed that participants would answer questions with substance, openness, and honesty. My hope was that they would share rich, meaningful, and true responses about their experiences of White privilege and implicit bias in their work. In an attempt to ensure these assumptions were met, I conducted practice interviews and assured participants that their responses would be kept completely confidential. Participants’ responses were uniquely number coded so that their identities were protected. Furthermore, I held the assumption that this research would uncover patterns and themes that pertained to the focus of the study. I operated under the final assumption that a sample size of 13 nurses was significant enough to draw conclusions on the influences of White privilege and implicit bias in treatment processes throughout the selected hospital sites. These assumptions were necessary for the design and conduct of the study.

Scope and Delimitations

Through this qualitative study, I intended to understand the experiences of White nurses and the impact of White privilege and/or implicit bias on their lived experiences interacting with and implementing treatment practices for pediatric Black patients. The participants were self-identified White nurses working in urban public hospital pediatric wards in California. There was no exclusion based on gender or age of participants; however, they needed to self-identify as White, due to the study's focus on the specific experiences of White nurses. Additional inclusion and exclusion criteria that were used for participation are further explored in Chapter 3. The participant recruitment techniques included a recruitment email from a nursing association list, a flyer posted at one of the approved hospital settings, and postings on a social media platform. At the end of the interview process, each participant received a $20 Starbucks gift card.

The research was narrowed to and focused in on the impacts of the concepts and experiences of White privilege and implicit bias, rather than the broader concept of racism, which was too general to tackle within one study. The ability to generalize the study is limited as there is no evidence that I can provide that the results of this study are relevant to other contexts or settings outside of the selected hospital sites. The purposeful sample was sufficient for thematic data saturation, which may make the results meaningful in other contexts and settings with White nurses.

Limitations

Limitations should be anticipated for any research study, and they should be acknowledged and evaluated to be transparent about potential concerns and challenges (Walters, 2001). There were limitations that I anticipated for this study. Anticipated limitations included the unwillingness of health care providers to participate in in-depth and exploratory qualitative interviews due to the sensitive nature of the topic. Another anticipated potential challenge was researcher personal bias, which can particularly present a risk to qualitative research (Creswell & Creswell, 2018). Throughout the processes of data collection and analysis, I made every effort to maintain impartiality and decrease the concern that personal biases could affect the results. In Chapter 3, I delineate the steps I took to mitigate these concerns.

When conducting a study that is based on interpretation, it is important to select participants through purposeful sampling to ensure that they all have had similar experiences related to the study topic (Bordens & Abbott, 2018). All participants for this study were self-identified White nurses working with pediatric patients in urban public hospital settings within California. They each met the criteria set forth for purposeful sampling. The results from the study describe the detailed experiences of the participants and do not necessarily extend to the larger population of White nurses outside of the preselected hospitals. However, the sample size of 13 reaches thematic data saturation, and, as such, the study has potential to deliver meaningful quality results (Creswell &

Creswell, 2018). According to Tracy (2010), using a purposeful sampling selection boosts the chances of gathering the most complete and comprehensive sample representing the target population. Additionally, the results provide a significant contribution to practical knowledge with a worthy topic, rich rigor, meaningful coherence, trustworthiness, and resonance to similar populations and settings.

In a research study it is very important for the researcher to confirm that their findings are consistent with the collected data. Creswell and Creswell (2018) described dependability as the consistency of the findings with the evaluation of the data collection process and analysis. To achieve dependability within the study, I completed member checking. I used the audio recording feature on Zoom to record each participant interview, and I reviewed the verbatim transcriptions that were transcribed through Otter.ai. I asked participants to review, approve, and send a confirmation email to indicate that the transcription was accurate. Furthermore, throughout the study, I kept an analytic memo with personal notes of my own thoughts and biases about myself and/or the participants throughout the process. The analytic memo became a compilation of written notes on how I internalized and processed the data during the study (see Saldana, 2016). I also kept audit trail notes of interactions with each participant. The data created included notes from before, during, and after each interview.

I also engaged in peer debriefing with a fellow student who was knowledgeable about the methodology and content of the study. Spall (1998) purported that utilizing a peer for peer debriefing permits the establishment of more integrity and honesty within the study, particularly with PhD candidates. According to Bordens and Abbott (2018) trustworthiness of the results is established through the credibility of the data collection process and reliability of the outcomes. The use of member checking, interrater reliability for result confirmation, verbatim transcriptions, analytic memo writing, an audit trail, and peer debriefing all helped to confirm the findings and strengthen the trustworthiness of the study.

Significance

This research study addressed a gap in the literature as to the impacts of White privilege and implicit bias on the lived experiences of White nurses in their implementation of treatment decision-making processes and interactions with Black pediatric patients. This study increased the nurse participants' awareness of White privilege and implicit bias and how both concepts contribute to health disparities in their interactions with patients. Through a self-discovery process of these concepts, the results highlight potential contributions among White nurses in their treatment of Black pediatric patients to the perpetuation of racial public health inequities. The data generated may support the improvement and development of policies and training in public hospitals on the potential influences of White privilege and implicit bias in health care workers' interactions with racial minority pediatric patients.

This study’s findings may bring about positive social change for Black children. Due to the potential for increased awareness of personal White privilege and implicit bias among health care providers, Black pediatric patients may benefit by receiving more equal and fair treatment. There is also potential for increased positive experiences with quality of care and health outcomes for these patients. The results of this study may also support advocacy efforts, education, and training focused on White privilege and implicit bias. Innovative protocols, practices, and policies can be implemented to address the impacts of White privilege and implicit bias in treatment. Furthermore, specific new implementation standards and treatment policies can be designed and implemented by health policy experts and hospital administrators based on the findings of this research.

Summary

This chapter provided an overview of the study delineating the background, the problem statement, the purpose of the study, the conceptual framework, RQs, and the significance of the research. I discussed the overarching concepts of White privilege and implicit bias, as well as how each of these contribute to the promotion of racial health inequities among White nurses. Furthermore, in Chapter 1, I highlighted implications for social change and impacts on health outcomes. In Chapter 2, I will present a more thorough review of prior literature that supports the framework and key concepts outlined in Chapter 1. More specifically, Chapter 2 will include a more in-depth explanation of the health disparities found between Black and White patients, specifically pediatric ones; the conceptual framework of the influences of implicit bias and White privilege explored within the study; and a deeper understanding of the connection between the two.

Chapter 2: Literature Review

Introduction

Racial disparities have existed for a long time in the United States. There is growing evidence of troubling racial health disparities between Black and White children. There have been recent higher morbidity and mortality rates associated with these disparities (Fortuna et al., 2020). These inequities have increasingly come to light since the COVID-19 pandemic. The recent pandemic intensified disparities with Black people accounting for 25% of positive cases and 39% of deaths, while only representing 15% of the total population (Bibbins-Domingo, 2020). Non-Hispanic Blacks have had the highest death rates from COVID-19 (Phillips et al., 2021). Due to increasing disparities over time, people from racial minority groups have been more affected by COVID-19 with increased risk for illness, hospitalization, and fatality than people from nonracial minority groups (Romano et al., 2021).

Racism is a factor in these disparities, research shows. Blankenburg et al. (2020) and Yearby and Mohapatra (2021) found that racism is a significant contributing factor that leads to health care injustices including poor health outcomes and increased morbidity and mortality rates. Furthermore, Blankenburg et al. spurred the Association of Pediatric Program Directors to recognize that antiracism awareness needs to be at the forefront of the minds of health care workers and implicit bias must be adequately and deeply addressed. Other researchers have indicated that self-awareness and reflection among White health care providers on their own contributions to bias and privilege is critical to truly dismantle the structures resulting in these health disparities (Alexis et al., 2019; Romano, 2018; White et al., 2018). The American Academy of Pediatrics (AAP, 2020) and, later, Lipman and Hawkes (2021) highlighted the complicities within providers and the need for them to embrace their own biases and reflect on their internal processes that may contribute to racial injustices and their significant impact on the health status of children. Furthermore, Reed (2020) identified the need for existing research to include more types of medical providers and patients to yield a stronger understanding of the impacts of privilege and bias on racial health inequities. Each of these highlighted pieces of literature came together to acknowledge the gap in literature this study addressed.

There were concerning gaps found in the literature on health disparities that merited further investigation. More exploration was needed to determine why these disparities occur and how pediatric health care workers may individually contribute to the perpetuation of the problem. The purpose of this basic qualitative inquiry study was to gain a better understanding of specific lived experiences of White nurses and the impacts of White privilege and implicit bias as these professionals make treatment decisions and interact with Black pediatric patients within an urban public hospital setting. In the first part of the literature review, I review the research strategies that I used to locate articles. I then discuss the concepts of White privilege and implicit bias, which constituted the study's conceptual framework. The literature review that follows addresses a range of topics pertinent to the investigation, including racial health disparities in the treatment of Black patients, the impact of White privilege and implicit bias on treatment disparities and decision-making processes, and self-examination of white privilege and implicit bias a professional responsibility.

Literature Search Strategy

For this research, I searched for, compiled, reviewed, and annotated literature relevant to the problem of racial health inequities in the treatment of Black pediatric patients. The focus narrowed to impacts of White privilege and implicit bias on these treatment outcomes as addressing racism and racial health inequities was too broad for the purpose of a single study. To access literature for the study, I used Walden University Library's Thoreau multidatabase search tool and the search engine Google Scholar. The keywords and terms I used to search the literature were *healthcare and racial disparities*, *healthcare and pediatric racial disparities*, *health inequities and pediatrics*, *health inequities and pediatrics and hospital and United States*, *pediatric treatment and racism*, *White privilege and healthcare*, *implicit bias and healthcare*, and *implicit bias and healthcare and model.* An iterative process was used to determine the key words and phrases for this review to narrow the focus and obtain an adequate number of relevant articles. An example of using an iterative process was narrowing the focus of the searches in the Thoreau database from *healthcare and racial disparities* to *healthcare and pediatric racial disparities,* which provided a more manageable number of articles. The search for the terms *health inequities and pediatrics* in the Thoreau database was also tightened by including the keyword *hospital* to obtain better results with several relevant articles. Additionally, within Google Scholar a keyword search for *pediatric treatment and racism* provided too many results. However, by sorting by date with the most recent at top, I was able to find several relevant articles. I limited all searches to peer-reviewed articles, and some searches were also limited by date to obtain relevant and manageable results. Most of the 55 articles include in this literature review were published in 2018 or later; however, the articles had publication dates that ranged from 1999 to 2021. Articles used to provide a strong foundation of seminal research and for the conceptual framework are included within this count. Earlier articles were only included due to their high relevance to the concepts being examined.

I used the selected articles to illuminate the impact of White privilege and the influences of implicit bias on racial health treatment disparities with pediatric patients. I was interested in the impact of these concepts on White nurses in their treatment of pediatric patients. However, I found a very limited number of articles tying together specific ways these concepts influence nurses within treatment decision-making processes and interactions that impact pediatric racial health inequities. The focus of this dissertation was on gaining insights into this area that presented a lack of information in the literature. Learning about the lived experiences of White nurses and the impacts of White privilege and implicit bias on their treatment decision-making processes and interactions with Black pediatric patients was crucial. The insights gained can potentially support positive social change, resulting in a shift in the treatment and health of Black children.

Conceptual Framework

For decades, racism has been interwoven within the fabric that holds the United States together. Individuals perpetuate racism by holding onto personal prejudices and biases (Gee & Ford, 2011). The conceptual framework centered on Hobbs's (2018) conceptual framework of White privilege and Blair et al.'s (2011) conceptual model of the influences of implicit bias. The background literature supported the use of both concepts for the purpose of this dissertation. The examination of White privilege and implicit bias in this study may contribute to further research and prompt new studies within the health care environment.

Hobbs (2018) presented a conceptual framework for White privilege that distinguishes advantages and privileges afforded to White people that are not available to others of a different skin color. He purported that White privilege is fundamentally connected to racism that is either structural, personal, or both, regardless of whether an individual is aware of their privilege. He identified White privilege as a prevalent problem within the United States health care system and promoted action to address the health disparities that exist because of it. He argued that implicit bias plays an underlying role at the individual level within the health care system connecting back to the formation of White privilege. Hobbs also contended that it is critical for White people to fully grasp the impact of White privilege on those who are non-White to completely understand it and its power. He stressed the importance of recognizing one's own White privilege and taking personal action towards mitigating it for there to be movement towards actual change. The emphasis that Hobbs placed on the impact of White privilege as well as its link to implicit bias grounded the framework for this study.

To tie implicit bias more directly into this study, as well as ground the concept more within the field of health care, I used a conceptual model of the influences of implicit bias on provider and patient interactions. Blair et al. (2011) provided a model on the influence of implicit bias on hypertension control within clinician and adult patient interactions that is shown in Chapter 1 (see Figure 1). They stressed that examining the experience and influence of implicit bias on health providers as they treat patients can increase understanding of the issue, and eventually help to eliminate health disparities. Blair et al. defined implicit bias within this model as a bias that occurs at an unconscious level, unknowingly and unintentionally, that does not require the perceiver to engage in it but is cued by a particular perception occurring within a situation. Considering differing ways researchers have used a framework of implicit bias, Blair et al.'s definition of implicit bias and the model used best fit with the framework and foundation for the study.

White Privilege and Implicit Bias

To fully understand the focus of this study, of which the intention was to explore the impacts of White privilege and implicit bias on the lived experiences of White nurses, it was important to understand the concepts of White privilege and implicit bias. For the purposes of this study the term *White privilege* was defined as the privilege that White-passing people are able to inherently receive more of in society due to having White skin (Hobbs, 2018). Frameworks have been established to understand the role White privilege plays within the U.S. health system and some research on the concept has been conducted. Vanidestine (2018) explored how policy initiatives addressing racial and ethnic disparities conceptualized race and racism. He discovered initiatives minimally addressed contributions of structural factors such as the privilege of Whiteness and analysis of racism and Whiteness within the discussion of racialized health outcomes.

Vanidestine stressed the importance of further exploration of the connection between individual responsibility and structural racism to address racial health inequities. Later, Vanidestine and Aparicio (2019) studied how health care professionals viewed and understood the definitions of words related to health and race including the terms *race*, *racism*, and *Whiteness.* They examined this with the claim that it is easy for people to engage more in their sustained beliefs, rather than embrace more difficult information such as Whiteness being related to racism or advantages people have from White skin color such as living longer. They found that professional participants described each of the terms as ‘self-defined skin color’ and Whiteness with the concepts of privilege and power. This research highlighted the idea of focusing on the self-identification of Whiteness and its association with privilege that contributed to the significance of this study. It also emphasized a need for further exploration of the connection between individual responsibility and the contributions of structural and historical racism to address racial health inequities.

Researchers have signified the rootedness of Whiteness and White privilege within the individual and shared experiences of people. They further connected this concept of Whiteness to the core cause of racial health inequities (Yearby, 2020). Limited earlier studies linked to connections to poorer health outcomes for non-Whites. Early studies showed that White privilege and social status work together to influence health outcomes, leading to Whites ultimately having better treatment and health than their non-White counterparts (Krieger et al., 1999). Moreover, Krieger et al. (1999) and later Lang et al. (2016) argued that racism, with White privilege as an intricate factor, harms health.

There was an indicated need to further explore this harm to health, with White privilege as a factor of causation, and the link to racial health inequities.

Research indicated that implicit bias goes hand in hand with White privilege. Hobbs (2018) argued that implicit bias plays an underlying role at the individual level perpetuating the built-in racism and privilege within a health care system. General bias is a maintained problem in the health care field. Implicit bias goes along with this, as it is an example of bias that plays out in a single moment rather than within an ongoing thought process and is found to be a main contributor to racial health inequities. For the intentions of this study, *implicit bias* was defined as an indirect bias that operates in an unintentional or even unconscious manner that does not require the person who perceives it to endorse it or devote attention to its expression (Blair et al., 2011). Maina et al. (2018) synthesized recent literature that used the Implicit Association Test with health care providers. They found that provider implicit bias played a role in racial disparities though only a few studies were conducted in the field of health care. They found mixed results from 37 studies indicating some form of implicit bias playing a specific role within disparities. The researchers concluded that there was an increased consistent correlation of provider bias with poor patient-provider interactions. Their research identified areas for continued study of implicit bias in everyday patient care including how potential outside factors could affect it within various cases. Many researchers have studied implicit bias; however, after review, Blair et al.'s model provided an understanding of it within the context of the clinical decision-making process in the health care environment, which aligned best with the framework of this study.

Literature Review Related to Key Concepts

Racial Health Inequities in Treatment of Black Patients

There has been some attention given to racial health inequities in the literature; however, the COVID-19 pandemic has spurred much more. Inequitable deaths of minority groups are becoming a more known and accepted truth. Recently, disparate mortalities among marginal and impoverished populations became more publicly transparent (Fortuna et al., 2020; Yearby & Mohapatra, 2021). Fortuna et al. (2020) argued that racial inequities built into systems of care in the United States have generated stressors among minority groups. These stressors lead to illness which produce a greater likelihood of poor health outcomes. One group of researchers concluded that Black mentally ill patients experience health disparities at a higher rate than White patients due to inequitable access to certain medications and differential treatment not due to being ‘sicker’ but due to influences of racism and implicit bias (Asonye et al., 2020). These researchers played an important role in addressing how literature describes disparities in health. They brought attention to the impacts of implicit bias and racism on health inequities and their continued status quo. This research was significant to my research because it brought to the forefront the role of implicit bias within health care and its contributions to health inequalities.

Peek et al. (2021) conducted an analysis of pertinent bioethical principles, various factors impacting health, and practices within public health in the United States to attempt to address worrisome disparities in mortality among Black and White patients. The researchers asserted there are distinct disparities that have surfaced throughout the pandemic and acknowledged a need to address the troubling gaps in literature and knowledge to understand the roots of inequitable outcomes more completely. This analysis was significant to this study because it highlighted the need to address the acknowledged disparities along with gaps in literature.

Inequities in Treatment of Black Children

Although health inequities have presented themselves for all age groups, this research focused on children. Racial health disparities have been shown to start as early as preinfancy. Condon et al. (2019) found that especially Black mothers' experiences of racism and unequal care transfer through vicarious racism to their children. The researchers conducted a cross-sectional urban study in Connecticut looking at child biomarkers of toxic stress in 54 mothers and their children aged 4 to 9 years old from low-income neighborhoods. They found that the toxic stress in mother's resulting from the impacts of the experiences of racism and unequal care transfers to their infants during pregnancy leading to poor health outcomes later for their children. Another study conducted by Horbar et al. (2019) looked at the degree to which preterm and low-birth-weight infants were segregated and receiving unequal care among neonatal intensive care units (NICUs) in the United States. The study included 743 NICUs and 117,982 Black, Hispanic, Asian and White infants born early between the start of 2014 to the end of 2016. They found that Black, Hispanic, and Asian infants were segregated from White infants in NICUs and received inadequate and differing quality of care. Black infants received care at the lowest quality. Furthermore, Beck et al. (2020) explored the impacts of racism, discrimination, and inequity on the health and welfare of minority newborn infants and their families, focusing on examining preterm birth and lower quality of care. They asserted that health care workers must address the range of determinants including racism that shape long-term outcomes before advances in care are experienced by infants and their families. Each of these studies were important contributions to my research because they stressed the significance of the trends of health inequities affecting those as young as infancy that continue to impact Black children of all ages.

Several other studies across disciplines in health care have highlighted racial health disparities among Black children. An example is a survey study that found that racism is likely to significantly affect differences in the severity of atopic dermatitis (the most common skin disease in children) between Black and White children (Tackett et al., 2020). The study was focused on domains connected to structural racism with 201 pediatric atopic dermatitis patients aged 0-18 (Tackett et al., 2020). Furthermore, studies from different fields examining connections between racial health inequities and surgical outcomes found that Black children have a higher risk for post-operative complications and death (Ingram et al., 2020; Nafiu et al., 2020). In a systematic review of disparities in appendicitis, Ingram et al. (2020) analyzed nine studies from 1983 to 2020 that included 350, 408 pediatric cases across the United States. They found relationships between race, age, and unequal treatment, rates of misdiagnosis, time to surgery and outcomes in childhood appendicitis. They asserted that further research is needed to better understand and diminish the disparities in pediatric surgical care. Nafiu et al. (2020) studied racial differences in surgical outcomes among seemingly healthy children through a retrospective study of 172,549 cases from 2012 through 2017. They found that even among healthy children, Black children in comparison to their non-Black counterparts, were 3.43 times more likely to die within 30 days of having surgery, had 18% higher likelihood of having complications post-surgery, and had 7% greater probability of developing severe adverse occurrences. They concluded that more needs to be understood to fully explain the underlying factors that contribute to the racial inequities found in the outcomes. Each of these studies, although having found a link between racial inequities and health outcomes, fell short in determining what specific factors lead to these disparities in children which was a focus of this study.

Black children have been found to experience assessment and care with less attention and quality than their White equals. Jabbour et al. (2018) conducted a qualitative and systematic review of databases for articles that focused on racial, ethnic, or socioeconomic disparities related to pediatric otolaryngology conditions. They synthesized available evidence regarding health care disparities and demonstrated potential impacts from patient and provider interactions, with children ages 0 to 18. They found that 39 out of 711 identified abstracts met inclusion criteria. Disparities were identified in nearly every subspecialty within pediatric otolaryngology and 21 out of 61 identified non-White race as a disparity. They concluded that minority children overall received less quality care and attention. This evidence suggested a need for more exploration into the root of the disparities as well as interventions to address the disparities at various institutional and professional levels.

Research of health disparities has been connected to many other branches of health care as well. For instance, Broder-Fingert et al. (2020) found that minority children with autism spectrum disorder are diagnosed later than others, have more difficulty accessing treatment services, and experience worse health outcomes. Another study looking at the association between race and the type and number of emergency department consultations given to pediatric patients found that White males had a 194% higher chance of receiving a specialty consultation in comparison to Black patients (Balter et al., 2021). Unequal access to adequate care and treatment linked to racial health disparities has been shown across all levels of care from the start of diagnosis and assessment to treatment outcomes. Rondini and Kowalsky (2021) purported that racism and racial disparities are integrated into established health care system guidelines. They provided the example that pediatric UTI testing guidelines are based on assumptions that Black patients meet a higher threshold of illness severity and duration. Similarly, Krist et al. (2021) found that recommendations the United States Preventive Services Task Force proposed to target the prevention of childhood obesity could not continue to be delivered due to the promotion of existing health inequities. They found that referring children and adolescents to behavioral interventions to encourage weight improvements were not interventions that would be equitable to people of color. The research indicated that racial health inequities among children are prevalent across settings and fields. Although this has been ascertained, a review of the research indicated there was a gap in the literature. Exploration needed to go further into the root causes of these disparities in the health outcomes of children, which aligned with the intentions of this study.

White Privilege and Implicit Bias as Contributors to Racial Health Inequities

White privilege and implicit bias are important factors contributing to the root causes of racial health inequities in the United States. Researchers have shown that White privilege and implicit bias are interwoven into the system of health care and that it needs to be more dissected and examined closely at the individual level to untangle it and bring about change. There was a need for new research to be conducted to more fully understand the structural racism that holds White privilege and implicit bias in place within the individuals who exist inside institutions. White privilege was found to influence the quality of care received by minority hospitalized patients leading to unbalanced effects in treatment (Yearby & Mohapatra, 2021). Research found that interpersonal racism with an expression of either explicit or implicit bias was experienced by Black patients who are more likely to experience an encounter with a White physician than a Black one (Yearby & Mohapatra, 2021). The researchers also referenced a study that found that increasing the number of Black doctors to counter Black patients' experiences of White doctors exhibiting privilege and bias, could lower the rate of Black people dying from heart-related problems by 19% (Pallock et al. as cited in Yearby & Mohapatra, 2021).

Furthermore, Menconi (2020) argued that racial privilege and bias built into the health care system influences the handling and treatment of severely ill Black patients. This was clearly demonstrated through the choices made for ventilator allocation during the recent pandemic, impacting the treatment of Black Americans of all ages. The scale used to triage patients for ventilator allocation placed Black Americans at the lower end of survival. This was due to ruling them out for allocation because of having chronic conditions they are 30% more likely to suffer from. This research clearly demonstrated that there is racial privilege and bias built into the health care system that needed to be further understood and addressed. Bailey et al. (2017) asserted that there is still much controversy around the root causes of the persistent racial health inequities that exist. They argued that the factors that hold the system in place at the structural and individual level must be further explored. They also purported that along with White privilege and general bias, racial implicit bias, a bias that occurs at a more immediate level, showed to contribute to health inequities, in a more minute however direct way (Bailey et al., 2017). The research exemplified an overall need for both White privilege and implicit bias to be further examined within the context of racial health inequities to reduce their presence within the systems of care that perpetuate them.

To change the dynamics of White privilege contributing to Black children's experiences of poorer health, the roots of it must be fully understood and the different ways it permeates the health system must be confronted. Researchers acknowledged that providers, and especially leaders in medicine, regardless of their personal background, conduct their work within an atmosphere of structural and institutional White privilege (Rodriguez et al., 2021). This structural and institutionalized White privilege attributes the notions and benefits of being White to institutions that have become associated with White racial identity (Rodriguez et al., 2021). White privilege, by those who yield it, especially in the field of medicine, can easily overlook it and misunderstand it and the harmful effects on those that suffer because of it (Rodriguez et al., 2021). Understanding

Whiteness connected to privilege is essential to dismantling the lived realities of people and the ways they interact as it is ultimately interwoven within the history of the United States. Alang et al. (2021) examined three core functions of public health and essential public health services and determined that structural racism sets up policies and practices within U.S. institutions that result in White-passing people benefitting from advantages. Along with these advantages, there is a structure to maintain and defend them that perpetuates the racism contributing to health inequities. These arguments were essential to this study because they brought to the forefront the significance of White privilege, its impacts on the individual within society, and the presented need to delve into understanding it more at a personal level.

Recently, some quantitative researchers indicated that it is challenging to determine clear empirical evidence of root causes of racial health inequities due to the complexity of racial influences and subtleties involved in factors contributing to the influences (Rosenbloom et al., 2021). One study synthesized research and examined disparities in pediatric anesthetic care for 69, 350 patients across the studies that met inclusion criteria (Rosenbloom et al., 2021). They found that there was diverse research conducted with evidence of low-quality (Rosenbloom et al., 2021). The researchers argued that more thorough study designs and enhanced data are needed to gain a full understanding of racial health disparities through a quantitative lens (Rosenbloom et al., 2021). Through review, quantitative studies mostly yielded results with low significance though there were a few indicating that White privilege may perpetuate health inequities within areas of neuropsychology, health insurance, and treatment outcomes (Cory, 2021;

Young, 2020). However, overall, qualitative studies yielded more promising results over quantitative studies or anecdotal evidence to direct continued study. This study followed this notion leading to a qualitative study design.

When examining White privilege, it was also important to examine implicit bias as it connectedly plays an important role in contributing to racial health inequities. White privilege and implicit bias together directed the framework for this study. In addition to White privilege, implicit bias was found to play a role in the facilitation of treatment and outcomes. Bailey et al. (2017) analyzed forms of structural racism as a determinant of health among a variety of disciplines, including health in the United States. They found evidence from a review of several studies that people received inadequate health care and substandard medical treatment because of explicit or implicit racial bias. A need was identified by the researchers to further explore how providers acknowledge and experience implicit bias as it relates to facilitating treatment.

A few studies explored whether there is a direct connection between racial implicit bias and treatment outcomes. Ingram et al. (2020) conducted a systemic review using search terms related to disparities in the pediatric care of appendicitis and found that although the existing literature was limited, racial inequalities are an influencing factor on treatment outcomes. The authors highlighted racial inequities within the treatment and management of children during their time of surgical care. Furthermore, disparities in treatment outcomes were notably found in pediatric patients and exacerbated by implicit bias of providers in hospital emergency departments (Raphael & Oyeku, 2020). Researchers examined disparities found in the analgesic treatment of pediatric patients in the emergency department setting and highlighted the demonstration of the impacts of implicit bias and need to further explore its contribution to the inequities (Raphael & Oyeku, 2020). These studies reinforced the call for more research to be conducted in this area, which supported the focus of this study.

Other researchers have highlighted a direct link to the important intersection of White privilege and implicit bias within structural racism to health care treatment inequities in children. Bailey et al. (2021) noted the historic contribution of structural racism within health care which demonstrates itself through examples of White privilege and implicit bias within treatment disparities. Results from another study concluded that unintentional bias among providers can impact decision-making processes in the treatment of patients from racial minority groups. The researcher found that implicit bias can happen unintentionally and cause inequities in health especially during the care of Black pediatric patients (Van Ryn, 2016). Some researchers have acknowledged that a change in treatment policies that bring more awareness to privilege and bias could make a difference. In a retrospective study, Lipman et al. (2020) found racial inequities to be persistent over a 15-year period (2011-2019) in the use of insulin pumps for pediatric diabetes. These researchers stressed the significance of health care providers needing to be aware of the disparities in treatment and argued that standardized treatment protocols may reduce unconscious bias. There has been adequate research presented on the impacts of privilege and bias, however researchers more suggestions on more specific ideas to address these issues moving forward have been needed. The research indicated a current need for more exploration of health care provider’s individual implicit racial biases and experiences of privilege to understand how it shapes interactions within pediatric treatment. This specific gap in the research was significant to propelling the course of this study.

The Influence of White Privilege and Implicit Bias on Treatment Decision-Making Processes and Interactions

Both White privilege and implicit bias, being inter-connected, play a part in the way providers make treatment decisions and interact with patients. Blair et al. (2013) conducted one of the first studies specifically examining clinicians' implicit bias in the context of their current clinical relationships. They explored whether it connected to Black and Latino patients' experiences of care. They found that implicit bias may be particularly problematic to clinicians' clinical interactions with Black patients and could therefore negatively impact other provided care. Contrary to other research, the study also suggested that clinician implicit bias may contribute to disparities in treatment outcomes (Blair et al., 2013). Dehon et al. (2017) reviewed literature and found inconsistent evidence regarding the effects of provider implicit bias. They found a limited number of studies showed that implicit bias does not influence provider clinical decision-making however other studies showed that implicit racial bias does negatively affect patient-provider interactions, indicating that provider implicit racial bias may indirectly contribute to racial health inequities. They suggested that future studies focus on exploring implicit racial bias and decision-making using clinical scenarios not associated with standardized protocols that had been used, to be able to account for the range of clinical presentations possible among patients. Like Dehon et al., Fitzgerald and Hurst

(2017) found through a review of literature that health care providers showed the same level of implicit bias as people in the wider population. They also found that provider-patient interactions, due to the various nature of patient characteristics, demonstrated a complexity in how implicit biases influence treatment decisions. Overall, they found that it is likely that biases impact diagnosis, treatment decisions, and level of care. Furthermore, they discovered that there is a distance from the norm in the exhibiting of proper impartiality in these processes on the part of the provider. Additionally, other studies have found more direct connections of implicit racial bias negatively impacting provider-patient interactions (Godsil & Richardson, 2017; Reed, 2020). In summary, through studies conducted specifically on provider implicit bias, researchers have showed a relationship between racial implicit bias and provider-patient interactions.

Self-Examination of White Privilege and Implicit Bias as a Professional Responsibility

The harm that White privilege and implicit bias causes within and throughout racial health inequities specifically for Black patients was presented in the literature. Literature also acknowledged that professional responsibility is a key factor to be able to bring change. Maina et al. (2018) conducted a study to synthesize the research that had been conducted on implicit bias within the health care field looking at the role of provider bias in health disparities. They had found that only a few studies had been conducted in the field of health care compared to other fields. Within 37 qualifying studies out of hundreds, they found that the seven that studied the impact of provider implicit bias on interactions with patients showed that poor provider-patient interactions and communication resulted from providers holding stronger implicit bias. Due to the results shown, the researchers concluded that more research on implicit bias is needed in real-world care of patients, factors affecting it during care, and strategies to target the reduction of implicit bias and therefore help improve provider-patient communication. These conclusions were significant because they amplified the need for further study on implicit bias within provider responsibility specifically, which aligned closely with this study.

A plan of action has been needed to mitigate this implicit bias through acknowledging it within the context of providers and how it negatively affects patients. Researchers in the oncology field found that although awareness of implicit bias and its influences on providers is increasing, health care professionals need to take on more responsibility to advocate and protect young patients (Martinez-Kaigi, 2020). They stressed the importance of self-awareness to bring about potential change within the provider regarding their own sense of privilege and implicit bias (Martinez-Kaigi, 2020). Through examination of evidence within the literature, the research provided numerous examples of the negative effects of White privilege and implicit bias on patients and reinforced the need to explore the issue further through the lens of the provider.

Recent research indicated that White privilege and implicit racial bias needed to specifically be critically evaluated within a self-examination process of health care providers. It has been discovered that racial competency training has been increasingly important for health care workers. For example, Reed (2020) presented data from patient interviews on the impacts of bias within the changing conversation that is occurring nationally on race. However, broadening the data to include the perspective of health providers would help to gain a better and deeper understanding and awareness of their own biases on patient experiences. The research acknowledged this bias exists. Although more pro-White bias was shown in a study among health providers who were not doctors or registered nurses, higher levels of anti-minority bias was found among the doctors and registered nurses (Tajeu et al., 2018). Lang et al. (2016) purported that implicit bias causes harm and that health providers must critically evaluate their own role in perpetuating implicit racial bias in the care of treatments. They examined implicit bias within the context of structural oppression and ethical standards related to causing harm in treatment. There was little literature exploring provider-based contributions to harm found from experiences of White privilege and implicit racial bias, through a self-examination process.

The research indicated that a duty is placed on the individual provider to take professional responsibility for their own examination of White privilege and implicit bias in their work. The AAP (2020) published a policy statement that identified racism as a driving force of health inequities and as a primary social determinant of health. The AAP has taken the stance that with a country that has mostly children of color, it is essential to support healing by examining personal truth and growth with honest reconciliation. This position of the AAP highlighted the need to embrace the personal process of acknowledging change that must occur from internal reflection. Researchers agreed with the statement from the AAP and emphasized the need for health providers to engage in a self-examination process through providing obvious attention to their potential personal contribution to racism (Vanidestine, 2018; Williams & Cooper, 2019). In response, Kowalsky et al. (2020) reported that the AAP's 2019 statement underscores the work taken on by scholars and scientists regarding racial health inequities, however, acknowledged the need for action. They supported the AAP's proposed integrated approach to combating racism through untangling the web of privilege and racism within systems impacting the health of children. Moreover, they acknowledged the critical need to address biases and interpersonal relationships with patients in the health care environment. In summary, focusing on a provider's individual initial awareness of one's role, responsibility and contribution through self-reflection, and interpersonal interactions with patients were found critical to move towards changing the dynamics of racial health disparities.

Some researchers explored components of the steps health care providers should take to engage in personal examination of their own contributions to privilege and bias, and ultimately racial health inequities. Addressing awareness was found to be an important factor to starting the process of recognizing the problem, not only in the research but in the health field as well (Romano, 2018). One qualitative study examined responses to a training designed to increase awareness of White privilege within health care providers (Alexis et al., 2019). The results indicated that the providers felt a sense of camaraderie with others of the same race and that the training overall caused them to reflect in a new way on their own attitudes and behaviors that contribute to the perpetuation of racial health disparities (Alexis et al., 2019). Another qualitative study examined the knowledge and perception of White privilege among child life specialists and its impact on patient and family care within a hospital setting (Jamar Lee, 2021). The researcher concluded that the participants in the study were able to define White privilege, share their perceptions of it, and grasp the impact on patient and family-centered care with the inclusion of the implications of their own attitudes and treatment of patients (Jamar Lee, 2021). Both studies demonstrated the contribution of qualitative studies in the research and steps toward the ability to gain insight into understanding influences on racial health inequities at a personal level. This perspective contributed to the direction of this study.

Additional research also indicated that attention to awareness of one's personal level of contribution to racial health inequities is the first step towards their mitigation, however deeper examination is also needed. In response to perpetual racial health inequities, White et al. (2018) implemented a course on cultural competency focusing on culture, medicine, and self-reflection. Many courses addressed the issue of treating patients from different backgrounds; there were very few that have centered on the provider themselves and helping to overcome the influences of their own cultural background and personal unconscious biases. In White et al.'s study, participants reported increased awareness of their blind spots at the end of the course. They also acknowledged that it would take reflecting on and paying attention to their biases for the rest of their lives to alleviate them. Furthermore, a survey following a longitudinal case conference curriculum, developed to address the influences of structural racism and implicit bias on provider care, showed that after participation most respondents indicated an elevation of personal reflection on implicit bias and a desire for change in future clinical practice (Perdomo et al., 2019). This study demonstrated that there was a need for both personal awareness and self-reflection to initiate change. A mixed-method study was conducted with faculty and residents in the South who spent time in a 4-day intensive learning about structural racism and justice designed to teach residents about cultural humility and increase their knowledge and understanding of structural racism (Marbin & Schudel, 2020). The authors found that the course objectives were met, and results revealed important lessons such as the need to sit with discomfort, create momentary spaces for healing, and acknowledge that learning may happen over an extended period (Marbin & Schudel, 2020). This study complemented the research by Perdomo et al. (2019), indicating the importance of both awareness and further self-reflection and examination to address personal impacts of providers on racial health inequities. Although there was little research conducted in this area, what does exist spurred the need for more and has the potential to provide significant contributions to the medical field for providers.

Even though there was very little research to indicate so, another way researchers acknowledged the importance of awareness in the process of addressing bias to reduce racial health inequities is through ensuring attention is provided to factors that may exacerbate biases in different settings. One earlier study that examined potential sources of racial health disparities found that providers under high time pressure and stress were more likely to shape their decisions in treatment in a way that disadvantaged Black patients (Stepanikova, 2012). They implied that providers should be aware of conditions that may impact implicit racial bias. Additionally, Maina et al. (2018) through a review of many studies found studies indicating a link between stress and higher rates of implicit bias. Then later, Narayan (2019) and Brockett-Walker et al. (2021) discovered that providers who are impacted by any level of either internal or external stress factors have a higher likelihood of relying on their initial responses and reactions such as implicit bias. These factors could come from any potential source within the present context or from experiences within the history of the provider. In summary, each of these researchers indicated the importance of addressing and fully understanding all the factors that may contribute to implicit racial bias and prejudice through White privilege in the health care field through a more in-depth fashion, including deeper exploration of internal ones within the provider. These components together identified and fueled the path for this study.

Summary and Conclusions

In summary, this review of literature indicated a current problem of racial health inequities in children, especially found within the review of treatment processes and outcomes. Researchers acknowledged that further research needed to be conducted, particularly regarding personal contributions of health providers (Marbin & Schudel, 2020; Perdomo et al., 2019; White et al., 2018). Although there were more quantitative studies in these areas to date, the literature suggested that qualitative studies were possibly a more effective path to focus on contributing factors to personal racism such as White privilege and implicit bias. Through a qualitative approach, it was possible to examine in-depth self-exploration of awareness and reflection on these personal components. Blair et al. (2011) argued that concepts such as implicit bias and White privilege cannot be measured within a survey and that the questions that needed to be asked required in-depth exploration of understanding. For instance, the implicit association test that is commonly used to study implicit bias looks at the concept from a particular perspective other than from a personal perspective of how it impacts one's life in a deep way. The concepts of White privilege and implicit bias were found to be main attributes to personal contributions to the perpetuation of racial health inequities. Furthermore, recent studies in a body of research signified that being a child does not protect against experiencing implicit bias in health, calling a need to address the issue with respect to treating pediatric patients (Raphael & Oyeku, 2020). Therefore, this research examined the impacts of White privilege and implicit bias on White nurses in their treatment decision-making processes and interactions with Black pediatric patients, through in-depth self-exploration. This research required a qualitative method design to capture the in-depth perspectives of the nurses. Furthermore, based on this literature review, a qualitative methodology was best suited to address the RQs outlined in Chapter 1 to fill the gap in literature. In Chapter 3, I will provide a more thorough explanation of the research method and design that was used for this study.

Chapter 3: Research Method

Introduction

For this study, I used a basic qualitative inquiry approach. I aimed to understand how White privilege and/or implicit bias shapes and impacts the lived experiences of self-identified White nurses as they implement treatment decision-making processes and interactions with Black pediatric patients. I used a one-to-one interview format to explore the experiences of the participating nurses and the influences on their decision-making processes through this self-exploration process. The purpose of this study was to address the gap in literature and knowledge concerning specific experiences of White nurses with White privilege and implicit bias. Particular attention was given to the impacts on how White nurses go through the process of making treatment decisions and interacting with Black pediatric patients within an urban public hospital setting. Researchers have found disparities in treatment outcomes for Black and White children and called for more exploration as to why this happens (Nafiu et al., 2020; Yearby & Mohapatra, 2021). Furthermore, there was a lack of information about the role of White privilege and implicit bias in individual responsibility, specifically in relation to the implementation of treatment decision-making processes and interactions by nurses in their work with Black pediatric patients (Asonye et al., 2020; Bailey et al., 2017; Van Ryn, 2016; Vanidestine, 2018).

In this chapter, I address the research design and methodology, as well as issues of trustworthiness within the study. I clarify why I selected a basic qualitative approach for this study. My role as the researcher is described and defined, along with the steps I took to ensure that an environment of trust was created for in-depth sharing of feelings, thoughts, and beliefs about the impact of White privilege and implicit bias. In the Methodology section, I include the rationale for the selection of participants. I also discuss the interview protocol and interview guide and how they were aligned with the RQs and based upon the concepts of White privilege and implicit bias. Last, I describe the process used for the recruitment of participants, the interview setting, and how the data were collected and analyzed.

Research Design and Rationale

The purpose of this study was to address the lack of information regarding specific racial differences in the treatment of Black patients. I specifically focused on the impacts of White privilege and implicit bias on decision-making processes in the treatment of Black pediatric patients. I explored and gained a deeper understanding of the lived experiences of self-identified White nurses and how they are impacted by these conceptual influences. Participants were from urban public hospital settings within California. This qualitative study could serve as the starting point for future studies that address disparities in treatment to understand the impacting factors of White privilege and implicit bias. Future studies can be conducted to determine and address any identified barriers to tackling the impacts of these concepts explicitly in personal interactions with patients. I developed the following RQs to explore and address the intentions of this research study:

RQ1: Does White privilege and/or implicit bias impact and shape the lived experiences of self-identified White nurses in the way that they implement treatment

decision-making processes and interactions with Black pediatric patients in urban public hospital settings within California?

RQ2: Does bringing attention to personal awareness or unawareness of White privilege and/or implicit bias play a role in decision-making processes and treatment interactions with Black pediatric patients?

RQ3: Does using a personal self-examination process concerning the impacts of White privilege and implicit bias bring more awareness and attention to how these concepts impact treatment decision-making processes and interactions and shape the way that White nurses plan to work with Black pediatric patients moving forward?

There were many qualitative approaches to choose from for conducting a research study. I decided to use the basic qualitative inquiry approach because it was aligned with the RQs. This approach was based on the research of Aliyu et al. (2020) at a public hospital center. Aliyu et al. explored clinical staff members' personal experiences and perspectives with meaningfulness using in-depth in-person interviews. Patton (2015) suggested that interviews are the best means of data collection for this type of qualitative research. Patton (2014) indicated that this approach best addresses questions exploring the perceptions and experiences of a presented context; as such, it fit best with my RQs. I wanted to explore the perceptions, thoughts, feelings, and attitudes through the lived experiences of White nurses working with Black pediatric patients. In-depth, one-on-one interviews were the most appropriate form of data collection to address and answer my RQs.

One-on-one interviews provided opportunities to engage in an iterative process and delve into in-depth discovery. With a sensitive topic, it was important for the interview process to allow for questions to be expanded upon with additional probes when needed. This allowed participants to elaborate in their responses. I explored the use of focus groups; however, I determined that they would not provide the in-depth discovery that could be gained through one-on-one interviewing (see Patton, 2015). Given the focus of the study, I concluded that participants would likely feel more relaxed and secure expressing themselves in a potentially vulnerable manner within the context of a personal interview rather than within a group. Participants could feel more inhibited in a group setting, where they could worry about speaking freely due to potential responses from other participants and/or repercussions if they were honest (Gill et al., 2008). Therefore, I concluded that the RQs would likely be best answered through an in-depth, one-on-one, iterative process of interviewing.

The basic qualitative inquiry approach is consistent with in-depth interviewing and the use of exploratory content analysis. It was of the most benefit to use an exploratory analysis process due to the focus of the data collection process on the exploration of individuals’ lived experience (Patton, 2015). An iterative process of analysis matched the iterative methodology process. The basic qualitative inquiry approach was the best one for my research which focused on lived experiences, utilizing an explorative method.

Role of the Researcher

A researcher's role can vary within a qualitative research study process. Ravitch and Carl (2016) suggested that a critical role of the researcher within a research process may be that of a data collection tool. In this role, it is crucial for researchers to consider and account for who they are as individuals and what they carry into a study process. There are other roles that a researcher can serve in, such as a colleague, peer, doctoral candidate, student, friend, family member, professional, interviewer, data collector and analyst, or a person who writes reports. Through positionality, the researcher can take on different perspectives that could influence the study in some way. It is essential that each of these various functions that a qualitative researcher can serve are contemplated and thought through so that the researcher can be continually aware of their role throughout the process. Ravitch and Carl suggested that the goal is for the researcher to grow into an instinctive contributor as they stretch themselves away from a stringent interpretation of their role. An example of this is how the researcher's understanding of their role within the interview process can shift as they realize their own positionality within the context and understand that they are able to change and probe the part that they are playing.

Rubin and Rubin (2012) purported that although a researcher typically uses an interview guide to direct the interview process, using responsive interviewing allows a researcher to change and be adaptable, to be able to change questions or words as needed to guide the interview to more rich and meaningful responses and levels of understanding. Researchers need to see themselves through the lens of being part of the research process; using an iterative process in interviewing makes this possible through the in-depth and explorative construction of the experience it creates. It was crucial for me to be fully transparent regarding all the various aspects of myself during the research process, including any and all thoughts or feelings that I had, so that I could examine myself and the contributions I made as a qualitative researcher. It was critical that I acknowledged how my personal perspectives could impact the research (Creswell & Creswell, 2018).

My interest in this research topic was piqued due to my own experiences of raising Black children and needing to interface and interact with the medical world on a regular basis. My youngest son, who has intense medical conditions, has had to be hospitalized several times and spent a good part of 2 years traveling from one hospital to another for potential diagnosis and treatment. During that time, we had many experiences with nurses from a variety of backgrounds. I believe that my husband and I may have put our son at an advantage at times due to us being White. However, because our son is Black, I have had beliefs (which he saw and experienced) that are different from those of other pediatric patients' families who are White. These beliefs reflect how we have been treated within our country's health care system. We have also had experiences with our Black prepubescent son who has endocrine problems. From these experiences, I have formed the belief that at times, people have held themselves in a certain position that felt above us and carried themselves in a particular way around us because we are raising Black boys.

In addition to the interactions that I have experienced with my sons, I have experienced many with our older daughter, who has been hospitalized several times with

Type 1 diabetes. Our daughter experienced overt racism as a Black teenager who also struggled and still struggles with mental health challenges. On several occasions, it was evident that a skin color difference led those who interacted with her and treated her to do so in a different way. These experiences, which I have had through my children and as a mother, have contributed to intense feelings that have been brought on by the racial inequities and injustices in our health care system. Due to these events in my life, I became interested in understanding more about the personal experiences that health care workers—particularly nurses, as they are on the frontlines of interaction—bring into their encounters and interactions in hospital communities, specifically with Black children. I became interested in understanding whether White nurses bring awareness to how White privilege and implicit bias may impact their treatment decision-making processes and interactions.

As a qualitative researcher, I knew that my own experiences could potentially bring influence and bias into the research study process. I am White; however, I have raised and continue to raise Black children. According to Ravitch and Carl (2016), it was important that I brought awareness into each component of the research study process of the ways that my personal reactions and biases could influence it, to have solid and strong results. There was definite potential for my personal reactions and biases to influence relationships with participants, so I needed to be extremely careful that none of them guided any of my actions in my role as a qualitative researcher. I knew that my potential assumptions and biases could interfere at any stage of the study, so they needed to be checked throughout the process, from the stage of invitation to the stages of recruitment and interviewing until the reporting of the results. This was done through processes of taking audit trail notes, keeping an anecdotal journal, peer debriefing, and member checking. My intention was to bring to light every aspect of my feelings, thoughts, and experiences throughout the study, so that credibility and trustworthiness were established within each stage of the process.

My role in this research was to design the study and then observe, review, analyze, and document responses from the participants throughout the process with accuracy. The process was complemented by the taking of audit trail notes, anecdotal note taking, recording of the interviews, and member checking. According to Creswell and Creswell (2018), it is important however for the researcher to maintain subjectivity during data collection and processing to avoid bringing bias into the study. Although my family's past experiences interacting with the health care system could have a positive impact as I collected and analyzed the data, I guaranteed and remained cognizant of not allowing my personal beliefs or feelings to influence the research study process.

Upon taking on the interviewer role, it is important to build trust with participants by focusing on the nature of the study and providing explanations that assure them their experiences are valid and important. Throughout the process, I strived to help each participant to feel comfortable sharing their personal thoughts and feelings with ease through demonstrating compassion and genuine interest. I did not use judgmental language or behaviors, let them know it was okay to make inquiries at any time during the interview, and reassured each participant throughout the process (Dang et al., 2017). During interview data collection, it is necessary for there not to be a feeling of power asymmetry created, which is the interviewer's responsibility (Creswell & Creswell, 2018). When a participant feels they are on a more level playing field with the researcher, they are more likely willing to respond openly and honestly. To encourage active engagement of participants throughout the data collection process, I demonstrated care and sincerity in interactions and let each interviewee know that I valued their contributed thoughts and beliefs. The intent of taking these actions was to facilitate trust with the participants through providing a warm, inviting, and comfortable setting.

Bias can be lessened through the researcher working to limit preconceived thoughts or ideas throughout the data collection and analysis processes. Creswell and Creswell (2018) stressed the importance of controlling for bias through the researcher reporting results that are indicated solely by the data without attempting to manipulate them in any way. For this study, there were not any conflicts of interest presented through previous knowledge or experience of participants or setting to address. I was aware that there was the potential for a conflict of interest to arise throughout the duration of the study and ensured that if one did, appropriate actions would have been taken to mitigate the issue. Furthermore, it was important that I engaged in continuous self-checking and self-reflectivity through journaling, reviewing of notes to address any biases presented, and peer debriefing. The participants for this study were self-identified White nurses from urban public hospitals in California. They were recruited through an email recruitment invitation contained within a nursing association distribution list, posted recruitment flyers at the hospitals, or through the leveraging of social media outlets. Last, thank you gifts were provided due to difficulties in the recruitment of participants and the sensitive nature of the topic. All participants for this research study were adult volunteers who chose to participate on their own accord and who were not coerced in any way to do so. Any potential ethical issues produced using incentives were mitigated by fair recruitment and every participant received the same thank you gift of a $20 Starbucks gift card.

Methodology

The target population for this research study consisted of self-identified White nurses working with children. They all met the criteria for having worked within an urban public hospital setting's pediatric ward in California for at least a year. The sample size was 13 participants and purposeful sampling was used to ensure an adequate random pool of participants was found.

Participant Selection Logic

Ravitch and Carl (2016) suggested that in contemplating the decision of which sampling strategy to use, it is essential to consider the RQs and what they seek to explore. It is also important to ensure that the participants used are the most likely to represent the points of view that the researcher is seeking (Ravitch & Carl, 2016). Taking these things into consideration led to a participant sample that would carry the most integrity and that provided the most appropriate responses with an array of perspectives. It was also critical that the selected participants met the inclusion criteria for participation in the study. Those meeting the criterion for inclusion included self-identified White nurses that had worked for at least a year with pediatric patients in urban public hospital settings within California. Additionally, the resources I used for the recruitment of participants matched the criterion to be able to source the right people for the study. Specifically, I focused recruitment to those working within public hospitals in California that are in urban settings. I recruited using a recruitment email through nursing association distribution lists, recruitment flyers that were posted and distributed throughout targeted hospitals, and through leveraging social media sites. These actions were taken only after receiving Walden University Institutional Review Board (IRB) approval and permission from the leads of the nursing association list-serves and the department heads at each of the targeted hospitals, confirming their approval of flyer distribution in their respective facility.

Purposeful sampling enabled collecting data that was rich in information; therefore, I selected to use it as the sampling method (Patton, 2015). Due to the vulnerable nature of this study's topic, I expected to not be able to indulge in a selection of participant cases that would be likely to provide the most information-rich responses. It was challenging to gain enough interested participants that met the inclusion criteria. However, presenting the topic of the study upfront in the announcement and invitation helped to elicit interest from those who were sincere and able to provide rich and meaningful responses. Patton (2015) indicated that it is important to evaluate each participant to ascertain whether they meet the conditions required for inclusion. Specific criterion for this research study included being a self-identified White nurse, presently working in a public hospital setting for more than a year with pediatric patients, and currently living and working within an urban setting in California. There were several different criteria for exclusion. These included being a nurse that was of different appearance than White, having a title other than a registered or licensed nurse, having worked in a hospital setting with pediatric patients for less than a year or not having worked in a hospital setting, and having lived or worked in a suburban or rural setting. Nurses who worked with adult patients or worked or resided outside the parameters of California were also excluded from participation. There were no exclusionary criteria based on age or gender.

Utilizing a basic qualitative inquiry approach for this research helped to determine and choose an appropriate sample size. Carrese et al. (2002) suggested that recruiting a reduced sample size from a greater one within an established setting serves as a random purposive sampling. There are many White nurses that have worked within an urban hospital setting within California, so a selection of 15 nurses would provide an adequate random sample size for a qualitative study. Due to utilizing a conceptual framework, rather than a theoretical one for this study, I did not plan to try to reach theoretical saturation with the data collected. From the sample size, I aimed to provide trustworthiness in meaning. Mason (2010) purported that for a basic qualitative study, the smallest acceptable goal for reaching saturation is a sampling of 15 participants. Therefore, the goal for this study to provide a chance for significance in results was a sample size of 15.

People who expressed their interest to participate contacted me through detailed contact information, which was provided within the recruitment emails and messages, and on the recruitment flyers. I then contacted them by email with the consent form to let them know that they were formally invited to participate in the study. The informed consent included in the email detailed their rights and responsibilities as a participant. Those who agreed with the information provided then replied to the email with "I consent" and were contacted back through email to set up a time for the interview. Following the email correspondences to schedule participants, an interview schedule was finalized.

The informed consent included a more in-depth description of the study's purpose and the potential risks for participating in the study. This provided the opportunity for each participant to make a clear choice to participate of their own accord. Due to the sensitivity of the study topic, I disclosed the potential minimal exposure and risk for emotional stress. To provide assurances to this, I let them know within the overview of the study as well as the informed consent that they could decide to end participation at any point during the study and especially the interview process. I also guaranteed that any information participants shared during the process would be kept private and confidential. I let them know that all their personal information would be assigned with a unique identifying code and their name would not be used at any point. Finally, I communicated with each participant that I would not share any of their identifying information at any time, including at the time the study is announced and published.

Instrumentation

The RQs for this study were grounded in the conceptual framework of White privilege and implicit bias and their influences on treatment decision-making and interactions with pediatric patients which has been explained in Chapter 2. The basic qualitative inquiry approach was used to explore these concepts in-depth. The first RQ tied into the concepts specifically in their relation to how these concepts impact self-identified White nurses in their implementation of treatment decision-making processes and interactions with Black pediatric patients. The other two questions focused on the exploration of how bringing attention to personal awareness or unawareness of these concepts plays a role and whether self-examination of these concepts can impact these decisions and processes. Each RQ was created to provide a contextualized and fruitful insight into the personal experiences of each participant (Patton, 2015). They were based on the goal of delving in-depth into the concepts noted.

Based on the RQs, I developed an interview protocol and guide (see Appendix A). The development of the interview questions was also informed by another qualitative study that involved interviews to explore the concept of White privilege (Donnelly et al., 2005). The use of an interview protocol and guide helped to establish content validity for the study. Open-ended questions were used throughout the interview. A concluding question was also used to allow participants to provide information that they felt was important to share and that had not been previously addressed through the questions asked (Patton, 2015).

In addition to the interview question responses, there were several ways data was collected in this study. Data was created through my development of audit trail notes which included recordings of each contact I made with all potential and actual participants from start to finish. Additionally, I generated an analytic memo that included researcher notes from before each interview, during each interview, and after each interview. The analytic memo included the thoughts and biases I had about myself and the participants throughout the study which have helped to contribute to a deeper understanding and knowledge of the process. Last, data were obtained through Zoom audio recordings of each of the participant interviews which were then transformed into verbatim documentation for the analysis process, as well as verification and validity.

Procedures for Recruitment, Participation, and Data Collection

I conducted one-on-one personal interviews through the Zoom online platform. A choice to use Zoom over the telephone was made because non-verbal cues could provide more information than what could be gained from simply listening to someone speak. The use of Zoom also enhanced the quality of data being collected. Opdenakker (2006) found Zoom to be a platform permitting a relaxed flow in communication through synchronic conversation. It permitted the iterative process to happen more effectively and effortlessly.

Recruitment email announcements were sent through nursing association distribution lists and recruitment flyers were distributed and posted throughout nearby urban public hospitals at which prior permission was been obtained for posting. The IRB approval number I received was included within the recruitment email and on the recruitment flyer that I created (see Appendix B). The recruitment flyer had a section that interested parties could tear off a piece from that provided my name, telephone number, and email address to contact me. This same information was included in the recruitment email announcement. Once I was contacted with interest, the potential participant was sent an informed consent form through email. They were instructed to review the terms of consent in detail and then return the consent form with "I consent" written in an email back to me. This provided confirmation of their willingness and consent to participate in the study.

All potential participants were provided with the chance to ask any questions about the study before the interview and I verified that the interviews would be conducted over the Zoom platform. In addition to providing the informed consent, I verbally confirmed that the video function would be turned on during the interviews and that they would be recorded through only the audio recording feature. Interview times were set up with each participant through email and an interview calendar and timeline was established. Each participant was told that the interview could last between an hour to an hour and a half, and all interviews were conducted over the course of a month. Participants were sent email or text reminders 3 days and 1 day prior to when the interview was scheduled to be conducted. After 15-20 interviews were conducted and data saturation was reached for purposeful sampling, recruitment efforts were concluded for this study.

Creswell and Creswell (2018) purported that it is important to conduct interviews in a setting that is familiar to the participant to create a trusting environment for open participation. Conducting interviews over Zoom helped to provide this type of atmosphere since each person could participate in the comfort of their own home, office, or other familiar place. Before each interview, I reminded each participant of their rights that were set forth in the informed consent and that they were able to withdraw themselves from the interview at any point if they felt uncomfortable. Every interview started with a self-introduction followed by a reminder that the interview was expected to take between an hour to an hour and a half and that all personal information would be kept private and confidential. Permission to record the interviews through the Zoom audio recording feature was acquired prior to the interview process. I reported all obtained information only in an anecdotal manner.

Throughout the interview process I performed member checking to ensure and verify that the data I collected was reflective of each participant's experience. I reviewed each Zoom interview audio transcription recording verbatim. Once the transcription process was complete, I followed up with each participant to ensure that my interpretations were accurate and exemplified a true reflection of their thoughts, feelings, beliefs, attitudes, and opinions. Additionally, at the end of each interview, I thanked each participant for the time they contributed to participation in the study process and gave them a $20 Starbucks gift card of appreciation. I let them know that their participation was truly valued and that I would provide them with an exclusive summary of the results once I had them.

Following the completion of each interview, I listened to and reviewed each Zoom audio recorded and written transcription for accuracy and copied it precisely into a Word document to ensure it was verbatim. Halcomb and Davidson (2006) indicated that verbatim transcription provides the best information for content validity and data analysis. Participant data was protected through the establishment of the signed informed consents. Each participant's identifying information was safeguarded by the provision of a unique identifier code for individual data collected, which provided protection within each stage of the process. A protected waiting room feature was enabled within Zoom so that only the participant and I were able to join. Member checking was used to confirm credibility. After analyzing the data, I provided each participant with information from the results regarding the themes I found. Following the disclosure of results, I debriefed the study with each participant by allowing them to provide any feedback and/or ask any questions through their preferred mode of phone or email. The process was concluded with them being thanked once more for their participation in the study.

Data Analysis Plan

How one interprets and analyzes the data within a qualitative study should be established through the methodological approach that is used. Sutton and Austin (2015) indicated that thematic content analysis aligns best with a basic qualitative approach. I used thematic content analysis because I wanted to delve into truly understanding the participants and their perspectives through finding commonalities and themes across responses. The first step in the analysis process was ensuring that each transcription of each of the interviews was recorded accurately verbatim. I decided to use the cost-effective approach of using the Zoom audio recording feature and used the Otter.ai transcription service to transcribe each interview and then hand coded the data into a Word document. Through reviewing the recorded transcriptions word for word, I was able to be more careful and accurate with the process and hand coding provided me with the opportunity to analyze data I was already closely familiar with. I was able to enhance the quality of my analysis through becoming more familiar with the participants' responses and through providing personal observations with anecdotal data. I was aware that this would be a time-consuming effort to review each transcribed interview word-for-word due to the amount of information each participant provided to be sifted through and organized into coding.

I chose hand coding rather than software analysis due to appreciating the ability to immerse in the data, work with it, and manipulate it intimately, through a hands-on approach. I confirmed my decision after reviewing both Dedoose and NVivo software, which are used for thematic analysis of data, and finding them cumbersome and challenging to use (Hart & Achterman, 2017). Through hand coding procedures I was able to examine the data at different levels as I manually entered it into a Word document. I was able to change the codes, categories, and themes as I saw fit through an easy format. In the document, I created a table with columns and color coding, which helped to distinguish individual data from one another and helped in the analysis process. I preferred to engage in this fully immersive process with the data and analysis of it. Sivakumar (2020) proposed that profound understandings can be gathered from qualitative data which participants express through the narration of their experiences. Provided that I used a smaller sample size, I was able to take the time to draw meaningful interpretations through an intimate approach that also matched best with my own level of processing and capabilities.

I reviewed each transcribed interview one at a time, word for word, while also reading over the provided information to determine if there was any additional information or meaning they were attempting to convey that I did not gather initially. I took notes during this process including personal insights gained and any information that I asked through follow-up questions. I utilized a spreadsheet to organize the data including each interview question and response, any anecdotal notes on the participant and/or interview process, and any key points from the data that helped to identify codes for the coding process. This included all the information needed to conduct data analysis.

I then reviewed and verified the data for thematic data analysis coding. Before beginning the analysis process, I first needed to acknowledge the initial filters through which I could interpret the data (Korstjens & Moser, 2018). According to Sutton and Austin (2015), I needed to recognize and examine my own reflexivity and personal and past experiences that could have an impact on the way I interpreted the data. I did this through keeping an anecdotal journal throughout the interpretation and analysis process. To conduct analysis, I used inductive coding and assigned codes, categories, and themes to the transcribed data (Saldana, 2016). I then synthesized and encapsulated themes that I gathered from the data.

Verbatim transcriptions of each interview were crucial to the inductive process of coding, which was applied to bring together information to enlighten the themes that emerged from the data. Saldana (2016) suggested that codes, categories, and themes are used in the data analysis process to assign meaning to transcribed interviews. The analysis process moved inductively from codes to the determining of categories through combining the codes to find patterns and then to figuring out larger representative themes that were built from common threads between data sources (Ravitch & Carl, 2016). Each element was used to describe the data at a different level of understanding which helped inform me of how to organize the information gathered. The process of coding can become a dull and monotonous one; however, it helped me capture as much from the experience as possible to be the most reflective of the interviewee's experience.

From the information gathered from the transcriptions, translation of the data occurred with the creation of strong and concise description words. A single descriptive word or short phrase was used to develop codes, as codes are meant to be direct and simple (Saldana, 2016). Through coding analysis, codes were compared and common information across the data was connected to one another. Categories were formed through this combining of codes and then from the categories, themes emerged. Each part of the process played an important role in promoting a deeper understanding of the data and ultimate outcomes of the study.

Throughout the data analysis process, I maintained organization and focus. I ensured that all the data was backed up on an external drive, which was kept in a lock box at my home in case I had any computer challenges. Data was processed as I collected it to ensure that I provided consistency throughout the study and was able to identify any gaps in the data. As indicated, I decided to not use any software for analysis, as I preferred to hand code the data. By being diligent in the analysis process of coding, I was able to identify relevant themes in response to the RQs. Together all the data created and illuminated findings on the influences of White privilege and implicit bias on the lived experiences of White nurses in their treatment of Black pediatric patients.

Discrepant cases were treated as a positive contribution to this research study. Eaton (2005) indicated that there are criteria for a study to ensure that there is sufficient data, and that adequate discrepant case analysis occurs. It is important for the researcher to deliberately search for discrepancies in findings to help combat their instinct to seek confirmation from the initial emerging discoveries (Eaton, 2005). Providing discrepant case analysis included noticing disconfirming instances of thought or meaning within the codes, categories, or themes in the data and comparing them repeatedly with others to be able to find and revise key assertions (Eaton, 2005). This practice happened until the accurate reflective experiences of the participants was conveyed. The process reinforced trustworthiness within the study as it battles assenting bias and precludes an unsophisticated interpretation of the data. Furthermore, a peer debriefer was used to help with assuring that I was credible in my data analysis and reporting. The peer I debriefed with, Sonya Arrington, was familiar with the peer debriefing process, the nature of my research study, as well as with the qualitative data collection and analysis methods I used. Using peer debriefing helped with assuring credibility and integrity in my data collection and analysis processes.

Issues of Trustworthiness

Taking issues of trustworthiness seriously within a study is key to its success. Credibility, transferability, dependability, and confirmability are all critical elements that support the creation of trustworthiness within the research (Lincoln & Guba as cited in Pandey & Patnaik, 2014). Meeting the standards set for each of these components was essential. According to Connelly (2016), for a study to be worthy of the efforts put into it and recognized and accepted within an academic community, it is vital that the confirmation of trustworthiness occurs. There is a different definition for each element contributing to trustworthiness. Korstjens and Moser (2018) defined credibility as the occurrence of factual data that is reasonably representative of the named participant. Another element is transferability. Transferability is defined as the ability to show that the outcomes of a study are relevant to other situations and locations and can be generalized within them (Pandey & Patnaik, 2014). Dependability is the ability to demonstrate that the results from a study can be repeated in future studies with consistency and ease of reproduction (Pandey & Patnaik, 2014). Finally, confirmability is needed to help determine the trustworthiness of a study. Korstjens and Moser (2018) describe confirmability as the ability to ascertain that the findings from a study can be reproduced and verified by another researcher to confirm that they came from the original study data. The standards for each of these elements had to be adhered to for trustworthiness of the study to be acknowledged. According to Shenton (2004), there are various methods and practices that can be used to ensure that quality and trustworthiness are carried within a study. I made several efforts to ensure that I was meeting the standards of credibility, transferability, dependability, and confirmability needed to obtain trustworthiness of this study.

Credibility

To meet credibility standards, I used triangulation of the data through the collection of different types of data. The different data included the information and transcriptions obtained from interviews, audit trail notes, and my analytic memo and used reflexivity. Furthermore, I conducted member checking throughout the interview process as well as data checks on the transcribed data. Additionally, I used a peer debriefer to confirm truthfulness of the data collected with accuracy in analysis. A peer that I had the experience of previously conducting peer debriefing with during a course, Sonya Arrington, a fellow PhD candidate, served as my peer debriefer for this study. A unique identifying code number was assigned to each participant to keep their data confidential, and names were not used on any of the interview transcripts. This number coding was used for all aspects within and throughout the entire study process. I shared the transcribed interviews with my peer debriefer as they were completed, along with the password protected data spreadsheet. The password was only be shared with her.

My peer debriefer reviewed each of the transcripts and first cycle coding for accuracy and provided me with feedback. She then reviewed each following cycle of coding along with final interpretations. During this process, I shared the process by which I decided on each of the codes, categories, sub-themes, and over-arching themes. We noted any differences in perspectives, discussed key points, and agreed on the ending themes.

Member checking was also conducted to help ensure credibility in the study. Member checking was used throughout the entire interview process and each participant was contacted following the interview to ensure that what I interpreted truly represented what they wished to convey and express. There was an open option provided to each participant to provide any additional feedback on my interpretations. Member checking allowed me to validate the perceptions, thoughts, feelings, and beliefs that each participant shared. It also helped to eliminate any of my own personal biases that could influence any participant responses.

From the outset of the study to its completion, I took audit trail notes detailing every interaction I had with each participant, to ensure objectivity. I practiced reflexivity through using an analytic memo. In the analytic memo journal, I recorded my thoughts, feelings, attitudes, opinions, and perspectives experienced throughout the course of the study. I also journaled on my past experiences interacting with White nurses in California urban public hospital settings. I examined how these past experiences and my personal biases could have an influence on any aspect of the study throughout its entirety. It was also important that I examined my interests and values regarding just treatment of Black pediatric patients and the influences of White privilege and implicit bias on White nurses. Patton (2015) specified that for basic qualitative inquiry, data saturation is reached with a minimum of 15 participants, unless meaningful thematic saturation is determined with fewer. The last way credibility standards were met for the study was with the use of 13 total participants, which met what is needed for thematic data saturation with meaningfully rich data that brought forth several relevant themes.

Transferability

An abundance of valuable data strengthens a study's transferability. An essential step I took to ensure transferability was to provide thick descriptions of the data full of rich details from the context of each interview (Korstjens & Moser, 2018). I also took detailed notes on each participants actions and experiences. I used open-ended questions and probes throughout the interview process to elicit in-depth descriptions of experiences in participant responses. Probes were used to obtain more elaborative responses to what was deemed significant. Additionally, transferability was established using purposeful sampling. Recruitment of participants through purposeful sampling ensured that those who participated in the study would truly represent and reflect the experiences that were intended to be gathered by the RQs. I reached thematic saturation with 13 participants which also helped to increase transferability of the study (Patton, 2015). Furthermore, I used the audit trail to guarantee I met conditions for transferability, as well as dependability and confirmability. According to Korstjens and Moser (2018), the audit trail consists of a transparent record of each interaction I had with each participant. I recorded each contact and step I took throughout the entire study. This ensured that all aspects of communication and correspondence that could interfere with any step of the process, were evident and accounted for.

Dependability

For this research study, I ensured dependability through triangulation with the use of peer debriefing. Peer debriefing helped to confirm the accuracy of my initial discoveries and interpretations. Furthermore, my peer debriefer reviewed my anecdotal and audit trail notes to ensure that there was not any bias portrayed within any of my documentation that was not explicitly stated as such. My peer debriefer determined that the data I collected and the analysis I provided accurately reflected one another. I, additionally, ensured that all participant data was kept securely and confidentially throughout the study from all parties, including my peer debrief partner. No identifying information was ever shared.

Confirmability

Patton (2015) indicated that confirmability demonstrates that the data collected and analyzed was strictly based on and shaped by the participants involvement and disclosure, rather than any potential researcher bias. The same reflexive practices that were used to confirm credibility within the study were also be used to check confirmability, with the use of an anecdotal journal throughout the study. To ensure trustworthiness through confirmability, it was essential that I was incessantly aware of the impact my involvement and subjectivity could have on the data, to be able to remain objective. I monitored my involvement and kept track of my own thoughts, feelings, and opinions, particularly during the interview and other data collection processes. I also did this during analysis of the data to ensure that I reduced any potential for personal bias on my part. I worked hard throughout the study to not let my own passion regarding the topic impede my involvement at any level and ensure integrity was held.

Intercoder Reliability

Saldana (2016) purported that inter-coder reliability measures how successfully and closely two coders match how they characterize and evaluate a response of a participant. I processed each interview individually and began the analysis process with each transcribed data set using thematic content analysis. I assigned codes and categories once all interviews were completed to produce a continual flow of data (Saldana, 2016). Following the assignment of codes and categories I sought to determine emergent themes and provided my peer debriefer with the data and a blank copy of my analysis document. Reliability was ensured through a process of reviewing the transcripts, codes, and conclusions with one another until we reached agreements on codes to be established. We did this through a process of reviewing two transcripts at a time over the Zoom platform through a shared and protected screen. All identifying information was kept private and confidential from my peer debrief partner throughout the process.

Ethical Procedures

It is crucial that ethical procedures are honored during qualitative research. Ethics set standards for actions taken within the framework of a research study determining what is appropriate and permissible or not (Patton, 2015). A strict consideration of ethics was given to achieve validity and reliability of my study's results. The procedures used to align with ethical standards for this study are delineated here to assure there was appropriate conduct. Research was only conducted for this study after Walden University IRB approval was obtained.

Agreements to Gain Access to Participants

It is very important to ensure that human participants agree to participate in research before they engage in any part of a study (Creswell & Creswell, 2018). Likewise, researchers must ensure participants are protected throughout all research processes (Creswell & Creswell, 2018). Before any research began, with the inclusion of participant recruitment, IRB approval was applied for and obtained. Consent for participation in this study was acquired from each participant. Potential participants that did not consent were excluded from participation. I first obtained permission to have the recruitment announcement email sent out to the nursing association distribution lists that it was dispersed to. Additionally, I gained permission from the head of each hospital department I posted recruitment flyers within. I received prior approval to post flyers in public places within their facility or to pass the flyer on to someone within the department to share with others. I also responded to any questions asked by the hospital department heads and potential participants before engaging in recruitment and research activities. Purposeful sampling was used through including criteria on the flyers specifying the types of participants sought after for the study. Additionally, I provided my contact information for interested parties on a portion of the flyer that could be torn off for them to take. When someone contacted me expressing interest, I sent them an email containing the informed consent that provided a detailed overview of the study and process. They assented by responding to the email with confirmation.

Protocols for the Protection of Participants

In a research study, to follow ethical standards, it is crucial to protect the privacy and confidentiality of each participant’s identity (Patton, 2015). I was the only one aware of identifying information throughout the research process and provided this assurance to each participant. Each participant was provided with a unique identifier code which was placed only with their name on a spreadsheet that was password protected. Additionally, all the participant data from the interviews, transcriptions, and coding processes was kept and protected on different password encoded spreadsheets in a password protected file.

Although the potential risks were minor, participants were informed of all potential risk of participation before they engaged in the interview process. The potential minor risks of participation included minimal emotional discomfort or reactions due to the sensitivity of the topic. The topic of exploring experiences of White privilege and implicit bias had to the potential to bring up uncomfortable feelings, thoughts, experiences, or memories. Given this, I observed for any discomfort presented and let each participant know that they could request a break at any point during the interview or end it should they needed to.

Required Components of the Informed Consent Process

The informed consent is a critical component of the research protocol for any study. Rubin and Rubin (2012) asserted that the intent of the informed consent is to provide an understanding of what the research is about and its purpose, any potential risks of participating, the voluntary nature of the study, and the right to withdraw from participation at any time. Every participant agreed to take part by signing the informed consent before any research began. A Walden University IRB approved consent must be used by every doctoral candidate to conduct research for a dissertation. An informed consent and all its necessary components is an assurance that all ethical guidelines are followed, and any subjectivity and power dynamics can be counteracted (Martin & Inwood, 2012). I used a consent that provided a summary for each ethical component that was required for the research to be conducted. It included the study's purpose, the expected length of the interview, additional time and participation requirements, a description of procedures, voluntary participation, and the right to withdraw from or end the interview, potential risks or discomforts of participation, and potential benefits. Additionally, counseling referral information should it be needed, the number of sought-after participants, a notice of participation appreciation gifts, limits of confidentiality, privacy and how data would be used, disclosure of potential conflicts of interest, contact information for me and the university's research participant advocate, and a statement stating that they should keep a copy of the informed consent were also contained within it. Informed consents were sent to potential participants and an email response was received with an "I consent" in an email response before any further research activities were conducted. At the start of each interview, participants were refreshed with an overview of the informed consent along with a reminder of their rights.

Protocols for the Safeguarding of Data

All the data from this study was kept in password protected spreadsheets within a password protected computer file. It was also kept within a password protected computer that only I have access to. An assigned unique identifier number code was used to protect each individual participant's identifying information which is how they were identified through all data processing. I personally reviewed each transcribed recording of all the interviews. The peer debriefer that helped as a coding reviewer for this study was only provided the identifying number assigned to each participant. I will continue to maintain the data for 5 years from the end of the study and after that period, I will delete the file and all the spreadsheets. These actions maintained the privacy and confidentiality of each participant and the responses they provided for this study. Additionally, all audit trail and anecdotal notes were identified by code, kept within the password-protected file system, and destroyed at the end of the same 5-year period.

Other Ethical Considerations

There were not any known potential conflicts of interest that could arise during the study due to previous knowledge or experience with a particular setting or participant that should have been disclosed in the informed consent. Furthermore, the awareness of a conflict of interest did not arise at any point during the study with any participant, to be addressed through its identification and elimination. To bring additional awareness to any potential conflict, as the researcher I engaged in reflexivity journaling and self-checking, the reviewing notes to address any potential biases presented, and involving peer debriefing with a previously identified peer. Each participant was made aware that they were to participate only of their own willingness and interest as a volunteer. Fair recruitment took place and appreciation gifts were given to each participant due to it being a sensitive topic to explore. Every participant equally received a $20 Starbucks thank you gift at the end of their interview.

Summary

This chapter presented an overview of the methodology for this study. A basic qualitative inquiry approach was applied, and participants met inclusion criteria through purposeful sampling. The goal was to include 15 self-identified White nurses within California who work with pediatric patients in urban public hospital settings. It was the hope, which was met, that a strong understanding of the influences of White privilege and implicit bias on nurses' lived experiences when making decisions in treating and interacting with Black pediatric patients was gained. Personal and in-depth interviews were conducted through the online Zoom platform. Open-ended questions and probes were used in attempt to gather meaningful responses to the RQs focused on the concepts of White privilege and implicit bias, attention to personal awareness or unawareness of the role of these concepts, and the role of self-examination within them. After interviewing the participants, I reviewed each transcribed recorded interview and then analyzed the data through thematic hand-coding with the use of a peer debrief partner for review and checking. Additionally, to explain how I strengthened trustworthiness of the findings, I included a discussion of the components needed to assure credibility, transferability, dependability, and confirmability. I also included a description of the inter-coder reliability, ethical procedures, and informed consent I used for the study. Once I received IRB approval, I proceeded with the recruitment of participants and collection of data, which then led to the analysis procedures and results. The results of this study will be discussed thoroughly in Chapter 4.

Chapter 4: Results

Introduction

In this study, I explored how personal experiences of White privilege and implicit bias can contribute to the racial inequities within the U.S. health care system, specifically for Black pediatric patients. Using a basic qualitative approach, I examined how influences of White privilege and implicit bias shape and impact nurses as they implement treatment decision-making processes and interactions with Black pediatric patients. I gained an in-depth understanding of how these concepts influence participating nurses' lived experiences. I also explored the potential for nurses to engage in self-examination about the impact of White privilege and implicit bias on their treatment decisions.

Applying an inquisitive and explorative perspective to this research allowed for an in-depth and iterative examination of the lived experiences of the participating nurses. Experiences from the context of each nurse's own personal histories and social and relational dynamics contributed to the study. I used basic qualitative inquiry methodology because it permitted the focus of understanding to be on the provision of rich and meaningful responses through in-depth quality interviews with participants (see Creswell & Creswell, 2018). I purposefully sampled 13 self-identified White nurses from urban public hospital settings within California to provide the best representative sample. The RQs I used to focus the study were

RQ1: Does White privilege and/or implicit bias impact and shape the lived experiences of self-identified White nurses in the way that they implement treatment

decision-making processes and interactions with Black pediatric patients in urban public hospital settings within California?

RQ2: Does bringing attention to personal awareness or unawareness of White privilege and/or implicit bias play a role in decision-making processes and treatment interactions with Black pediatric patients?

RQ3: Does using a personal self-examination process concerning the impacts of White privilege and implicit bias bring more awareness and attention to how these concepts impact treatment decision-making processes and interactions and shape the way that White nurses plan to work with Black pediatric patients moving forward?

I used these RQs to design the interview guide and direct the focus of the interview process. They allowed for rich and meaningful responses to be provided to target and help fill the gap in literature that was found. In this chapter, I provide an overview of the results of the interview process through the basic qualitative inquiry methodology used for this study. Information is provided regarding the setting, demographics, and data collection and analysis processes. I also provide evidence of trustworthiness and present the results.

Setting

To recruit participants, I used nursing association distribution lists and circulated flyers at urban public hospitals throughout California, as well as leveraged social media outlets and connections. Prior permission was obtained to post and distribute the flyer. I included Walden University’s IRB approval number (04-26-22-0750949) on all recruitment materials. Potential participants sent me a direct email to express their interest in the study. Once the individual confirmed their participation through their emailed response to the informed consent, an interview day and time was set to meet over Zoom. Each participant agreed to the use of the Zoom video and audio recording features to ensure that consistency was maintained across interviews. The focus of the data was on the participants' experiences as White nurses serving Black pediatric patients and the influences on their lived experiences of White privilege and implicit bias. Although it was challenging to recruit participants willing to engage in the topic of my study, there were no known personal or organizational conditions that influenced the participants and that may affect interpretation of the results.

Demographics

All the participants were pediatric nurses who worked in urban public hospitals in California. They had lived and worked in an urban setting for at least a year. I conducted a total of 13 interviews, and all were included in the data analysis. Of the 13 participants, 12 identified as female and one as male. Twelve of the participants self-identified as White and one as White and Latina. Three of the participants came from diverse backgrounds, and 10 of them came from backgrounds with limited diversity when they were younger and then were exposed to more diversity as they grew into adulthood. Each participant shared that they were currently exposed to diversity daily through living in an urban environment of people from almost every nationality and racial background. All the participants had been working in hospitals with a very racially and ethnically diverse patient population, including White, Asian, Pacific Islander, Latinx, and Black patients. The Black patient population in participants' hospitals ranged from 10-60%.

Data Collection

The data collection process began on June 1, 2022, and concluded on September 30, 2022. Study participants were recruited through nursing association distribution lists, circulation and posting of flyers at urban public hospitals across California and leveraging social media outlets. I instructed potential participants to email me directly to express their interest in participating in the study. They were sent the informed consent in an email and were asked to review and respond to indicate their agreement. Then, via email, an interview date and time was scheduled to be conducted over the Zoom platform with each participant. A few days before the interview date, I sent a reminder email, and the day before the interview, I sent an email with the Zoom ID to the participant. The length of the interviews ranged between 23 and 79 min, with an average duration being 51 min.

Each interview started with an informal greeting and confirmation that it would still work to engage in the interview process for 60-90 min at that time. I then read my formal introductory script in which I stated the nature and purpose of my study, reiterated voluntary participation, and restated the ability to forego any uncomfortable question or end the interview at any time. I answered any questions asked about the process and, after confirming compliance with audio and video recording of the interview, pressed the record button on Zoom before beginning.

Throughout each interview to ensure comprehension, I rephrased questions as needed, while leveraging probing questions to ensure the richest possible responses. At the end of the set of interview questions, I asked each participant if they had anything they wanted to add, comment on, or ask before ending the recording. The responses from all participants seemed to be genuine, authentic, and passionate. I based this assessment on participants' eye contact, tone, diction, and nonverbal communication as observed through the Zoom platform. Details of the interview introduction, questions, and guide can be found in Appendix A. Following each interview, I sent the gift card thank you gift to each participant's email address and completed my anecdotal notations. Transcription was then conducted through Otter.ai rather than through the original intention of Zoom transcription due to complications with the Zoom transcription software. A copy of the individual participants transcription was sent to each participant for review and then sent back to me with any feedback. Feedback was received from all but two participants either stating that there was nothing to change or with a minimal number of words to be changed due to how they were incorrectly transcribed. Other than the complications with the Zoom transcription feature, I found the process to be efficient. Also, I found that immediately recording my thoughts of each interview was effective for personal critiquing purposes. The methods used increased my level of comfort and confidence in conducting the interviews.

Data Analysis

It was of importance to ensure the highest level of thoroughness and objectivity throughout the data analysis process. In alignment with my research design as outlined in Chapter 3, I reviewed the purpose and protocol of my study. Each of the interviews were transcribed through Otter.ai and then were organized for consistency within an Excel spreadsheet by coded participant and by each interview question and response. Verbatim transcriptions were then copied from the identified participant's tab and sent to participants for review to ensure accuracy. The process of inductive coding was reviewed by my peer debriefer.

Following verification of the transcripts by participants, I began coding the responses to each question for every respondent. The process of data analysis was iterative and inductive in nature which led to six cycles of coding to achieve the most succinct, meaningful, and impactful results possible from the highly rich data presented. These cycles of coding led to sub-themes and over-arching themes that tie the interview question responses to each corresponding RQ. RQ1 resulted in 10 sub-themes and three over-arching themes; RQ2, 11 sub-themes and four over-arching themes; and RQ3, eight sub-themes and three over-arching themes. Using an iterative and inductive process to determine over-arching themes and sub-themes allowed me to combine codes and categories to conceptualize and capture an understanding of the data in a concise and meaningful way. In total, the results developed into 10 promising over-arching themes. Thematic saturation was established and strengthened through the involved, hand-coded iterative process and ensuing in-depth analysis of each transcript from all 13 participants. Each sub-theme was created from combined codes found in over half of the participants responses. The over-arching themes were formed from combining the sub-themes to best respond to answering the RQs.

Evidence of Trustworthiness

It is important to confirm the highest level of rigor is maintained in qualitative research and my research study is no exception. Throughout my study, trustworthiness was practiced through implementing all four components. I reviewed each element of credibility, transferability, dependability, and confirmability to ensure I practiced the highest level through the duration.

Credibility

To promote and strengthen credibility in qualitative studies, as outlined in Chapter 3, I used triangulation through the collection of data using different forms of data. In addition to the transcriptions from each participant and information gathered from them, I used audit trail notes, my analytic memo, and reflexivity to meet credibility standards. Throughout the interview process I took audit trail notes on correspondences and immediately following each interview I took reflective anecdotal notes. Each anecdotal note entry included any perceptions I had of the participant that could potentially influence possible bias. Moreover, I conducted member checking throughout the interview process through reflecting responses back to participants as needed, as well as on the transcribed data which was sent to each participant through email. Each participant was requested to review the transcribed interview for accuracy, make any edits they felt necessary, and send it back saying it was approved, to ensure validity. Last, throughout the process of data analysis, I confirmed authenticity and accuracy in the analyzed data using a peer debriefer who reviewed the transcriptions in conjunction with each stage of data coding. As the interviews progressed and it simultaneously became increasingly more difficult to recruit additional participants, I recognized I was not learning any added insights and likely reached thematic saturation. I then proceeded with data analysis which determined that thematic saturation in the data had truly been reached.

Transferability

Transferability standards were met through the implementation of open-ended and probing questions during the interview process. Purposeful sampling additionally supported validation of transferability. Each of the approaches reinforced a diverse group of participants and their elicited responses. A disparate group of participants was also reinforced through the varied recruitment from nursing association list-serves, distribution of flyers at qualifying hospitals, as well as the leveraging social media outlets. Additionally, I was forthcoming regarding the incentive I extended of a $20.00 Starbucks gift card as part of the recruitment practice.

Dependability

Dependability was strengthened through using a peer debriefer for triangulation purposes. My peer debriefer confirmed the precision and veracity of my initial discoveries and interpretations within the transcribed data, notes, and coding analysis. It was determined that the data I collected, and analysis provided, accurately reflected one another and that bias was not conveyed through any aspect of it. Additionally, all participant data was kept securely and anonymously throughout the study without any identifying information being shared at any point.

Confirmability

Confirmability in the research process was checked through the same reflexive practices that were used to confirm credibility of the study. Using the anecdotal note-taking method ensured that I was relentlessly aware of my potential impact on the data and the analysis process which helped me to remain objective. I was able to capture my own opinions, thoughts and perceptions, personal experiences, and feelings as well as monitor for and note any potential bias. These processes ensured that the conclusions drawn were not influenced by me, as the researcher, and instead directly from feedback of the participants.

Results

My research study used a basic qualitative approach with the intention to discover how influences of White privilege and implicit bias shape and impact nurses as they implement treatment decision-making processes and interactions with Black patients. Through this study I explored and gained an in-depth understanding of how these concepts influence nurses' lived experiences, through a self-examination process. Through the lens of my RQs and the one-on-one, in-depth interviews, I analyzed each transcript to develop cycles of codes and identify sub-themes. From the combining of 29 identified sub-themes, 10 compelling over-arching themes arose to answer each RQ congruently and meaningfully. I provide a comprehensive analysis of the results by each guiding RQ. Each participant was provided a unique identifying code number-letter combination (i.e., 1.1A, 1.2B, 1.2C, etc.) to keep confidentiality throughout the data collection and analysis process. The results analysis below identifies each participant by their unique identifier. This prevents disclosure of their identity throughout this dissertation.

Research Question 1

RQ1: Does White privilege and/or implicit bias impact and shape the lived experiences of self-identified White nurses in the way they implement treatment

decision-making processes and interactions with Black pediatric patients in urban public hospital settings within California?

White nurses were asked six different questions connecting to their experiences with White privilege, immediate thoughts or reactions related to privilege or bias when realizing a patient is Black, consideration of treatment goals, and their thoughts on any differences in treatment between Black and White patients. All 13 participants provided detailed replies and insight into their personal experiences in response to each of the interview questions. There were three over-arching themes that arose from the data in response to the questions matching RQ1.

Theme 1: White Privilege Benefits, Emotionally Negative Implicit Biases, and Negative Impacts on Treatment and Interactions with Black Families

The first over-arching theme that arose from the data in response to RQ1 was corroborated by statements that supported the ideas that all White people hold White privilege, people benefit from White privilege in many areas of life, and emotionally negative implicit biases are acted on and reported to have adverse impacts on treatment with Black families. Most of the participants described White privilege as an experience at a subtle level that innately all White people have whether they are aware of it or not, and that is generationally and systemically perpetuated. They all described it as an inherent and systemic ability to access more advantages, opportunities, and resources with power, freedom, luxury, and/or security. A common theme among more than half of the participants was that White privilege is relationally beneficial with more positive attention, social status, trust, and treatment for White people and Black families are treated differently, with more aggression. Another common thread among most of the respondents was that treatment interactions are led by factors such as feeling uncomfortable, hesitant, fearful, and judgmental due to biases of Black families' responses which lead to poor decision-making and negative treatment. Participant 1.1A explained "I think all White people experience it, whether or not they're aware of it, is a different thing." 1.3C shared,

> I think White privilege is something that we are not always aware of but is certainly there. That's a pretty broad question, because I think pretty much all White people in this country experience it to one degree or another. Some are more oblivious to it than others. So, I'm not sure how I would characterize it, I don't think it's necessarily something that people have chosen and that there it's good or bad, it just exists, and it's part of who they are and different people act it out in different ways.

1.5E conveyed,

> It's really any way a White person or at least here in America, experience privilege just by walking outside in the world with people potentially trusting them more than trusting people of other groups. You know, getting by without being harassed, like in bliss, or without a care. And kind of a lot of it is often unknown to the White person out there, that they actually do have privilege. It can be somewhat invisible to them.

1.2B mentioned, "I also have a bias that they may be more questioning or unsure of me. Just because you know, we don't necessarily look the same." 1.7G expressed,

> But I do sometimes have a feeling like oh, are some people gonna like treat them a little bit differently? Or are they going to be like, on their defense, like right away, even like walking into a situation because of, you know, the color of their skin or their race and so maybe they're like defensive initially. Then that can cause like a domino interaction. Sometimes the first interaction can set the tone for the rest of the day. Different interactions cause more issues and more mistrust. So, I guess that kind of comes from my mind and situations and then hoping that, you know, the interactions are kind and caring, and they would act like they would interact with anyone.

1.9I communicated,

> I guess my bias goes to, or my thinking is, oh this child, which is most of the children anyways, but a lot of them I feel like, oh, you were probably not supervised. And so that's, that's where my thought process goes. And so yeah, it just depends on I think the involvement of the adult that's with that child and if they're gonna be willing to do a dressing change at home, and then bring it back in a week, so we can see them in the clinic, versus you know what mom or Grandma's not really interested… And probably if it's a Black family, then it's like, okay, this family says they're going to do one thing, and they're not doing it. When I have to go in to see a Black patient, because they have such a flat effect, it makes me think like, ah, should I go in there right now to check? No, I'll wait another 20 min because I know they don't want to talk to me. Whereas I'm maybe

> not as scared to go into another family because I know they don't have that, that annoyed look on their face.

And 1.11K shared,

> So, it's more like, is the mom going to trust me? Is she going to be nice to me? Is she going to, like, believe that I'm giving her son or daughter the best care, you know, because of their skin tone? So, I'm more like, I think, a little defensive at first, like, wait… but I'm still trying to be myself. But I do think that initially when you see that your patient is Black, there's very much like, whether you want to or not, you're wondering like, what is the parent dynamic going to be? I will say that we get a lot of parents in that will claim that we're not taking care of their kid because of their color of their skin. I had a mom who, you know, claimed that I wasn't taking care of her son because they're Black and that they weren't getting seen quickly enough. So, there's a lot of those questions of like, how much of that is true? How much of that is just a situation? And you know, it's really hard to quantify. So, but yeah, it's something that I've become more interested in after having those really painful interactions with parents and yeah, I mean, is that why it's happening?

Theme 2: Race Is Not a Factor, Other Things Are, However Doctors More Often Override Black Family's Desires

In response to RQ1, the second over-arching theme that came from the data was: Race is not a factor, other things are, however doctors more often override Black family's desires. There were several participants who shared similar reports to the statement: 'race is not a factor’ saying other factors such as education, individual patient and family-centered goals which are dependent on diagnoses and long-term health and adaptability, as well as individualized care plans, play a role. However, it was also mentioned that doctors will more often override what Black families want than families of other races. Seven participants conveyed messages related to the sub-themes of race not being a factor and the same expectations being held for all patients. The same number of participants communicated that treatment options are based on follow-up care needs and resources available, though close to the same number shared that Black families do not often have what is needed. The comprised over-arching theme was supported by many participants and arose from the subthemes depicted in Table 1. 1.3C expressed,

> No, I mean, certainly, way over half of the patients are Black, and it doesn't make any difference. I mean, there are people I would maybe make those assumptions about, but it is not based on race. It is other types of affects. I mean, yeah, we have a wide range of people from a variety of economic levels, a variety of lifestyles, people living on the street, and race isn't particularly a factor.

1.4D shared,

> I can't think of specific instances where anything's changed based on race. I think it's mostly been based on the whole picture of how we feel that the patient is doing, what we feel that the patient's near future goals are, and things like that. And I think usually then the family's ability to provide whatever care the baby might need when he goes home. I can't see an instance where race has played a role. But I think overall, just seeing how the family cares for their baby and their

> comfort level in caring for the baby, while they're in the NICU kind of gives us an idea of what level of care they would be able to provide at home as well. You can kind of get a gut feeling of how, how complicated care they can provide. As far as my personal experiences again, I try to approach everybody with the same sort of expectations. I mean, I try to gauge my patients and families and as I interact with them, I try to see where they're at.

1.5E communicated,

> For the babies, it's a little bit interesting, because, you know, the parents are the guardians, however, they aren't in a sense, once the baby is in the intensive care nursery. The doctors actually have a medical responsibility to make sure that the baby receives the treatment that they deem is necessary. So, our doctors are really diligent in in trying to make sure that the parents are part of the whole process of determining the care for the baby, because they don't want to have any disagreements that would cause the family to either try to take the baby home or take the baby to another hospital. It's not like you can decide no I don't want surgery for the baby if the baby really needs the surgery. They get it sometimes regardless of even what the parents hope for or want – um you know, from everything that I've seen so far.

1.6F explained,

> The fact that I'm White, and I first see that the patient or the family is Black, what do I feel? As a nurse, I don't think I feel, I don't think I think that white and black. Yeah, I don't think I do. I have to look at the care plan individually, for what the

> family is going to have to do at home, for like a digestive thing if the child had to go on a special diet for 6 months because that child had abdominal surgery. I would have to see if they could follow it. So, I would be teaching those parents, and what may come up and what may be the difference is what you get a sense of in conversation, like you find out what the educational background is of those parents, you also find out how much they can handle emotionally and physically. Some parents dive right in and want to help their child, you know, and other parents can’t handle the sight of blood, right? So, I take into account the individual family upon discharge.

1.8H reported,

> No, I mean, I hope I treat that baby the same as I treat every other baby. Um not really, I mean, that I can think of specifically that comes up that I would automatically think of based on race. How do I determine treatment goals for patients? Um, well, it's a group effort, based on the individual baby, I guess, with the team and the doctors, and, you know, we round every day, and we make a plan for what's going to happen next and if the family is there to be involved, that's great.

And 1.12L mentioned,

> I really think that, you know, African American patients are usually lovely, they're sweet, their families are kind are grateful for the care they receive. Yeah, I have like nothing to say. I mean, that doesn't mean that a kid deserves less of a

> chance because they have a different skin color. Like maybe they deserve more of a chance, you know, like they need the extra help.

Theme 3: White Families Live Fearless, Care-Free, and Privileged Lives, and Black Families Live in Fear with Emotional and Dangerous Interactions

To support the third over-arching theme, through a shared thread of response, various participants reported that White families live with a care-free and fearless privileged life, while Black families live with more fear and emotional and dangerous interactions. 10 participants supported the sub-theme that White privilege comes with a feeling of ‘my sense of life, is that it’s made for me’, living with no fear and being treated with fairness and respect. This was reported to come with a care-free and fearless privilege and ability to go anywhere and do anything with less struggle. Several participants supported statements related to sub-themes of White privilege and implicit bias being tied to many reactionary feelings that could be emotional and dangerous and Black families being treated differently, often with more aggression and hostility. Numerous respondents shared a theme that interactions with Black families are often led by feeling uncomfortable, hesitancy, fear, and judgment. 1.1A shared,

> It means to me that I can move thru the world without really having to think about being White. I can move thru the world with a comfort and an assumption that the systems and the services around me are going to be accessible to me and that I don't really have to think about it. Um, that things that, my status in the world or the things that I have- my house, my comfort, my neighborhood, my access, everything I have, I have because my parents are White, and they had it and that I

> don't really have to think about it. I can go everywhere I want, and I can do whatever I wanna do and it's all just going to be there for me. You know, I'm sure there have been situations where I've been sort of hesitant or reluctant to go into a room or answer a call, if I know that, like, oh, this parent is just going to be angry and upset about the situation… There has definitely some discomfort and some hesitation.

1.5E expressed,

> I can speak more for what I notice with my co-workers. They are predominantly White women and I do feel that they sometimes judge. I wouldn't say they judge the babies, but definitely can judge the parents or families based, you know, on racial lines, like they might say, oh, you know, she's trying to bring food in here.

1.8H conveyed,

> White privilege, I mean, I probably experience it every day, you know, when I don't worry about the things that people who aren't White worry about, whether it’s more likely that people don't trust them, or, you know, they go into social situations, and the people don't trust them. We'll go to stores, but why would they if people don't trust them, you know, like, they get profiled wherever they are. So, I mean, I feel that probably all the time that that doesn't happen to me, and I don't have to worry about it.

1.9I mentioned, “African American patient, pediatric patients tend to have this flat affect like they don't want to be bothered.” 1.10J reported,

> I would view it as like an unknown or like an unintended shield, I guess. And like to define it, I, these are very good questions that I want to think about them. Um, yeah, I think I sort of like see it or define it as like an unknown shield and also a born advantage. I guess sort of unassuming. I think it's something that's, not really a known entitlement. So, I guess, like unassuming, but also maybe a little ignorantly entitled.

And 1.13M relayed,

> So, I think that my White privilege exists in I mean, honestly, it probably permeates every facet of my life, even if I don't want to accept that I can walk down a street, and no one moves their body away from me because I am scary. I can voice my opinion loudly. I think that implicit bias exists both in that way of maybe dismissing and even unintentionally dismissing lived experiences because I assume it's something else.

Table 1 includes the interview questions, themes, and subthemes associated with RQ1.

Table 1

Interview Questions and Corresponding Themes and Subthemes for Research Question 1

Interview question	Overarching theme	Subtheme
2, 3, 4, 11, 12, 14	White privilege benefits, emotionally negative implicit biases, and negative impacts on treatment and interactions with Black families.	Inherently all White people have it with awareness or unawareness as it's generational and occurs through a systemic innate perpetuation at a subtle level.
		Pervasive entitled and inherent and systemic ability to access more advantages, opportunities, and resources with power, freedom, luxury, and security.
		White privilege comes with a "sense of life is that it's made for me"- no fear and treated with fairness and respect with a care-free/fearless privilege and ability to go anywhere and do anything with less struggle.
	Race is not a factor, other things are. However, doctors more often override Black families' desires.	White privilege is relationally beneficial with more positive attention, social status, trust, and treatment.
		Race is not a factor as other things play a role. There are the same expectations for all patients.
		Treatment is focused on educating the family and patient/family-centered goals dependent on diagnosis/long-term health and adaptability/and individualized care plans. However, doctors will override family when they feel necessary/more with Black families.
	White families live fearless, care-free, and privileged lives, and Black Families live in fear of emotional and dangerous interactions.	Treatment is based on follow-up care needs and resources available, and more Black families often do not have what is needed.
		White privilege and implicit bias are tied to lots of feelings and can be emotional and dangerous.
		Treatment interactions can be led by feeling uncomfortable, hesitant, fearful, judgmental due to assumptions of Black families' responses, which leads to poor decision-making and negative treatment due to implicit biases.
		Black families are treated differently and experience more aggression than non-Black families.

Research Question 2

RQ2: Does bringing attention to personal awareness or unawareness of White privilege and/or implicit bias play a role in decision-making processes and treatment interactions with Black pediatric patients?

There are four over-arching themes that arose from corresponding responses to RQ2. Through the associated interview questions, I asked nurses questions connected to their personal past and present experiences of race and privilege, and how they compared. I included similar questioning related to implicit bias. I explored through the interview questions how privilege and bias may influence their current interactions with their pediatric patients, as well as what considerations and decision-making occurs when thinking about treatment options for them. Each participant provided in-depth responses to the questions and there were 11 sub-themes that comprised the four over-arching themes to answer this RQ.

Theme 4: White Privilege Benefits and Implicit Bias Occurs in the Workplace, But Only Some See It Occurring in Themselves

The first over-arching theme that developed for RQ2 stemmed from statements supporting that most participants benefitted from White privilege in their lives though only some saw implicit bias occurring in themselves. However, all participants have seen examples of implicit bias occurring in others, including in the workplace. 12 out of 13 respondents reported to believe they have benefitted from White privilege in their lives; one respondent could not think of an instance of benefitting, however had a unique background as a female in the military. Eight participants shared seeing implicit bias occurring in themselves, however all reported seeing it occurring in others. 1.4D stated "Oh, man. I would think that probably being Caucasian is for the most part beneficial. I think it's because it makes life easier." 1.12L conveyed,

> Um, yeah, I mean, I guess, everybody that's White benefits. I mean, the fact that I have like a middle-class life because my parents could afford college, and they, you know, we have a safety net. And I think that a lot of families that are not White and privileged don't have that safety net to help them.

1.13M expressed,

> Oh, absolutely, like my whole life. I think that anyone who is White and says they haven't benefited from it simply doesn't understand what White privilege actually is. I think a big thing is just even having some, like generational wealth.

1.1A shared,

> I'm sure I do it all the time. I'm sure that it does. I think I have gotten to a place where I am aware of it. And, in any given moment, I like, I have like, a conversation with myself, in my head about it. Um you know, like, if I'm walking down the street, and the big Black guy who is kind of disheveled is walking towards me, I'm going to kind of say, okay, like, you know, the initial reaction is to shove a black man coming but now I think more through it like where might he be coming from.

1.2B reported,

> I, sort of in my work, if I see an African American person, I first off think that they live locally. I definitely you know, most of my clientele does live nearby

> where I work, and I don't always think of the difficulty they may be struggling with to get to the hospital or the struggles of not having close, complex health care. So, I might already think like, well, you live right here just show to the hospital, it's not a problem where they may live hours away. Yes, other people I work with, I think, have more. I've seen sort of more negative versions of it. I think that they don't always think that people of color have the same educational levels or higher. Or they don't believe that they understand what's going on or are as well versed in the health care of their child, that they don't necessarily understand the picture of what's going on as well. So those are the kinds of things I see where I think it's sort of a disparity.

1.4D communicated,

> I don't know that I could say that I would react so much to race. I mean, maybe subconsciously, I might. But consciously, I would react more to behavior. If someone is acting awkwardly suspiciously, you know, agitated. That kind of a thing. I think I'm more inclined to go by behavior than race. I kind of operate by the thought of a, you know, gut feeling and trying to read people for their behavior rather than presuming things. I'd like to think that that's what I do anyways.

1.5E relayed,

> I wouldn't say that I am immune to implicit bias, but I feel like because of my particular experience, growing up with and around people of a lot of races, and from all different parts of the United States, I think I have less of it, because I'm

> aware that basically, I don't feel that race actually defines people. I think race is just part of, you know, an influence in someone's life. But I feel that I have less implicit bias than most. And part of that I think, is actually growing up in the military, but also in my line of work. I'm used to, you know, being a nurse to people who of all races and all walks of life.

And 1.13M mentioned,

> People are, many physicians, especially White women, are much more likely to dismiss the concerns of an African American because they don't think they present the same way, and they think they have a higher threshold. They think they're complaining and seeking unreasonable care, or they get accused of drug seeking. So, I'd say making, making negative assumptions that negatively impact delivery of health care.

Theme 5: All Have Had a Growing Understanding of Unfairness Between White and Black People Regardless of Background and Believe Implicit Bias Occurs Subtly, Internally, With or Without Awareness, and Mostly Towards Black People

The next over-arching theme identified for RQ2 connected statements from participants to support a common thread that although having differences in awareness of race growing up, all have had a growing understanding and awareness of unfairness between White and Black people over time. To add, they all believe that implicit bias is an internal process that occurs inadvertently, with or without awareness, as a subtle bias towards a specific other race and mostly Black people. Each of the participants relayed detailed descriptions of their experiences of race during their childhood, as well as how it has changed over time, if it has. They each shared a personal perspective of how their understanding of the existence and impact of racial differences and unfairness between White and Black people grew over time as they grew into adulthood. Furthermore, they all shared a common explanation of implicit bias and how it plays out towards other people. Examples from responses to support this theme are provided here. 1.4D indicated "I never spoke with anyone there that was of a different race or color. They weren't, I don't feel like they were very well integrated." And in reference to now, 1.4D shared,

> Now, I mean, living here, you know, it's such a crazy melting pot. And it's, I think it's awesome, it's very cool to meet people from different cultures and hear about their traditions and stuff. And I think sometimes I feel like I wish like people were more open with sharing things that are important for their culture, because it would help me like as a nurse.

1.11K noted,

> California is more diverse, so I definitely feel like it's more a part of my day-to-day life, especially working in the bay area. And like, wanting to be a more anti-racist person than I grew up being, so it's something I'm paying more attention to than I used to. And so yeah, more diverse, more interested in like, self-awareness and but still, you know, most of my friends and family are White. So, it's in some ways it's different and in some ways, it's the same.

Furthermore, exploring implicit bias, 1.1A defined it as,

> Implicit bias, so that's like I mean, obviously making assumptions about people just based on what they look like, and how they present or not even. It's making

> assumptions, making judgments that you know, like going into a patient's room and yeah, like changing my own behavior and judgments and way that I approach someone based on assumptions and judgments that I'm making about them just off the bat.

To add 1.3C shared, “I mean, implicit to me sounds like implied. I mean, it's sort of the way, the way people react to other people. Sometimes, it’s not necessarily intentionally, or sometimes they will deny it.” Moreover, 1.4D explained it as,

> I guess it makes me think mostly I have things that me as a Caucasian person, or vice versa, I mean, racism can go the other way as well. Where someone treats somebody of a different race differently, inadvertently, more often than intentionally. That's kind of what it makes me think of. It probably occurs to a certain level, subconsciously.

To conclude, 1.7G reflected,

> It makes me think of, you have, like, you can have bias towards something without even thinking that you have bias. You can like walk into a situation and you're gonna maybe act a certain way just because of what you've been through in your life, different things you're experiencing, or what you've heard and then you might act in a certain way or think a certain way and not even like consciously know that you're doing based on race.

Theme 6: Participants Saying Biases Come from Behaviors or Past Experiences and Race Is Not a Factor Impacting Treatment Mentioned Influencing Factors That Could Be Impacted by Racial Dynamics

The third over-arching theme for this RQ arose from more than half of the participants and is connected to a larger compilation of statements including: Some participants who reported that implicit bias does not exist for them and that initial judgments come from behaviors and past experiences rather than race, also claimed that race is not a factor in interactions and treatment with patients and their families and is rather due to other influences. However, some of the influences mentioned, contributing to decision-making processes, were also noted as ones that could potentially be prejudiced by racial dynamics. Seven people supported this theme with statements that agreed with the sub-theme describing implicit bias: An initial judgment operating from a reactional place based on past experiences and behavior rather than an assumption based on race. Also, seven people shared support of the sub-theme: Race is not part of decision-making and treatments. Everyone is given the same options. Decision-making and treatments are based on factors that are not related to race. They are dependent on the individual patient and diagnosis, whether the treatment will work, and to provide the best comfort. Examples to support this over-arching theme under these sub-themes, included, 1.3C’s explanation,

> I think it's a situation by situation. There will be times I'll walk past somebody on the street, and other times I'll cross the street and it may be because of something I see or sense, like, I definitely crossed the street when I could tell from a distance

> that there was a Black man, but he also had his pants down and was peeing on the street. And I didn't know why, but I don't think it was racially motivated. Um, probably, I mean, there were probably a zillion little things that I don't realize but I don't see it in a big way or think that it is a major part of how I live my life.

1.4D shared,

> I mean, I try to be aware of people around me, regardless of race or color, you know. From my work and just life in general, I know that anybody can be not in their right mind or unpredictable at any time. I don't know that I could say that I would react so much to race. I mean, maybe subconsciously, I might but consciously, I would react more to behavior. If someone is acting awkwardly suspiciously, you know, agitated, that kind of a thing. I think I'm more inclined to go by behavior than race. I kind of operate by the thought of, you know, a gut feeling and trying to read people for their behavior rather than presuming things.

1.7G reported,

> I don't really think so. I feel like our teams are pretty good. We have a lot of different treatments for like cancer. We have a ton of the different clinical trials and different things and good treatments. And I suppose I haven't experienced like, someone not necessarily getting the treatment, that I've personally been involved in, because of their race. I guess, I don't know if that sometimes happens with transplants but that's mostly- I don't really think that's like a race thing. I think maybe it’s more the resources like if there's someone that's not going to be

> able to be close, so usually for transplants, they have to live close to the hospital for like 3 months.

And 1.8H communicated,

> I don't, I don't see, any. I don't know if I've ever seen any, like real racial difference between making decisions if that, you know, like, it doesn't really matter. Everyone's a mom, or everyone's a dad, you know? To be honest, I feel like, at least, you know, I've been at one hospital a year and a half, and I feel like they treat all the families the same. We give them the same options and withdrawal of support.

To go along with the over-arching theme, however, 10 people agreed with the sub-theme: Decision-making and treatments are based on factors that could be influenced by race: level of pain tolerance, level of caretaker responsibility, follow-up care ability of caretakers, resources available, living situation and lifestyle, affordability, socioeconomic status and insurance, and educational ability. This sub-theme demonstrated that there are factors that people shared that are ones commonly influenced by race, even if the participants were not aware of the direct connection. 1.6F conveyed,

> You find out what the educational background is of the parents, you also find out how much they can handle emotionally and physically. Some parents dive right in and want to help their child you know, and other parents and just people in the hospital can’t handle the side of blood, right? So, I take into account the individual family and upon discharge, I would teach and explain to the ability I

> think the parents or caregivers can handle and can do and I would give supplies as much as I can.

And 1.10J relayed in response to treatment considerations,

> Financial ability to pay for treatments, educational or like intellectual ability to follow the treatment plans, and caretaker responsibility and reliability. Because these are pediatric patients, their caretakers are often the ones who are implementing the treatment plan. Patient age and compliance, so the patient's age has a lot to do with their, like developmental ability to comply with certain treatments. And yeah, socioeconomic status is a huge one, just to make sure that these parents are able to, or, you know, whoever the caretaker is able to adequately get supplies or medications or whatever else they might need and like comply. So, I don't think that it's necessarily based on race. It's a lot more to do with insurance coverage.

Theme 7: Participants Who Acknowledged Racial Implicit Bias Whether Wanted or Aware or Not Also Reported Initial Negative Feelings and Fear Towards Black People, a Need to Understand Them More Personally, and Relayed Negative Reports from Black Families of Painful Interactions

Participants who responded that implicit bias is associated with an initial judgment based on race, whether aware or wanted or not, also shared having initial negative feelings or fear of Black people resulting in more painful interactions with them. However, these were also participants that relayed receiving negative reports from Black families that they were not taken care of and experienced more aggressive, dismissive, and painful interactions. There were four sub-themes that were combined to determine this over-arching theme and they were supported by most of the participants. Particularly, 10 participants supported the sub-theme: An innate automatic subtle positive or negative, wanted or unwanted, initial bias/judgment in White towards Black people that is based on outer appearance around education, level of connectedness to what's going on, and/or state of affluence. 12 participants used statements that support the sub-theme that: There is a need for more understanding of where patients are coming from and their lived experiences, life situations, and backgrounds. In support of this over-arching theme, participant 1.2B shared,

> Basically, without any context when you first meet a person what are the things that are already pro and against for them? So, what do you already pretty much think of them without having much input at all, you know, on a variety of terms of who they really are.

1.6F explained, "A bias that you have in your being that you see someone that's different from you and you automatically are biased. Negatively or positively." 1.7G expressed,

> Me personally, I don't feel that, but I definitely have experienced it at work, where I feel like I'll get reported and be like, oh, this feeling was like, very difficult. Like having the thought like they weren't ghetto or they're, like, ghetto, and you think this is like happening. And then I'm like, okay, I don't even know these people. We're just gonna start fresh and see what happens, but I feel like I'm very like conscious of it because of things I've been through in my life.

1.5E explained,

> I would say so the health care field is incredibly complex. It's like we have our own language. You know, all the medical terminology that we use, and I would say that sometimes there's an implicit bias, where we may assume that people of other races won't understand some of the things going on with their loved ones and so sometimes, we don't give complete information. So, I'd say sometimes education level is assumed to be lower. And then also, I think, maybe times there, there may be avoidance of having tough conversations because people assume that people of other races are going to handle it in a stereotypical way or in a very dramatic way. And then, I've actually, to some degree seen the care sometimes is different in the sense that sometimes black babies are cared for less or get less interventions and in some ways, I think that sometimes we don't have the conversations that we need to have around dignity and potentially, like, death and dying because we're afraid of the consequences and the fallout that might ensue.

1.9I conveyed, "African American pediatric patients tend to be flat like they don't want to be bothered. They don't want more, like they're annoyed sometimes when I go in there because of that flat affect." 1.10J communicated,

> I have had a few experiences where like, and again this may be like a cultural thing to where like non-White families like Black or Latinx families like react poorly or get like very, very upset about the way that like people are handling their child and they have, a heightened sense of like, I think, security for their child, like maybe a protective, a higher protective factor. And they, they like, perhaps feel that their kid is more prone to not being treated equally and that

> comes out in getting like really, really angry about what seems to be like minor things.

1.11K proclaimed,

> But there are some attendings that will say like, oh, yeah, just let's just do one more dose of Dilaudid and there's some that will like just toe the line. I'm not sure. Since I'm not a physician, like how implicit bias or racism plays into that. I will say that we get a lot of parents in the ED who will claim that we're not taking care of their kid because of the color of their skin. This is one of the reasons that this became more of something I became more interested in again after like years of not, you know, not really thinking about it. I had a mom who, you know, claimed that because they were Black weren't getting seen quickly enough. So, there's a lot of those questions in the ED of like, how much of that is true? How much of that is just a situation. And you know, it's really hard to quantify. So, but yeah, it's something that I've become more interested in after having those, like, really painful interactions with parents.

And 1.13M concluded,

> So, I think that it exists both in that way of maybe dismissing it and even unintentionally dismissing lived experiences because I assume it's something else. Then I see it at work all the time. We started to roll out a new way of triaging people that eliminates the objective measure of pain. So, it has become only whatever the patient said their pain is, it doesn't matter if they're laughing and smiling. If they say their pain is at a level 10 pain, then 10 is what it will be.

> Otherwise, we would find a lot of times people would downplay it. The patient might report it as a nine, but the nurse would say, oh, well, they're texting and laughing, it can't be a nine. They would peg it for a six and they would adjust it to what they objectively thought they were seeing. You know, in that way, I'd say definitely, I see it played out every day in the triaging of African American patients.

Table 2 includes the interview questions, themes, and subthemes associated with RQ2.

Table 2 *Interview Questions and Corresponding Themes and Subthemes for Research Question 2*

Interview question	Overarching theme	Subtheme
5, 6, 7, 8, 9, 10, 13	White privilege benefits and implicit bias occurs in the workplace, but only some see it occurring in themselves.	All but one believes they benefit from White privilege.
		See implicit bias in self.
		See implicit bias in others, including in the workplace.
	All have had a growing understanding of unfairness between White and Black people regardless of background and believe implicit bias occurs subtly, internally, with or without awareness, and mostly towards Black people.	Childhood not diversified/childhood naivety; in adulthood more diverse bringing a growing understanding of diversity and impacts of unfairness.
		An innate automatic subtle positive or negative, wanted or unwanted, initial bias/judgment in White towards Black people that is based on outer appearance around education, level of connectedness to what’s going on, or state of affluence.
		An initial judgment operating from a reactional place based on past experiences and behavior rather than an assumption based on race.
	Participants saying biases come from behaviors or past experiences and race is not a factor impacting treatment mentioned influencing factors that could be impacted by racial dynamics.	Black families are more dramatic, difficult, ’ghetto’, ‘bothered’, noncompliant, more resilient and more tolerant of pain therefore, receive different/less care, and treatment interventions.
		Related that Black patients have reported having painful interactions, not being taken care of, different treatment, having concerns dismissed, and aggressive interactions with White nurses.
	Participants who acknowledged racial implicit bias whether wanted or aware or not also reported initial negative feelings and fear towards Black people, a need to understand them more personally and relayed negative reports from Black families of painful interactions.	Decision-making and treatments are based on factors that could be influenced by race: level of pain tolerance, level of caretaker responsibility, follow-up care ability, resources available, living situation and lifestyle, affordability, socioeconomic status and insurance, and educational ability.
		Race is not part of decision-making and treatments. Everyone is given the same options. Decision-making and treatments are based on factors that are not related to race. They are dependent on the individual patient and diagnosis, whether the treatment will work, and to provide the best comfort.
		There is a need for more understanding of where patients are coming from and their lived experiences, life situations, and backgrounds.

Research Question 3

RQ3: Does utilizing a personal self-examination process of the impacts of White privilege and implicit bias bring more awareness and attention to how these concepts impact treatment decision-making processes and interactions and shape the way White nurses plan to work with Black pediatric patients moving forward?

Questions related to RQ3 were designed to explore if, for these nurses, using the self-examination process of the interview and delving into their personal experiences with White privilege and implicit bias, would help to bring more awareness and attention to their work with Black pediatric patients. I sought to understand if it would help them to recognize how these concepts may impact their treatment of patients in the ways they make decisions and interact with them, and if the process will shape the way they plan to work with them moving forward. There were three over-arching themes that arose from eight sub-themes in response to this RQ.

Theme 8: All Acknowledged the Existence and Impact of White Privilege and Implicit Bias, Though Some Refuted It Occurring in Them Personally and Claim to Treat Everyone the Same

To address RQ3, the first over-arching theme that surfaced came from a common thread of all participants acknowledging that White privilege and implicit bias exist and have an impact on their life. However, some participants claimed that biases do not occur within them personally and that they don’t want to treat anyone differently, but rather all the same. Supporting statements created two sub-themes. The first was: ‘Sure, biases happen all the time, but racial biases don’t happen with me’. They reported they purposely do not want to treat Black people any differently and are making efforts to do things differently and get to know people for who they are and where they’re at in their lives. The second was: That they see implicit biases acted out in fellow nurses through unfair treatment of Black families either directly or behind backs, however not in themselves. More than half of the participants shared in this common thread of thought. 1.3C asserted,

> Trying to think yeah, I mean, I worked in an area like I said, that had a high percentage of non-White patients had a high percentage of Black patients. And I feel like the treatment that the patients got did not vary. I think sometimes, the way people were talked about behind their backs, the way some of the nurses would talk about people, when they weren't there may be buried. But it didn't carry over to the care that they weren't given.

1.6F explained,

> For me, personally, I don't think so. I think I really do look at that family or that patient, who they are not what their race is. I've seen that in others. Let me think, I can give you an example. I think I remember the resentment of Black parents resenting a White nurse and resenting the White nurse telling them what they need to do, or it's like a defensiveness. I think I have seen, and I have felt it, but not with the kid, right at all. Kids don't have that. You know, it's the family.

1.7G reported,

> I don't, I don't think I have personally, like changed the way I treat anyone from any race. I guess maybe the only thing is maybe I was a little more, no, I don't

> even know if I was, I mean, like maybe a part of me was a little more like, let me try to make sure that maybe I try a little harder in the sense of like, not wanting to come across as like judgy. Maybe I could say that, but I feel as a nurse like I always just like to get to know my patients very well. People are like you're just getting too close and I'm like I can't not get close. I treat them like they were my own kids. I would want my kids to be treated the same way too. So, I feel like I kind of am like that with all of my families.

1.11K conveyed,

> With families, there's just yeah, like, so many, so many, like variations, it's hard to just categorize. There's just so many different, like, income levels and education levels, and it's just crazy, especially with the volume that we see in the ED. You know, just kind of, I'm happy to generalize, but yeah, it's definitely a different place after the BLM movement. There is definitely a lot more anger and maybe questioning of the system afterwards, really too cold. I've noticed that.

And 1.12L shared,

> But truthfully, as you learn over time, like some people are louder. Some people are quieter, you know, it is culturally like some people have to be louder to get noticed, or that's just the way your family talks at your house. Like everybody talks loudly, you know, in my house, we all talk quiet. But I think I just had to get used to differences. I don't know, if I ever was like, that person is this way or that way because of their skin color. It's been just more, we're all different, you know, because of the way we are, we are raised, but I wouldn't say it's a bias.

Theme 9: Questions Brought Awareness to Negative Impacts on Health Care Delivery and Unfair Thoughts and Treatment of Black Families Stemming from Varied Implicit Biases and Hesitancy in Interaction and Communication

The ninth over-arching theme that developed from the data in response to RQ3 supports an all-encompassing statement: Many participants conveyed that these questions brought awareness to negative impacts on health care delivery and unfair thoughts and treatment of Black families. They acknowledged them stemming from issues such as making assumptions without thinking more about who someone truly is and where they come from, initial thoughts of Black families which they had not previously realized were more negative than positive, and a hesitancy that tends to exist in having real and hard conversations with Black parents. Most participants agreed with statements that supported this common thread of understanding. For example, 10 participants supported the sub-theme: Implicit bias towards Black people is something everyone should consider and reflect on as it is ingrained in many individuals' thought processes. It is very important to reflect and have open and honest conversations because it can reveal where distrust lies. Furthermore, 12 participants shared in the support of the sub-theme: There are many assumptions in the workplace about people and their lived experiences without much thought into individual circumstances, who they are as people, and their needed supports. Moreover, eight respondents conveyed messages congruent with the formed sub-theme of: There are initial thoughts, mistrusts, resentments, and defensiveness towards Black people and biases that they don’t want to talk, are louder, more defensive, argumentative, or are rule breakers. 1.1A expressed,

> You know, I'm sure there have been situations where I've been sort of hesitant or reluctant to go into a room or answer a call. Like, if I know that this parent is just going to be angry and upset about the situation. And I don't know, I mean, that's changed I think with experience. I kind of feel like I can take whatever is going to come so I just go in.

1.2B communicated,

> My experience has been in the past I've sort of skipped over or really didn't put a lot of thought into where they live. I have definitely not really put a lot of effort into wondering where the family is going to spend the night or where they're going to eat or where they're going to shower and things like that, because I think they live right nearby. And, in reality, I've had families that have lived 2 hr away and I failed them basically in terms of securing them those resources to help them make it easier so that they didn't have those stressors while they're in the hospital. So that's definitely it.

1.5E shared,

> I think unfortunately, a lot of people's behaviors or judgments are so like ingrained and part of their thought process that it can be difficult for them to notice anything but overt racism. So, I would say there's not very much overt racism where I work. But I definitely think there's implicit bias and there is avoidance of hard topics with people of various races. So, I think it's difficult because a lot of these people that, you know, believe in the rules also think the rules are right. It's hard for them to imagine being on the other side, where, you

> know, the rules are too harsh, or hard too hard to, like, work with them. They're not used to that feeling of being oppressed. They don't understand why people might not want to follow those rules, or why they ignore the rules. I think for a lot of people they don't understand because they've had the benefit of creating those roles and, you know, benefiting from those roles. So, to them, the roles are very important and part of the culture that they want to hold up. I that's also one of the issues that I find with when people talk about higher mortality and morbidity with Black babies or Black mothers is it's like, I don't think it's something that we can just fix from this side. We have to fix it from all sides. Because just the physiological strain of being in an oppressed or marginalized group is enough to impact the mother's health and therefore it impacts baby's health.

And 1.9I relayed,

> So that's my initial thinking is, they don't want to talk to me, they're gonna be annoyed with me, and they don't want to talk to me. Maybe I go in there 20 min later, instead of going in there right now because I know that I'm gonna have to work a little extra hard, you know, to kind of break down that barrier. And sometimes we break it down and sometimes we don't, it just depends. Like I said, if I'm going to be there, that depends on the stay of the patient, if they're only going to be there 3 days and you're annoyed with me, I'm not going to push myself on you. So, it's just a snap decision or not a snap decision, but it’s a judgment, where I'm just like, oh, this family's not gonna want to see me again. But I just break through that, depending on their length of stay.

Theme 10: New Acknowledgment to Issue of Implicit Bias and White Privilege, a Belief That Everyone Should Consider and Reflect on the Issue, and an Initiative to Bring More Conscious Effort to It for Personal Growth Moving Forward

To help answer RQ3, the last over-arching theme that surfaced came from most participants sharing similar ideas. They reported that this study helped them to acknowledge something new and a belief that everyone should consider and reflect on the topic, whether they believe they currently participate in racial implicit bias or not. They also shared in their own way that they will bring more of a conscious effort to paying attention to this issue, while holding a growth mindset with a desire to further self-examine. Seven participants contributed to the sub-theme: It is not an easy process to self-examine as it can be challenging to verbalize and challenge yourself on. There are feelings of worry about how it may be interpreted, can be embarrassing, or can also feel attacked because it is a heavy topic. Furthermore, 12 respondents shared in a common thread of statements that supported the sub-theme: ‘I wouldn’t have reflected otherwise.’ These questions create awareness, and it is helpful to highlight unawareness and it is important to look deep and examine. And all 13 participants shared a third sub-theme of having a growth mindset looking forward after this study and a desire to self-examine and question thoughts and actions further. 1.4D communicated,

> It's definitely an eye opener. It's definitely something I think we all have to consider. And obviously, I think a lot of it is, I don't want to say the big, we become brainwashed, but you do hear and see so much in the news, and you know, a lot of ideas and thoughts get put in your head. And, you never know what

> your mind is doing behind the scenes and how it makes you behave behind the scenes, and you don't realize how you're behaving. So, I think it definitely creates awareness for me and makes me think about it, some more, and so forth. I think I will definitely continue being aware of, you know, how I interact with all the other races and things like that.

1.6F shared,

> I think it’s really good. That's why I said, I’d do it, you know, if it was bad or uncomfortable, or I thought it was ridiculous, or a waste of our time, I wouldn't have done it. I think it's great that you're looking into it as a student, and it's good for me to reflect and I've never had these questions asked to me, point blank. So, it's a good thing. We all should reflect on how our behavior impacts. So, you have helped me reflect.

1.7G conveyed,

> I think it's important to self-examine yourself. I think you have to be in the right mindset and be open to different things. Because even if you're having a conversation with my husband, like, we're still not quite there, you know, I still feel a certain way and he says, you know, I grew up and didn't have a lot and we were super poor. And so, he, I guess he's constantly like, somewhat feeling attacked. So, what I, myself, realized is that I had to, take step away and get in the right mindset. And I really had to dig deep and think. So just knowing that it's not going to be an easy process and just being open. I definitely think that's important because we all deserve the same level of care, kindness, and access.

1.9I mentioned,

> I might just look at my actions and the other nurses actions a little bit more and think, oh, yeah, people are interested in this because there is maybe an issue or a problem. Obviously, there is because people are looking into it and studying it.

1.10J reported,

> I think it's important. I think it's hard too because sometimes you say stuff and you're like, oh God, like you know, you come from like the best place and oftentimes you know, it's hard to like verbalize. It's really difficult to verbalize it and like I worry sometimes about the way that things are said or interpreted and things like that. But I think it's really important. Thank you for taking the time to dive into this huge, hugely important topic and it affects so many of our patients and their families and their children. And so, I think it's really beneficial and important work.

1.11K expressed,

> Yeah, just that I consciously have to make an effort not to like worry about the racial dynamic, and just to try to be the best nurse I can be. But also still, like, be aware that I have my implicit biases and that I have to check them.

And 1.13M shared,

> I am always being like, wow, like, that's another thing I have. I think that it's an ever- learning thing. And the more I am open to understanding that, I don't have to feel guilty because I have this privilege. It's not my fault but it is my responsibility. I think that I'm constantly finding ways that I can better use my

> privilege to support elevating African American voices to elevate African American care experiences and knowledge and businesses. So, I think that I'm just learning every time, examining more ways that I can make myself uncomfortable, rather than expecting someone else to maintain this lifestyle on this level of discomfort. I think this is some important info to get out there and you know people are dying because of it.

Table 3 includes the interview questions, themes, and subthemes associated with RQ3.

Table 3 *Interview Questions and Corresponding Themes and Subthemes for Research Question 3*

Interview question	Overarching theme	Subtheme
15, 16	All acknowledged the existence and impact of White privilege and implicit bias, though some refuted it occurring in them personally and claim to treat everyone the same.	There are many assumptions in the workplace about people and their lived experiences without much thought into individual circumstances, who they are as people, and their needed supports.
		"Sure, biases happen all the time, but racial biases don't happen with me". Purposely don't want to treat Black people any differently and are making efforts to do things differently and get to know people for where they're at in their lives and who they are.
		See implicit biases acted out in others in unfair treatment of Black families from fellow nurses either behind backs or directly.
	Questions brought awareness to negative impacts on healthcare delivery and unfair thoughts and treatment of Black families stemming from varied implicit biases and hesitancy in interaction and communication.	There are initial thoughts, mistrusts, resentments, and defensiveness towards Black people and biases that they don't want to talk, are louder, more defensive and argumentative or are rule breakers.
		Implicit bias towards Black people is something everyone should consider and reflect on as it's ingrained in our thought processes. It is very important to reflect and have open and honest conversations with ourselves and others about it as it can help us all to see where distrust lies.
		"I wouldn't have reflected otherwise". These questions create awareness, and it is helpful to highlight unawareness and it is important to look deep and examine.
		Have a growth mindset looking forward after this study and desire to self-examine and question thoughts and actions further.
	New acknowledgment to issue of implicit bias and White privilege, a belief that everyone should consider and	It is not an easy process to self-examine as it can be challenging to verbalize and challenge yourself on. There are feelings of worry about how it may be

	reflect on the issue, and an initiative to bring more conscious effort to it for personal growth moving forward.	interpreted, can be embarrassing, or can also feel attacked because it’s a heavy topic.

Summary

For this basic qualitative research study, I conducted one-on-one in-depth interviews with 13 self-identified White nurses to describe how influences of White privilege and implicit bias shape and impact them as they implement treatment decision-making processes and interactions with Black pediatric patients. Codes and subsequent sub-themes and then over-arching themes emerged guided by the iterative process of thematic coding analysis. Outcomes from the 13 White nurse interviews supported assumptions that overall bringing awareness to personal White privilege and implicit bias elicits acknowledgment of their existence and impact on treatment decision-making processes and interactions with Black pediatric patients, through a self-examination process. In sum, all participants reiterated similar experiences and insights. The results of this research provided a detailed, and in-depth understanding into the current experiences of a sample of self-identified White nurses living and working in public urban hospitals with Black pediatric patients in California. In Chapter 5, I will further discuss conclusions and recommendations to continue and expand upon this research study topic.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to address the lack of information regarding specific racial differences in the treatment of Black pediatric patients. I focused on the impacts of the concepts of White privilege and implicit bias on decision-making processes in treatment and interactions between White nurses and their Black pediatric patients. A basic qualitative inquiry study with in-depth, one-on-one interviews was used to gain a deeper understanding of the lived experiences of the nurses in this context and the potential for self-examination involving White racism and implicit bias. Throughout the course of my research, I gained deeper insights into the lived experiences of the 13 White nurses who participated in the study and their interactions with Black pediatric patients and patients' families.

Key findings showed that there were two different paths the White nurses took in the exploration of their own White privilege and implicit bias in their lives and how it potentially impacts the patients they work with in some way. There are those who focused on self-reflection and examining who they are and how they act when they are interacting with their patients. Then there were others who were struggling to see these concepts occur within themselves, though they acknowledged seeing it in others. However, all participants expressed a desire after participating in the interview to further question their thoughts and actions moving forward. In conducting my research, I drew from Hobbs's (2018) conceptual outline of White privilege and Blair et al.'s (2011) conceptual model for the influences of implicit bias on the treatment of patients. The study's three RQs were answered through the lens of this conceptual framework, and the outcomes gathered from the participants were congruent. In Chapter 5, I interpret the results, discuss the limitations of the study, offer recommendations for future research, consider the study's social change implications, and provide a conclusion.

Interpretation of the Findings

The results of this qualitative research study may aid the health care community by bringing more awareness and attention to the needs for educating staff and improving and changing policies related to the treatment of Black pediatric patients. The outcomes of this study highlight the lived experiences and influences of White privilege and implicit bias in the White nurses who participated and the ways these concepts impact the interactions and treatment processes with Black pediatric patients. There continues to be a significant gap in the literature as to the impacts of White privilege and implicit bias on the lived experiences of White pediatric nurses in their implementation of treatment decision-making processes and interactions with their Black patients (Nafiu et al., 2020; Yearby & Mohapatra, 2021). Consequently, the findings from this study add to the body of knowledge and may be pertinent to addressing the dynamics underlying the perpetuation of racial public health inequities as they speak to the self-discovery of personal experiences regarding the impacts of White privilege and implicit bias in this relationship, within the hospital setting.

For this study, I used three RQs to explore the lived experiences of White pediatric nurses as the treat and interact with Black patients. In analyzing data to answer the RQs, I identified 10 total overarching themes. The 10 themes were developed from pertinent and relevant subthemes from the interview data to enhance and support them fully with meaningful influence. Each RQ will be answered with analysis and interpretation of the findings through the context of the themes joined together with corresponding previous research and the conceptual framework for the study. The interpretations of the results will be examined and resolved through a lens of understanding racial health disparities, White privilege, and implicit bias.

Johnson (2022) provided an overview of the concepts of racial health disparities, White privilege, and implicit bias. In her definition, health disparities are "preventable differences…or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (p. 2). She purported that the disadvantages experienced are related to how people are grouped relationally in terms of affluence, "power", and/or "privilege" and that the most prominent health disparities found among children have been distinguished based upon race and/or ethnicity (p. 2). Last, Johnson stated that the unconscious attitudes that people hold have the potential to influence their behaviors. The way that Johnson described these concepts succinctly align with the concepts illuminated throughout my research and analysis. They provide a context to understand and absorb the results through analysis in answering each RQ.

However, the modified conceptual framework highlighted in Chapter 2, concretely sets the stage for contextualizing the concepts of White privilege and implicit bias to understand this research and will be focused on throughout the interpretation of results. My modified model, featuring Blair et al.'s (2011) model of influences of implicit bias to include Hobbs's (2018) conceptual framework of White privilege, ties together these two concepts in the context of a health care setting and interactions in treatment between White nurses and Black pediatric patients. Furthermore, the results will be linked to the issue of racial health disparities and potential contribution of these concepts to playing a role within pediatric White nurses in the treatment of their patients. The results will be interpreted by RQ.

Research Question 1

RQ1: Does White privilege and/or implicit bias impact and shape the lived experiences of self-identified White nurses in the way they implement treatment decision-making processes and interactions with Black pediatric patients in urban public hospital settings within California?

Responses to the interview questions confirmed that both White privilege and/or implicit bias impact and shape the lives of each of the participants. All the participants shared definitions of White privilege that align with Hobbs's (2018) conceptual understanding of White privilege that White-passing people can inherently receive more of in society due to having White skin. All participants acknowledged that White privilege provides countless benefits to White people, and all but one shared that they had benefitted from it personally in their lives. All responses also supported that White privilege is something all White-passing people experience, whether they know it or not, because it is inherent and generationally and systemically propagated. Therefore, they each explained in one way or another that it impacts and shapes their lived experiences today. Theme 3 was that White families live fearless, care-free, and privileged lives, and Black families live in fear with emotional and dangerous interactions. The theme elucidated that the participants reinforced the construct of thinking that White people inherently live with clear and, to some extent, extreme privilege, which impacts their lives. In contrast, participants expressed that Black families live with having to always feel defensive and in fear. Responses from participants affirmed that Black families often live this way within the hospital setting when interacting with White nurses, indicating the nurses are impacted by their own privilege and advantage. Many of the participants reported similar sayings close to "it’s a feeling or sense that life is made for me" and "I can walk through life, knowing life is for me, with the ability to go anywhere and do anything."

The nurse participants more easily connected with White privilege shaping their lives and framework for understanding than identifying implicit bias within themselves that leads to negativity. Many of them could see it more easily in other people. However, responses support that whether they concurrently acknowledged it occurring in themselves or not, there are observed initial reactions and biases that lead to poor treatment decision-making and ultimately negative treatment of their Black patients and families. Those who more easily identified their own implicit biases and reactions more easily also acknowledged more unfair treatment of their Black patients. All participants shared that the initial judgments and implicit biases that do exist are negative, often emotionally charged, and sometimes even dangerous, even if unintended.

These findings bolster Blair et al.’s (2011) definition of implicit bias used for the purpose of this study, which describes it as an indirect bias that operates in an unintentional or even unconscious manner that does not require the person who perceives it to endorse it or devote attention to its expression. Maina et al. (2018) validated these responses in their research outcomes having found an increased consistent correlation of provider bias with poor patient-provider interactions. Additionally, Yearby and Mohapatra (2021) uncovered influences of White privilege on the quality of care of hospitalized pediatric minority children which led to unequal treatment, adding to Jabbour et al. (2018) finding Black children to receive less quality of care, reinforcing support of this study's results. This study furthers previous research with its finding of emotionally charged interactions and, specifically, fear in participants' accounts of their interactions with Black patients and their families.

Rodriguez et al. (2021) recognized that providers, irrespective of their personal backgrounds, work within an environment promoted by structural and institutional White privilege. This was strengthened in my study by a second train of thought that was found among the participants in response to RQ1. The theme found was that race is not a factor, other things are, however doctors more often override Black family's desires. The latter part of this theme coincides closely with the assertion of previous research that racism and racial disparities are interwoven into the already developed guidelines that support the health care system (Rondini & Kowalsky, 2021). Many of the nurses claimed that race does not play a role in their interactions and treatment of their Black patients and that the same treatment options are provided to each patient with the same expectations for all. They attributed the differences in care to other factors they said play a role such as patient and family-centered goals, individual diagnosis, long-term health and adaptability, and resources available for care.

Research Question 2

RQ2: Does bringing attention to personal awareness or unawareness of White privilege and/or implicit bias play a role in decision-making processes and treatment interactions with Black pediatric patients?

The responses to this RQ reinforced and aligned with previous research that has stressed the need to bring attention to potential personal contributions to racial health inequities (AAP, 2020; Kowalsky et al., 2020; Vanidestine, 2018; Williams & Cooper, 2019). This study's results revealed that the more participants have given attention to how White privilege and implicit bias are defined in their own lives or even nominally during the interview, the more they acknowledged, at minimum, the potential for them to play a role in decision-making processes and treatment interactions with their Black pediatric patients. As Blair et al.'s (2011) definition of implicit bias suggests that it can occur with or without awareness or intention, Hobbs (2018) also indicated in his description of White privilege that it can manifest in ways that are with or without awareness. The key implication found in this study is its highlighting of the benefits of bringing more attention directly to the concepts of White privilege and implicit bias; when this occurs, more growth in understanding of the issues that arise due to these concepts can be reached.

All the participants reported to believe they have benefitted from White privilege in their lives; however, they had differing views of implicit bias. They all agreed with a common definition of what implicit bias is, that it occurs in the workplace, and mostly towards Black people; however, only some reported seeing it occurring in themselves.

All participants also shared in experiencing a growing understanding of unfairness between White and Black people. Each of the participants had varying backgrounds and understanding of racial differences and racial unfairness, however each of them shared that over time their understanding has grown. They all communicated a knowledge that implicit bias in an internal process that occurs inadvertently, with or without awareness, and with a subtle bias towards someone else, based on their outer appearance.

My study results showed that participants who reported that implicit bias does not occur within themselves but rather in other people and that initial biases and judgments come from observed behaviors and past experiences also claimed that race is not a factor in interactions and treatment of Black patients. However, in disclosing the other factors they claimed to play a role, many of the nurses did not recognize that some of the ones mentioned such as the ability to participate in treatment care needs, follow-up care needs, insurance, and resources available, could be greatly influenced by racial dynamics and a stance of White privilege. This indicated a continuing unawareness within this group of nurse participants, of the role that White privilege could potentially play in their treatment decision-making and interactions with Black patients.

The other group of participants claimed more specifically that implicit bias is associated with an initial judgment based on race, mainly Black people, whether aware or wanted or not. These nurses also reported having initial negative feelings, reactions, or fears of Black people which result in more painful interactions with them and expressed a need to work towards more understanding of their Black patients personal lived experiences and where they come from. To add, these participants relayed negative reports personally received from Black families that they were not taken care of due to their race and that they experienced more aggressive, dismissive, and painful interactions while in the hospital. Each of these different data perspectives aligned with the reports from participants and how much attention has been brought to these concepts of White privilege and implicit bias throughout the course of their lives. Overall, most participants acknowledged through a common thread of response that the more attention and awareness they or others have brought to these issues, the more understanding there is of how the concepts of White privilege and implicit bias impact their lives, and therefore potentially their interactions with Black patients.

Research Question 3

RQ3: Does utilizing a personal self-examination process of the impacts of White privilege and implicit bias bring more awareness and attention to how these concepts impact treatment decision-making processes and interactions and shape the way White nurses plan to work with Black pediatric patients moving forward?

The findings from this study reinforced previous research suggesting that White privilege and implicit bias cause harm in health care interactions. It has been posited that providers must seriously assess their own role in the perpetuation of the influences of these concepts on racial inequities in the care and treatment of pediatric Black patients (Alexis et al., 2019; Blair et al., 2011; Hobbs, 2018; Lang et al., 2016; Romano, 2018; Tajeu et al., 2018). Results have provided an understanding that it is more likely for more harmful treatment interactions to occur between White pediatric nurses and Black patients when there is less self-examination of the impacts of White privilege and implicit bias on their own lives. To address this last RQ, I asked specific questions at the end of the interview. One question was regarding their experience of consciously or unconsciously being biased by White privilege or implicit bias in their treatment of Black patients. I specifically asked this question to see whether their response changed at all from ones given to similar questions asked at the start of the interview. Although the more prevalent theme in responses to the other questions supported a personal recognition and awareness of the role White privilege plays, it was more difficult for some participants to acknowledge personal implicit biases and particularly behaviors based on them. This theme was important to acknowledge within the data. It was easier for these participants to recognize seeing it in others and refute it within themselves, as well as claim to treat everyone the same. This was still true for some participants when reiterating their response to the question that was framed a bit differently at the end. However, the majority of this thread of participants responded to this latter question with an insight or two more than they previously had into their own personal contribution to potential unfair treatment of their Black patients. Furthermore, my anecdotal notes revealed that the participants whose responses did not change much between questions, were ones that gave shorter responses specifically when it came to questions related to their personal interactions and treatment of their Black patients and the potential influences of White privilege and implicit bias.

The last two over-arching themes that emerged from the data arose from the responses to the last interview question. Participants all provided favorable and positive statements in response to the study. Many participants conveyed that the interview questions brought awareness to unfair thoughts and interactions with Black families and the negative impacts on treatment in health care delivery. They acknowledged that the unfair thoughts and actions stem from issues such as making assumptions without thinking more about who someone truly is and where they come from, initial thoughts of Black families which they had not previously realized are more negative than positive, and a hesitancy and fear that tends to exist regarding having real and hard conversations with Black parents. Additionally, most participants reported that the study helped them to acknowledge something new. A common thread of statements supported that everyone should consider and reflect on this topic, whether they reported to believe they currently participate in racial implicit bias or are impacted by White privilege or not. Last, there was a common sub-theme reported that they will bring more of a conscious effort to paying attention to White privilege and implicit bias with a desire to further self-examine their personal thoughts and actions while caring for their Black pediatric patients. Overall, participants shared in having a desire to grow moving forward and reaffirmed the research body indicating the need for more self-examination on this topic.

Interpretation of Findings Through the Lens of the Conceptual Model

The research findings overall indicated that there is a cycle of influence of White privilege and implicit bias on treatment decision-making and interactions in White nurses with Black pediatric patients. Whether the influence is positive or negative, as the conceptual model suggests, there is a cycle that begins with the clinician or White nurse (see Figure 2). The nurse has an experience of White privilege and/or implicit bias that is influenced by their own personal background and experiences. That nurse then is either aware or unaware of it and it influences their behaviors and judgments as well as their lived experiences which then in turn impacts their clinical interactions and treatment decision-making processes. The Black pediatric patient as the receiver has their own personal background and experiences that are impacted by the experiences and processes of the White nurse, which ultimately produces the quality of treatment outcomes. The findings of this study indicated that whether the background and experiences were influenced by awareness or not within the White nurse's experience, most judgments and behaviors presented by the nurses resulted in negative interactions and impacts on treatment decision-making processes. Continuing with the context of understanding being rooted in this conceptual model, the quality of treatment outcomes would therefore be influenced by the negative interactions and treatment decision-making processes. An assumption could then be made that racial health inequalities would show in the results.

Limitations of the Study

Bordens and Abbott (2018) described finding trustworthiness in the results as establishing credibility of the data collection process and reliability of the outcomes. Despite strategies used to lessen them, there were limitations to this basic qualitative study that could have impacted the findings. The findings of my research study were limited, and reflective, of the White nurses that participated voluntarily. The initial anticipated limitations of unwillingness of people to participate due to the sensitive nature of the topic was confirmed during the execution of the recruitment process. It was challenging to recruit enough participants to continue with the study. However, once 13 participants were interviewed, it was determined that a sample size of 13, for this type of qualitative research study, was acceptable upon reaching thematic saturation. The participant sample however does not reflect all White nurses in California and the findings of this study are not generalizable to other nurses.

According to Patton (2015), researcher personal bias is always a concern in qualitative research. To alleviate this challenge of researcher personal bias, I implemented several strategies. Throughout the data collection process and analysis, I utilized participant checking, interrater reliability for result confirmation, verbatim transcriptions, analytic memo writing, an audit trail, and peer debriefing. Throughout the entire study, I also made every effort to maintain impartiality to mitigate this concern of bias. During the interviews I was especially aware of my body language, language usage and diction, as well as disposition.

Due to the timing of my research study and its coinciding with the pandemic, I was required to conduct interviews using the online Zoom platform. I used the audio recording feature on the Zoom platform and the video was left on for the duration of the interview for each participant. The video feature as well as environmental distractions in their home could have diminished vulnerability in sharing and comfort level during the personal in-depth interviews. Additionally, the overall sample population consisted of predominantly females, potentially limiting a range of representation of experiences.

Another limitation that surfaced was that it was challenging for the participants to say much regarding the pediatric patient themselves without including the whole family. Most biases that were recognized were acknowledged in the context of interactions with the pediatric patient’s caregiver along with the child. Overall, the results confirmed a significant contribution to practical knowledge with a worthy topic, rich rigor, meaningful coherence, trustworthiness, and resonance to similar populations and settings. Many strategies were implemented throughout the course of the study to confirm the findings and strengthen the trustworthiness to reduce the impact of any limitations.

Recommendations

Racial health disparities, which were increasingly highlighted during the recent pandemic, have been a mounting and continuing concern across the country within the U.S. health care system. The rate of racial health disparities and the influences of White privilege and implicit bias are not exclusive to the group of White nurses who elected to participate in my research study. This dissertation study sought to understand the lived experiences of self-identified White nurses in California who work in urban public hospitals with pediatric patients. I closely examined the impacts of White privilege and implicit bias on their lived experiences in treatment decision-making and interactions with their Black patients. Leveraging a conceptual framework based on White privilege and implicit bias allowed the outcomes of this study to be rooted in a conceptual foundation that attempts to explain a cycle of the impacts of these concepts on the dynamics of White nurses and Black pediatric patients during treatment decision-making and interaction processes. Additionally, I sought to explain why some White nurses may engage in a particular cycle of assumptions leading to action and others do not, and whether a self-examination process of personal experiences of White privilege and implicit bias makes a difference. The data from this dissertation project will initiate a body of knowledge in this area of study; there is little to none presently of the same caliber.

The data identified the lived experiences of White nurses, while emphasizing the usage of and barriers to the practical application of understanding the concepts and impacts of White privilege and implicit bias on their treatment of Black pediatric patients. As racial health inequities persist throughout the health care network and nurses become more integrated into treatment decision-making teams, it is important to conduct further research that will secure the best interactions with and treatment of Black pediatric patients, to facilitate the best equitable outcomes. It is critical that more research is continued with other nurses and clinicians within urban public hospital settings that are involved in treatment decision-making processes for Black pediatric patients. The process could impact how others, as well as nurses, in the pediatric field interact and treat their Black patients. This could lead to more meaningful and positive interactions and therefore treatment outcomes. It is also crucial to understand the influences of White privilege and implicit bias on treatment decision-making processes and interactions during the COVID-19 pandemic when racial disparities were illuminated, and the Black Lives Matter movement took place. Furthermore, it would behoove stakeholders to better understand the impact White nurses and other clinicians could have in the post-COVID era where health issues among all Americans are dramatically rising.

Additional basic qualitative inquiry studies will bring more awareness and expand upon the need for more understanding of the influences of White privilege and implicit bias within the pediatric health care arena. This type of research will inform and assist hospital administrators when developing trainings and programs. It will also help to redefine and reform policies related to racial health disparities which will positively impact health care delivery as practical application in the field. Moreover, research combining this topic and organizational experts such as public health policy experts, as well as hospital administrators with the foremost authority in addressing racial health inequities could conclude in scholarly excellence.

Social Implications and Recommendations for Future Initiatives

Pediatric racial health inequities have been an increasing focus as they persist throughout the pediatric health care system and throughout society, especially considering the recent COVID-19 pandemic (Jindal et al., 2022). Black children are among the highest targeted in disparate health treatment outcomes (Jindal et al., 2022). The reasoning for this difference is not well understood within scholarly works and knowledge. This study’s findings highlight the need for pediatric White nurses and other clinicians to self-examine their understanding of White privilege and implicit bias and the potential impact of these concepts on their lives and interactions with Black patients. The results also emphasize the importance of acknowledging the influences of these concepts on treatment decision-making processes and interactions, specifically with Black pediatric patients. The implications of the study not only indicate the positive impact of bringing more awareness and attention to these impacts on the pediatric patient, but also on the child’s entire family. They also have the potential to shed light onto dynamics that arise from these influences that impact interactions with the caregivers of the pediatric patients and potentially positively affect the way adults involved in the child’s life view and interact with the health care system. This could create a more trusting, equal, and viable environment for optimal healing within a hospital setting for all children. Black children could have a better hospital experience as well as end results within treatment outcomes. Additionally, the effects could trickle to branch out to helping the dynamics for children of other races that are negatively impacted by racial biases and influences of privilege as well.

The themes that emerged from the study yielded a better understanding of the impact of White privilege and implicit bias on White nurses' treatment of Black pediatric patients. The study findings may lead to positive social change. As Walden University (2021) defines it, positive social change is “a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies.” This type of research design has not been conducted until now with White pediatric nurses; the findings set the foundation for future study and contribute to the body of knowledge and literature. The outcomes of this study draw attention to the need for self-examination on the influences of the concepts of White privilege and implicit bias within treatment decision-making and interactions with Black pediatric patients by White nurses. The results suggest that it would also be prudent to examine these concepts and their impacts on other health professionals within a pediatric hospital setting. This self-examination process has the potential, as indicated in the results of this study, to lessen the degree of racial health disparities in treatment outcomes of Black pediatric patients. Furthermore, the outcomes from this study highlight how impacts of White privilege and implicit bias manifest in interactions and treatment of Black pediatric patients with White nurses. There are practical applications for use within the field through bringing awareness and more training designed to bring further attention to these concepts within each professional that interacts with a Black pediatric patient in a hospital setting.

A significant implication for White nurses working in pediatric hospital settings, is their alignment with health policy and other experts on racial health disparities on the benefits of examining one's own thoughts and actions when interacting with Black pediatric patients and their families. While also acknowledging personal challenges to do so, all study participants acknowledged benefits of being interviewed on the topics of White privilege and implicit bias. They confirmed that the interview helped to bring awareness and attention to the potential impacts on treatment decision-making processes and interactions with their Black patients.

The outcomes from this study stress the need for professionals within pediatric hospital settings to bring knowledge and attention to the potential impacts of White privilege and implicit bias and their negative impacts on health care delivery with Black patients and their families. This is a critical implication that could benefit from strategic collaborations to drive those in leadership to propel towards bringing more trainings and policy changes to hospital settings. This is crucial to help lessen the degree of racial health inequities and reduce higher morbidity and mortality rates reported among Black pediatric patients. It is vital that White nurses and other health care professionals receive training and support to use a self-examination process to help decrease the impacts of White privilege and implicit bias that are inherently generationally and systemically perpetually reinforced. The recognition of the burden of these mindsets and understandings in the White community may help to promote a greater sense of acceptance, equality, and better-quality outcomes within pediatric hospital settings around the country.

Conclusion

This research study addressed a gap in the literature pertaining to the lived experiences of White pediatric nurses and the impact of White privilege and implicit bias on treatment decision-making processes and interactions with Black pediatric patients. My study was guided by a modified conceptual model of influences of White privilege and implicit bias on treatment decision making and interactions with Black pediatric patients. It was based on the defined concepts of White privilege and implicit bias of Hobbs (2018) and Blair et al. (2011). Study outcomes displayed two places on a continuum of self-understanding of the concepts of White privilege and implicit bias and their impacts on personal treatment decision-making processes and interactions with Black pediatric patients. All nurse participants agreed that White privilege and implicit bias exist in the workplace, and that they both have negative impacts on health care delivery. One group strongly reinforced that the more attention and awareness that is brought to these issues, the more understanding they have had of how White privilege and implicit bias impact their lives and potentially their treatment and interactions with Black patients. The other group acknowledged that White privilege and biases exist and are aware of that, however, do not believe that they are currently influenced by these concepts and treat all patients the same. This group also supported a theme together that race is not a factor in treatment decision-making or interactions. However, it was indicated that most of this group added insight into how they may be influenced by these concepts in their responses to the last questions, after going through the self-examination process of the interview. The outcomes highlight that a self-examination process of the potential impacts of White privilege and implicit bias on the lives of White nurses, as well as other White hospital professionals, is critical. If adequate trainings are provided and policies are reformed to bring more attention to these issues, there is a real potential to help change dynamics that bring about racial health disparities within the pediatric population.

Additional research is needed to grow the knowledge base, fully explore, and evaluate other potential contributions this type of self-examination process could make to the health care field. Study's utilizing the same or similar interview guide and questions with a different professional hospital sample could determine other factors that could be beneficial to understanding the impacts of White privilege and implicit bias on the treatment of Black pediatric patients. The goal of this research was to understand the impact of White privilege and implicit bias on the lived experiences of White nurses in treatment decision-making processes and interactions with Black pediatric patients. Sharing the outcomes of this research study with professionals in the health care field and policy initiators is important to necessitate more attention and understanding of the impacts of White privilege and implicit bias on pediatric hospital settings. There is a potential to bring about positive social change and transform lives through more helpful interactions that will lead to encouraging treatment outcomes for Black pediatric patients.

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Appendix A: Interview Guide

Date:
Time:
Interviewee Identifier Code:

Parts of the Interview	**Interview Questions**
Introduction	❖ Hi, my name is Tara. Thank you very much for helping me with my doctoral dissertation research study. The purpose of this interview is to help to understand the influence of white privilege and implicit bias as you make decisions in treatment and interact with your pediatric patients who are Black. I ask that you answer questions to the best of your ability. Some of the questions will require you to think deep and I ask that you try answer them with complete honesty as much as possible. I also want to reiterate that the topic is sensitive and there may be discomfort. We can move past any question. If at any point you feel uncomfortable and would like to refrain from answering, please let me know. You also have the right to end the interview at any time. I would like to ask that you please keep your video on throughout the interview as it is a way that can help us to connect more throughout our time together. Additionally, I again want to ensure you again that you will not be identified during any part of the data collection or reporting procedures and that your information will be kept confidential with an unique identifying code number. I will not identify you in my documents and no one will be able to identify you with your answers. I also need to let you know that this interview will be recorded for transcription purposes and analysis with the Zoom recording feature. This interview could potentially take up to 90 minutes based on how in-depth we go. However, we will plan to limit the interview to 60 minutes. If things indicate it will take longer, then we will end. ❖ Do you have any questions for me before we begin? ❖ Okay, are you ready to start?
Question 1:	Q1: First, can you tell me about the racial make-up of the pediatric clients that you serve?
Question 2:	Q2: Can you tell me what the first three thoughts are that come to mind when I use the words "White privilege"?

Question 3:	Q3: How would you define “White privilege” in your own words?
Question 4:	Q4: How would you characterize someone who experiences White privilege?
Question 5:	Q5: Think of certain times in your life when you may experience or have experienced White privilege. Do you believe benefit from it in anyway or has it hurt you? Q5a: What beliefs or experiences do you feel contribute to your response? Could you provide me with some examples?
Question 6:	Q6: Tell me about your own personal experience of race during childhood compared to now? Q6a: Please tell me more about any similarities or differences. Q6b: Is there a story you can share that stands out to you personally?
Question 7:	Q7: What were some of the racial differences that existed while you were growing up? Q7a: What about ones that you experience now?
Question 8:	Q8: Hearing the term implicit bias, what does it make you think of? Q8a: The common definition of implicit bias is that it is a bias that occurs during an instance in which someone jumps to a conclusion about another person or provides them with a stereotypical label, due to a difference of skin color. An example could be someone sees a man, who is Black walking down the street carrying a baseball bat and assumes that the man is about to try to break into someone’s house. Do you believe implicit bias operates in your life? If so, how? Q8b: Do you have other examples or ways you have seen it work in others?
Question 9:	Q9: Thinking of your patients and experiences working with them. What comes up for you when you think of White privilege? Q9a: Is there something that you are particularly aware of that you can share with me that you feel has an impact on you

	personally?
Question 10:	Q10: Now thinking of your patients and experiences working with them. What comes up for you when you think of implicit bias? Q10a: Think of a time or an example in which implicit bias may have played a role in interactions with them, or possibly could in the future. Tell me about that.
Question 11:	Q11: Are there any thoughts, feelings, or reactions you have related to privilege or bias when you first see that the child you will be working with is Black? If so, can you describe them for me? Q11a: Are there any immediate thoughts of bias, and if so, what are they?
Question 12:	Q12: How do you determine treatment goals for your patients? Q12a: Some organizations focus on a patient-centered approach, others are more educational, others are more philosophy-based, and others are based on quantity versus quality. How would you describe your organization's treatment philosophies?
Question 13:	Q13: What are some things that you think about as you consider treatment options for pediatric patients? Q13a: Can you provide an example of times it may change based on the child's race? Q13b: I'm interested in discussing how racial bias may impact decision-making regarding treatment options and care. Can you name a time when it may influence your decision-making processes? Q13c: In reflecting on the previous question, can you name a time when it may influence your interactions with Black patients?
Question 14:	Q14: Reflecting on your experiences as a nurse implementing treatment with pediatric patients who are Black, what can you share about any similarities or differences compared with those who are White?
Question 15:	Q15: What has been your experience of consciously or unconsciously being influenced by white privilege or implicit bias in your treatment of patients who are Black?

Question 16:	Q16: What are your thoughts about this self-examination process on these topics of White privilege and implicit bias? Q16a: If these questions have made an impact on you, can you share what kind of impact? Q16b: In what ways, if any, do you believe the questions that I've asked in this interview will influence the way you will think about your work with Black pediatric patients moving forward?
Closing:	❖ Is there anything else that you would like to share with me as a follow-up to any of the questions I've asked, or anything more that you'd like to add? ❖ Do you have any questions for me? ❖ Within the next two weeks I will follow-up with you by phone or email, whichever is your preference, to ensure that my interpretations of what you have shared is accurate and reflective of what you have wanted to convey. I greatly appreciate you taking the time in advance! ❖ Thank you very much for taking the time to interview with me today. I am very grateful to you for your help!

Appendix B: Recruitment Flyer

Interviewees Needed for a Research Study

Who? California pediatric nurses working in urban public hospitals for more than a year, who self-identify as White.

What? There is a new study called: "Impacts of White Privilege and Implicit Bias on Treatment Implementation with Black Pediatric Patients". It could help nurses better understand how they can personally help racial health inequities through a self-examination process. This study invites you to describe your experiences with White privilege and/or implicit bias in treatment decision-making and interactions with your patients. It is understood that this is a sensitive topic, and it will be assured that your identifying information and responses will be protected. This study has the potential to be of great benefit to understanding how to best help your Black patients.

Format? Interviews will be one-on-one, in-depth interviews conducted online through the Zoom video platform.

Time? The time for participation will include a 60-to-90-minute Zoom interview and 30 to 60 minutes of follow-up time.

All participants will receive a $20 Starbucks gift card.

This research is part of the doctoral study for Tara Geer-Leiker, a Ph.D. student at Walden University.
IRB Approval #: 04-26-22-0750949

Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]	Research Study Contact: [Redacted]