Editorial

Racism and Nursing: A Preliminary Reflection on Literature

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The death of George Floyd and subsequent *Black Lives Matter* protests made me confront the fact that my "Silence is not an Option" (Lemon, 2020a). Since I watch CNN news every day, most often when working on my computer, some might say that my information is biased. Nonetheless, I continue to watch and to focus on the facts as presented, chiefly facts associated with protests, community member–police incidents, COVID 19 reports, healthcare topics, and media reports that for me contextualize issues in the United States of America. That America is now portrayed on occasion as a white supremacist environment. Following George Floyd's death and the ensuing protests, my thoughts have been predominated by and worried about the need to carry out an initial self-assessment of my implicit racism.

The United States's situation is not entirely different from what goes on in the world. This suggests that I want to share the blame for major world problems with other countries. I do not, but realized that I had an opportunity to deepen my understanding of what my whiteness means. I decided to focus this editorial on racism in nursing. I agreed that " . . . my understanding of whiteness is recognition of the centrality of racial beliefs as an organizing principle of the modern world that exerts as profound an impact on nursing as it does on other aspects of everyday existence" (Puzan, 2003, p. 193). In addition to listening to Don Lemon's podcasts, I searched the literature on nursing and racism. I needed to learn and to reflect on my implicit biases. Although I had confronted my implicit biases because of one of my Doctor of Nursing Practice student's project (Johnson-Coleman, 2019), I worried that as editor-in-chief of the *International Journal for Human Caring*, I needed to gain some surface understanding by a check on the history and implications of whiteness that I did not understand. "I needed to get trained up" (Lemon, 2020b). I had a problem.

Not surprisingly, I intellectualized my approach. I searched La Salle University's Summon database. The search terms were racism, whiteness, nursing, and leaders. I added *leaders* last because the initial results came out of nursing education and I wanted clinical literature as well. So, I offer the following as an opportunity to share some perspectives based on the following account of a small sample of literature.

Selected Literature

Garneau and Varcoe (2017) pointed to nursing's engagement in social justice initiatives and analyzed it using critical antidiscriminatory pedagogy (CADP). They focused on nursing education programs and contended that nursing was dominated by liberal individualism. The authors connected social inequities with health and many other problems and asserted that the World Health Organization (n.d.) cited racism as a social determinant

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of health inequities. They cautioned that race and racism had not been well integrated into nursing curricula and that racial discrimination was magnified through poverty, addiction, and stigmatizing chronic conditions. They applied CADP in an analysis of social justice issues and nursing's need to understand the systemic, structural nature of many forms of discrimination. Although social justice is a nursing norm, the authors noted, it may be absent or just rhetorical. Furthermore, nursing faculty's teaching on health inequities had been focused on cultural sensitivity and cultural competence theories and models and the need for nursing to provide culturally congruent care. They explained that individuals' choices were consequences of racialized social and economic disadvantage and resulted in limited access to care. According to Garneau and Varcoe concepts of racism, discrimination, and institutionalized racism need to be compared to individualizing and Euro-centric focuses in curricula through discussion.

Garneau and Varcoe (2017) proposed CADP, as a contextual, structural approach to understand racism and discrimination, using intersectional and cultural perspectives. CADP includes antiracist pedagogy as an initial start toward the inclusion of social justice in the curriculum. Adding antidiscrimination content systematically, followed by continuing nursing education after graduation, could foster development of nursing students' and registered nurses' critical consciousness. Discrimination against patients, students, and nurses also warranted inclusion. The authors explained that CADP is evidence-based and takes a broader look at discrimination and institutional and societal influences on health and healthcare. It is grounded in intersectional approaches as they influence health: "complex dynamics of racism, gendered inequities, economic disparities, stigma, and other social processes" (p. 4). Power relations are also examined. Transformational learning is emphasized as praxis learning, and shifts occur in students' premises of thought, feelings, and actions. Reflection and action help learners to develop critical consciousness. Reflexive dialog encourages students to address racism and discrimination. Attention is also paid to antiracism and antidiscrimination. Additionally, as framed by CADP, educators are expected to develop different teaching methods that foster critical consciousness and to acknowledge the collective responsibility of both students and learners. They suggested that teaching strategies needed to be developed to position nursing practice in knowledge of health inequities and the development of power.

Schroeder and DiAngelo (2010) submitted that antiracist education was emancipatory, because it addressed social, cultural, and institutional dimensions that maintain white supremacy and assist white power and privilege to remain invisible. According to the authors, whiteness equates with characteristics of racism that elevate white individuals over people of color. They developed a school of nursing project including antiracist workshops for faculty and staff and implemented a diversity statement requiring continued, antioppression action. Further, the school leaders examined: the social isolation and lack of support of underrepresented faculty and staff of color; the difficulties of students of color when witnessing racist comments in class without faculty comment and unfair faculty and preceptor evaluations; and faculty-staff relationships during stressful work situations. They scrutinized a curriculum and identified it missing a systematic examination of power, white privilege, and racism/antiracism. They identified the unacknowledged structural advantage of whiteness based on the school's and the United States's demographic characteristics of nurses. Schroeder and DiAngelo fostered school initiatives that led to acknowledging that a profession characterized as *caring* created and maintained color blindness. The dean publicly apologized for the school's institutionalized racial discrimination. The school's initiatives expanded to the university, beginning with a self-appraisal and a report on diversity.

To influence the nursing school's climate, workshops on *Un-Doing Racism* were implemented, presented by a national organization offering transformative antiracism workshops (Schroeder & DiAngelo, 2010). A formal curriculum on the dynamics of white privilege followed on the school's institutional context, structural dynamics, psychological dimensions, and behavioral dimensions that support a climate of diversity in the workplace and classroom. Conflict arose among participants, and strategies were implemented on leadership/dominance and other issues. Innovation diffusion methods were initiated along with action plans to improve the school's inclusivity. Examples of action plans consisted of a discussion on racism/antiracism at monthly meetings, a diversity committee, and

a course on privilege, oppression, and social justice in healthcare. A new diversity statement was also developed. The project's outcomes showed positive changes for participants.

Not only is racism evident in mentor–student relationships (Scammell & Olumide, 2013), it is known in the work life of diverse nurses who have experienced *otherness* and discrimination (Vukic et al., 2012). Racism also shows in the experiences of black nurse leaders. For example, Jefferies et al. (2018) studied discrimination, invisibility, and underrepresentation of black nurses in formal and informal leadership roles in the workforce. They indicated that black nurses face many challenges in the nursing profession and the healthcare system. Policies, practices, and assumptions have been normalized, based on historical and structural harms and the oppression fell by marginalized groups. The authors used a black feminist, poststructuralist framework to examine nursing education and clinical practice challenges of the nurses. Their critical analysis of the literature described marginalization and oppression of black nurses as leaders, leading to invisibility.

In a discursive analysis of the literature, Jefferies et al. (2018) observed that Canadian and American nursing schools have excluded admitting and training black people, leading to significant underrepresentation in the profession. They shared that curricula were oppressive and restrictive for black nurses, and that applicants' academic and financial barriers complicated acceptance. On enrollment, few if any black faculty were available as mentors. High attrition rates were also evident. Therefore, the outcome of low numbers of black students was underrepresentation of them in the workplace. The authors cited research, confirming a tremendous amount of discrimination, racism, marginalization, and oppression in the nursing profession. Black nurses may be over-supervised, disciplined, and terminated more than nonblack nurses. Discriminatory and racist practices also limited career advancement, so that upper level manager and head nurse positions were few. Overt racist behavior and microaggressions had a significant impact on black nurses' self-perception, confidence, physical stress, emotional pain, not feeling trusted, and health problems.

Jefferies et al. (2018) next explained that black feminist poststructuralism helped to achieve an in-depth analysis of the many ways power affects the intersections of race, class, and gender and how such intersections influence black nurses' circumstances, such as oppression, and leads to invisibility. They asserted that power was also critical in examining domination in social organizations. In nursing, race has had a great effect on power relations. Oppression operates in nursing schools and hospitals; hidden racism is normalized in policies, procedures, and practices. Racism is found in textbooks, too, as stereotypes appear as assessment findings. Perspectives on black leaders in nursing depends on subjectivity and how they position themselves and discriminatory practices restricted career movement. Jefferies et al. (2018) observed that strong, black women may be nurturing and caring, sometimes to their own detriment, and act in a specific manner and avoid voicing challenges, difficulties, or stress in their roles. For the black nurse leader to be valued, the dominant patriarchy needs to be taken apart.

Conclusion

Although my initial search located a large amount of relevant literature, I stopped this review and committed to reading more literature on racism, such as the work of Waite and Nardi (2017), and other literature on discrimination in nursing and healthcare. I was encouraged by the efforts of the persistent work of ethnic nursing organizations that have provided some solutions to increasing the number of ethnically diverse nurse leaders through membership activities (Matza et al., 2018). I also have appreciated the perspectives that the diversity of the workforce has been identified as a factor adding to the quality of patient care and that a linguistically-prepared nursing workforce is needed to care for emergent majorities.

My overwhelming concern about this journal and the International Association for Human Caring is this: discrimination and intolerance are antithetical to the ethical principles grounding caring concepts, theories, and action. However, it is in caring action that I think I have failed. I need to continue to get "trained up" and to act. I need to speak up when hearing biased speech and to learn first from the diverse members of my family so that I might understand more about their lived experience of being members of marginalized groups suffering from intolerance and hate. I also need to continue my promise not to hate anyone and to know that all of us, even those dramatically opposed to our views and ethics, are humans worthy of respect. Finally, I am compelled

by Schroeder and DiAngelo's (2010) statement and ask us, does the caring that we have created maintain color blindness and a lack of vision about other marginalized groups? AQ1

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AQ1: AU: Lemon (2020c) is not cited in the text. Please provide text citation or remove from reference list.