National Commission to Address Racism in Nursing

REPORT SERIES

Report #2 of 6

Systemic Racism in a Contemporary Society

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Some may reasonably question the extent to which systemic racism exists in a contemporary society and falsely assert that court rulings like *Brown v. Board of Education* in 1954, legislation like the Civil Rights Act of 1964, and constitutional changes like the 13th Amendment were powerful instruments that extinguished the fiery acts of racism. However, Wilkerson (2020) asserted that racism "goes about its work in silence, the string of a puppet master unseen by those whose subconscious it directs … cast in the guise of normalcy, injustice looking just, atrocities looking unavoidable," constantly fueled by the seemingly innocuous actions that sustain its mobility. Not recognizing how racism continues to exist or understanding how it operates under the cloak of anti-racist legislation has deleterious effects in nursing and healthcare (Centers for Disease Control and Prevention (CDC), 2021).

A plethora of literature supports the idea that the remnants of racism continue to smolder in and around the discipline of nursing (Adams, 2021; Beard & Julion, 2016; Broome, 2021; Doede, 2015; Fitzsimmons & Peters-Lewis, 2021; Hassouneh et al., 2012; Waite & Nardi, 2017; White, 2018). In an October 2021 study on racism in nursing fielded by the National Commission to Address Racism in Nursing, 94% of respondents indicated agreement with the statement "there is some or a lot of racism in the nursing profession"; 76% of respondents attested to witnessing racism in the workplace; and 63% reported personally experiencing racism in the workplace, with Black nurses (92%) reporting having experienced racism the most (National Commission, 2021). Lamentably, racism continues to undermine the ability of minoritized groups to access and graduate from nursing school (Barbee & Gibson, 2001), be hired as nurses, advance to leadership positions (American Nurses Association, 2021), and attain tenure in academia (Beard & Julion, 2016; Iheduru-Anderson, 2021). What's more, racism extends into and through the profession of nursing and impacts clinical outcomes. Recently, the CDC (2021) identified racism as a fundamental driver of health disparities. This section briefly asserts the omnipresent force of racism in the denial of opportunities, continuance of race as a risk, and the paralysis of deconstruction.

In an October 2021 study on racism in nursing:

94% **AGREED THERE THERE IS RACISM IN THE NURSING PROFESSION**

76% **ATTESTED TO WITNESSING RACISM IN THE WORKPLACE**

63% **REPORTED PERSONALLY EXPERIENCING RACISM IN THE WORKPLACE**

(National Commission, 2021)

Omnipresent Force of Racism

Racism does not exist in a silo, and its actions are not always explicit. Rather, racism is metastatic in nature, spreading throughout healthcare, education, and other systems, and emerging unambiguously through the actions of others, according to an institution's degree of permissibility. In higher education, racism is demonstrated when minoritized groups are "ignored, assumed to be staff or a student, and … unsupported as a researcher in a teaching institution" (Beard & Julion, 2016, p. 590). In the clinical arena, racism is manifested by the assumption that leaders who identify as Black are presumed to be patient transporters or told that they won't last in the position because the color of their skin makes them unliked or that they won't fit in (Fitzsimmons & Peters-Lewis, 2021). In the classroom, racism creates an ethos of intolerance to difference and has moved some faculty to verbally assault students by exclaiming that they don't like their face and they will make it extremely tough for them at school (Villarruel et al., 2001). Among peers, racism has stoked the myth of intellectual inferiority (Broome, 2021) and has prompted some white students to say that Black students are not bright enough to be successful in nursing and they would do better in low-level nursing positions (Barbee & Gibson, 2001).

Evidence of Continuance

Could a system of disadvantage rooted in more than 400 years of false rhetoric and based on or assigned to skin color continue to exist in a contemporary environment? Beliefs regarding the superiority of whites and the assumption that individuals from minoritized groups are considered "less than" were once ingrained in educational policies and hiring practices. Although the racial and ethnic demographics of nursing have increased, the American Organization of Nurse Executives revealed that the representation of minoritized groups in nurse executive positions in 2016 was less than 4% (Iheduru-Anderson & Wahi, 2017). Additionally, racism shows up under the guise of hair policies that, in a discriminatory way, determine how one must wear their hair. Hair policies can be rooted in dehumanizing beliefs about one's hair texture and the association of one's hairstyle with uncleanliness or unprofessionalism (Cox et al., 2020). Racism is endorsed by faculty who tell students, "You can't wear your hair like that" (White, 2018, p. 348). In healthcare, individuals from minoritized groups are further marginalized when some patients refuse to be treated by them, and leaders fail to see how their inaction makes them complicit (Beard, 2021). Some educators view themselves as the standard of normalcy and individuals from marginalized groups as abnormal (Tengelin & Dahlborg-Lyckhage, 2016). In the Commission's 2021 survey, BIPOC (Black, Indigenous, people of color) nurses reported experiencing the highest percentage of racism from a co-worker or peer, followed by a patient and manager, supervisor, or administrator (National Commission, 2021).

Deconstruction Paralysis

The arduous journey to deconstruct policies, practices, processes, and beliefs that have derailed efforts to build an inclusive discipline that values diversity is critical to nursing and might sound daunting. Nevertheless, institutions can take actions to mitigate racism in nursing. For example, admission essays for nursing programs could include questions that seek to understand what the applicant has done, will do, or believes should be done to eliminate systemic racism and advance health equity. Professional scholarship could encourage anti-racism research along with studies that identify and mitigate the ways in which racism operates at the institutional level. Resources should be allocated to support efforts to engage in anti-racism work. All faculty should learn how to contextualize healthcare disparities and teach students how racism interrupts efforts to improve clinical outcomes. Self-reflection exercises should prompt leaders to consider the ways in which policies and practices can give life to racism and limit racial and ethnic diversity among leaders.

The seismic activity of an earthquake may not register at a magnitude that generates a national alarm. Likewise, the degree of racism may fail to result in a national protest similar to the outcry following the death of George Floyd. Nevertheless, the fallout of racism in a contemporary society contributes to health and educational disparities that limit the profession's ability to live up to its value of justice and standing as the most trusted profession. Nurses must acknowledge and be sensitive to the distinct and indistinct nature of racism if they are to co-create steps that affirm professional values. To advance nursing's ethical values, all nurses should be equipped with the tools to recognize and begin to mitigate racism in nursing.

Intersectionality Between Social Injustice and Racism

In response to nationally broadcast race-based violence and acts of hatred toward BIPOC individuals in 2020 following the murder of George Floyd, we witnessed a national uprising and awakening to the societal atrocities of racism. The national call for justice cascaded into calls to address the multitude of societal injustices resulting from racism and a call for awareness of everyday biases, prejudices, and micro- and macro-aggressions. Social justice is commonly defined based upon two major theories, both centered on equality of opportunity, yet both fall short of addressing the foundational elements of human dignity and respect (Watson, 2019). As asserted by Watson, "constructed on difference, social

injustice dramatically shapes the psyche of individuals, groups, and nations). At its most basic level, social injustice is about distribution of wealth, power, resources, and opportunities resulting in marginalization, disenfranchisement, and exclusion" (Watson, 2019). When we look at the intersectionality between social injustice and racism, we see the same elements. Racism as it is defined by the Commission includes comprises assaults on the human spirit in the form of actions, biases, prejudices, and an ideology of superiority based on race that persistently cause moral suffering and physical harm of individuals and perpetuate systemic injustices and inequities (ANA, 2021). In a contemporary context, when we translate actions of social injustice and racism into the purview of nursing and nursing practice, we see the same inequities in the distribution of power, resources, and opportunities in the form of lower pay, fewer opportunities for advancement to leadership positions, lack of opportunities to gain tenure, derailed opportunities for research, fewer BIPOC nurses advancing to faculty, and pay inequities.

Moving Beyond Allyship to Anti-Racism

Allyship, one of Merriam-Webster's 2021 words of the year, is defined as "the role of a person who advocates for inclusion of a marginalized or politicized group in solidarity but not as a member, and the more traditional relationship of persons, groups or nations associating and cooperating with one another for a common cause or purpose" (Merriam-Webster, n.d.). In a contemporary context, allyship extends beyond bystander support to active engagement and advocacy to challenge accepted group dynamics that perpetuate racism. As asserted by Waite and Nardi (2021) in "Racism as a Historical Trauma: Implications for the Nursing Profession," "to promote health equity and support the human rights mandate contained in the *American Nurses Association's Code of Ethics for Nurses with Interpretive Statements*, the nursing profession must understand historically the creation of race, white supremacy in the United States, and entrenched racial terror and brutality toward black and brown racialized populations" (Waite and Nardi, 2021). Allyship in a contemporary context draws upon this understanding to foster anti-racist actions and ideology to dismantle systemic inequities. At the individual level, as defined by Kendi, "being an anti-racist requires persistent self-awareness, constant self-criticism, and regular self-examination" (2019). Extrapolating this understanding to the organizational level and to the nursing profession, nurses striving to foster equity and inclusion within the profession must understand how the historically constructed hierarchy of race continues to create disparities for BIPOC nurses.

Privilege, Power, and Internalized Oppression

Racism continues to manifest itself in the 21st century through structures, legislation, and policies that place Black and brown people at a disadvantage leading to inequity and inequality. The recent social and health justice movements sparked by widespread media attention on police brutality and the disproportionate morbidity and mortality of COVID-19 have resulted in the medical community's own reckoning with its contribution to these disparities in health outcomes and hindered advancement of health professionals equipped to serve the communities they represent.

In the current reality, it is important to revisit and examine the relationship of privilege, power, and prejudice through the lens of the downstream impact of oppression. The "4 I's of Oppression" as outlined and defined by the Chinook Fund Winds of Change will provide a framework to clarify the experiences and perceptions of nurses who personally experience racism and nurses who unconsciously normalize an environment that masks and perpetuates racism. Clarifying and differentiating the definitions of the 4 I's of Oppression will help provide understanding of how the rooted history of racism and its historical trauma from colonization have been internalized and passed down for generations and continue to manifest in our workplaces, environment, policies, and society.

THE 4 I'S OF OPPRESSION
IDEOLOGICAL Oppression
INSTITUTIONAL Oppression
INTERPERSONAL Oppression
INTERNALIZED Oppression

Ideological oppression views one group as better than another, with the right to control groups seen as inferior. This manifests as perceptions of higher intelligence, work ethic, physical strength and endurance, and superiority in one group compared with the other groups, which are perceived in the converse as unintelligent, incompetent, lazy, weak, or inferior (Chinook, 2021). In the context of nursing, this ideological oppression is embedded in practices that hinder school admission and advancement and career progression. This is made evident by qualitative data from the National Commission's 2021 survey through written statements such as "Patients assume people of color are 'the help' and not skilled to help them. They will ask for 'a real nurse'" (National Commission, 2021).

Ideological oppression transcends individual thoughts and is embedded in systems and structures in the form of institutional oppression. **Institutional oppression** is how supremacy is embedded in "institutions of society" such as laws, education, hiring policies, public policing, and housing development, and zoning laws (Chinook, 2021). In the National Commission's qualitative survey data, 72% of respondents discussed discrimination broadly in terms of race and racism, bias, prejudice, and stereotypes when asked why there is agreement with the statement of racism existing within nursing.

Interpersonal oppression is the downstream impact of ideological and institutional oppression that reinforces the dominant group's disrespectful behaviors and mistreatment of groups seen as inferior. It is the result of internalized negative stereotypes driving unconscious oppression under the guise of normalcy (Chinook, 2021). This is seen through micro- and macro-aggressions, racist jokes, stereotypes, patient denial of treatment, dismissal of BIPOC nurses' knowledge and ideas, and discrediting of work.

The compounded impact of ideological, institutional, and interpersonal oppression is **internalized oppression**, defined as the internalization of "the ideology of inferiority" (Chinook, 2021). As identified through the Commission's qualitative data, this is described by accounts of demoralization, insecurity, self-doubt, feelings of being "less human," sadness, isolation, and fear. Nurses attested to seeking treatment for anxiety, depression, posttraumatic stress disorder, and hypertension as a result of racism in the workplace.

Conversely, there is internalized privilege. People who belong to the dominant group feel the most benefit from these systems and internalize privilege, thus accepting the belief in the inherent inferiority of the oppressed group and normalizing one's privilege in one's own internal belief of inherent superiority. This creates entitlement, the denial of the existence of oppression, and the expression of this privilege or entitlement as paternalism (Chinook, 2021). Internalized privilege is seen in the majority of positions in power or even titles occupied by white nurses compared to BIPOC nurses. It is embedded in the structure and governance within organizations, legislation, and policy.

The four I's are integrated, and the relationship between racism, power, and privilege will continue to exist in the absence of nurses' conscious examination of their own biases, social identity, internalized privilege, and how these factors affect their work and interpersonal relationships.

Driving Toward Change

**"What is more important than knowledge, asked the mind?
Caring and seeing with the heart, answered the soul."**

Flavia Khoi Tu, a recognized organizational thought leader, says, "Culture is a celebration of what we hold as important … what we believe and hold sacred." We add that it is more likely to be felt than stated, and it often shapes a lived experience for those in the workplace and resides in the memory as if attached by superglue. Culture, like genetics, has a group definition but individual expression. It is shared, learned, dynamic, and evolutionary. With this said, Gendlin (1973) and other researchers' insightful observations come to the fore, including that "if experience appears, it talks back," and when it speaks, it does so loudly. They tell us that **every experience comes to us in one of four ways**:

1) **A feeling**
2) **A thought**
3) **An action**
4) **A sense of being**

The experience also brings along an attached emotion that typically comes from five predictable care concerns:

1) **Appreciation (recognition of value)**
2) **Affiliation/belonging (emotional connection to others)**
3) **Autonomy (freedom to feel, think, decide)**
4) **Status (standing compared to others)**
5) **Role (job label and related activities)**

In other words, our professional/workplace culture's language includes emotions, which cannot be erased or extracted. In today's nursing environment of work and learning, for many who are BIPOC, these emotions and experiences continue to occur daily, as if cloned and launched, unchanged over time, as they encounter the vestiges of racism. In fact, they tell us that walking into these spaces makes them feel as if they have stepped into a time warp that sends them back four to five decades. Take a moment and think about what stirs your emotions to the point of tears or anger. It is likely something you care deeply about, something that violated your trust, or something you did not expect to happen that placed you in harm's way. No one gets emotional about something that does not matter to them in a personal way, and how

one is treated or viewed matters to every member of humanity. Thus, belonging to a profession that has the fundamental tenets of care, respect, and human rights yet treats certain members of its own in dehumanizing and structurally disadvantaging ways is hurtful. Once these acts occur, anything can be done or said to those in the crosshairs of its sight.

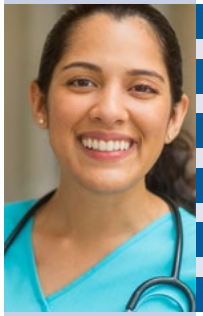
Currently, where nurses are educated, practice, conduct research, and of course face policy in all its forms, "othering" and silencing continues to occur and is highly prevalent. It is baked into our relationships and the updated needs of the operating systems in use. Light must also be shined on the resultant violence and harm that occur due to such covert and overt acts to the individual who is the target – the one to be silenced, invalidated, and not heard, and in ways that leave the modus operandi of power inequities and non-inclusive structures and systems in place so long that they become the norm and not the exception to ways to be and operate.

This violence and abuse of power, the subliminal, epistemic kind with its ways of silencing our colleagues and the combative hurling of rhetoric, whether verbally or in written form, as well as through acts of denial, can be either procedural or relational. It is entangled with all other forms of violence, including direct and physical violence. It's about discourse and representation as well as excluding all other ways of knowing. The identity and self-esteem theft that accompanies it is ever present, dynamic, and oppressive. Despite health professionals' vows to "do no harm," harm is done, revealing the hypocrisy behind what can produce moral assaults, trigger fear, threaten safety, stoke anger, and enhance the potential to cause suffering physically and mentally.

Storytelling puts before each of us, front and center, the damage caused by the violence against the subject of knowledge, the object of knowledge, the beneficiary of knowledge, and the knowledge itself of operating modes of racism/sexism, separation, pecking order, and naturalization. It leaves the marginalized fighting for existence; fighting to be afforded, not robbed of, opportunities others get; and in a constant battle to be seen, heard, understood, and valued. For the hearer of the story, an inside view of the experience is provided, which further allows the chance for common humanistic desires to be identified. The results could make code switching, colorism, and passing acts of the past and lead to equitable changes within systems and within individuals.

Driving Toward Change CONTINUED

What is being requested in this present day by our BIPOC colleagues requires moving beyond resilience, the ability to quickly recover from challenges to survive. According to Cigna's 2020 Resilience Index Report, two-thirds of full-time health-care workers do not have high resilience compared to the national average and are less likely to rate their mental/social health as very good. Surviving is no longer inspirational or aspirational. The ability to thrive is the clarion call, as well as tapping the six inspirational acts captured in the composed acrostic outlines how those in thriving environments behave in the world.



Tell stories and never stop so that understanding can take root.

Hold multiple perspectives without judgment because they are in a constant learning state.

Reach for and display sights or visions that actualize their hopes, dreams, and unleashed potential.

Ignite the world with integrity. Speak the truth and be the truth!

Validate the humanness and legitimacy in each of us regardless of color.

Erase labels placed on you or others that put people on paths both intentionally and unintentionally.

The future is in relationships, and nurses act from discrete, adaptable, and relational places of power. Relationships may not scale, but culture can and does, so it is incumbent on us all to take it from invisible to visible. We cannot talk our way out of what we behaved our way into. It takes extra psychological work to manage in a world that cannot be seen as morally just and fair. The resultant stress has related costs. Accountability, transparency, and reflection are powerful modifying contributors to galvanizing change and promoting human flourishing and are essential to both the business of healthcare and the acts of health caring. Put them into action, and cease the insistence on conformity and the snuffing out of difference. Failure to do so will thwart innovation and the futurizing necessary for the elimination of suffering and the safe delivery of care. Authenticity, the full expression of oneself, has never been more important.

References

Alexander, G. R., and Carter, Brigit. (2021). Entrenched White Supremacy in Nursing Education Administrative Structures. *Creative Nursing*. Vol. 27 #1.

Alexander, G. R. (2018). A Sigh Too Deep for Words. *Nursing Education Perspectives*. 38(6) 295.

Adams, V. (2021). Because Black lives did not matter. *American Journal of Nursing*, 121(1), p. 11.

American Nurses Association (ANA). (2021). National commission to address racism in nursing. https://www.nursingworld.org/practice-policy/workforce/clinical-practice-material/national-commission-to-address-racism-in-nursing/.

Barbee, E., & Gibson, B. (2001). Our dismal progress: The recruitment of non-Whites into nursing. *Journal of Nursing Education*, 40(6), 243-244.

Beard, K. V. (2021). Taking action: Racism in the workplace. In D. J. Mason, E. Dickson,M. R. McLemore & G. A. Perez, (Eds.), *Policy & Politics in Nursing and Health Care*. (pp 465-468). Elsevier.

Beard, K. V., & Julion, W. A. (2016). Does race still matter in nursing? The narratives of African American nursing faculty members. *Nursing Outlook*, 64(6), 583-596.

Broome, B. (2021). Racism, nursing, and strategies for change. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 50(5), 507-511.

Centers for Disease Control and Prevention. (2021). Racism is a serious threat to the public's health. https://www.cdc.gov/healthequity/racism-disparities/index.html.

Chinook Fund. (2021). General Terms and Forms of Oppression. https://chinookfund.org/wp-content/uploads/2015/10/Supplemental-Information-for-Funding-Guidelines.pdf.

Cox, G., Sobrany, S., Jenkins, E., Musipa, C., & Darbyshire, P. (2020). Will nurse leaders help eradicate 'hair racism' from nursing and health services? *Journal of Nursing Management*, 29, p. 2014-2017. https://doi.org/10.1111/jonm.13286.

Doede, M. S. (2015). Black jobs matter: Racial inequalities in conditions of employment and subsequent health outcomes. *Public Health Nursing*, 33(2), 151-158.

Fitzsimmons, M. J., & Peters-Lewis, A. (2021). Creating More Diverse C-Suites: From Intention to Outcomes | AONL. *American Organization for Nursing Leadership*. https://www.aonl.org/news/voice/mar-2021/creating-more-diverse-csuite-from-intention.

Gendlin, E. T. (1973). Experiential phenomenology. In M. Natanson (ed.), *Phenomenology and the Social Science* (pp. 281-322). Evanston, Illinois: Northwestern University Press.

Hassouneh, D., Akeroyd, J., Lutz, K., & Beckett, A. (2012). Exclusion and control: Patterns aimed at limiting the influence of faculty of color. *Journal of Nursing Education*, 51(6), 314-325.

Iheduru-Anderson, K. C. (2021). The White/Black hierarchy institutionalizes White supremacy in nursing and nursing leadership in the United States. *Journal of Professional Nursing*, 37(2), 411-421.

Iheduru-Anderson, K. C., & Wahi, M. (2017). The hypocrisy of diversity: Institutional racism as a barrier to ethnic minority leadership in nursing. In 4th annual Massachusetts Healthcare Workforce Summit.

Kendi, I.X. (2019). *How to be an Antiracis*t. Random House Publishing Group.

References CONTINUED

Merriam-Webster. (n.d.). Allyship. In *Merriam-Webster.com dictionary*. Retrieved January 7, 2022, from https://www.merriam-webster.com/dictionary/allyship.

National Commission to Address Racism in Nursing. (2021, October). Racism in Nursing Survey. [Data set] National Commission to Address Racism in Nursing.

Tengelin, E., & Dahlborg-Lyckhage, E. (2016). Discourses with potential to disrupt traditional nursing education: Nursing teacher's talk about norm-critical competence. *Nursing Inquiry*, 24(12166).

Villarruel, A. M., Canales, M., & Torres, S. (2001). Bridges and barriers: Educational mobility of Hispanic nurses. *Journal of Nursing Education*, 40(6), 245-251.

Waite, R., & Nardi, D. (2017). Nursing colonialism in America: Implications for nursing leadership. *Journal of Professional Nursing*, 35(1), 18-25.

Waite, R., & Nardi, D. (2021). Understanding Racism as a Historical Trauma That Remains Today: Implications for the Nursing Profession. *Creative Nursing*, 27(1), 19–24.

Watson, M. F. (2019). Social Justice and Race in the United States: Key Issues and Challenges for Couple and Family Therapy. Family Process, 58(1), 23–33.

White, B. J. (2018). African American nurses describe pre-licensure education experiences: A qualitative study. *Journal of Professional Nursing*, 34( ), 346-351.

Wilkerson, I. (2020). Caste: *The origins of our discontents*. New York: Random House.

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