Systemic Racism in a Contemporary Society

Some may reasonably question the extent to which systemic racism exists in a contemporary society and falsely assert that legislative rulings like Brown vs Board of Education in 1954, the Civil Rights Act of 1964, along with 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, 2021).

A plethora of literature supports 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 et al., 2021; Hassouneh et al., 2021; Waite et al., 2017; White, 2018). In an October 2021 study on racism in nursing fielded by the National Commission 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 et al., 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 Center for Disease Control (2021) indicted 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.

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 et al., 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 unlike or they won’t fit in (Fitzsimmons, et al., 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 over 400 years ago in 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 has 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 et al., 2017). Additionally, racism shows
up under the guise of hair policies and discriminately determines 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 hair style 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 health care, 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 et al., 2016). In The Commission’s
2021 survey BIPOC nurses of all racial categories reported experiencing the highest percentage
of racism from a co-worker or peer followed by a patient and manager, supervisor, or

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 give life to racism and limited 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 Mr. George Floyd. Nevertheless, the fallout of racism in a
contemporary society contributes to health and educational disparities that limit the
professions’ 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 from 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 unjust murder of Mr. 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 macroaggressions. 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 (Stevenson, 2014). At its most basic level, social injustice is about distribution of wealth, power, resources, and opportunities (Rothenberg, 2007) 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 is 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, deemed, one of Merriam-Webster’s 2021’s 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, 2021). 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 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 Dr. Kendi, “...being an anti-racist requires persistent self-
awareness, constant self-criticism, and regular self-examination.” (Kendi, 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 of
crime 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 four I’s of Oppression will help
provide understanding of how the rooted history of racism and its historical trauma from
colonization has been internalized and passed down from generations and continues to
manifest in our workplace, environment, policies, and society.

Ideological oppression views one group as better than another with the right to control groups
seen as inferior. This is evident by perceptions of higher intelligence, work ethic, physical
strength and endurance, and superiority, compared to the other groups 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,
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, 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

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as inferior. This is the result of internalized negative stereotypes driving unconscious
oppression under the guise of normalcy (Chinook, 2021). This is seen through micro- and
macroaggressions, 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 ‘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 normalizes one’s privilege in their own internal
belief of inherent superiority. It creates entitlement and denies the existence of oppression and
expresses this privilege or entitlement as paternalism (Chinook, 2021). Internalized privilege is
seen by 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 to superglue. Culture, like genetics, has a group definition but individual
expression. It is shared, learned, dynamic, and evolutionary. With this said, Gendlin 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:

- A feeling
- a thought
- an action
- 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 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 our emotions to the point of tears or anger. It is likely due to something you care deeply about, violated your trust, or 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 so 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 put on the resultant violence and harm that occurs due to such covert and overt acts to both the individual who is the target...the one to be silenced, invalidated, not heard and in ways that (2) leaves 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 of 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 is ever present, dynamic, and oppressive. Despite the vowed proclamations as health professionals “to do no harm”, harm is done and such hypocrisy is 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, 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.

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. For 3 to 5 Americans according to Cigna’s 2020 Resilience Index Report, two thirds of full-time healthcare workers do not have high resilience compared to the national average and are and less likely to rate mental/social health as very good. Surviving is no longer inspirational or aspirational. The ability to thrive is the clarion call and tapping the 6 inspirational acts captured in the composed acrostic outlines and operationalizes 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 which 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 which 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, reflection are powerful modifying contributors to galvanizing change, promoting human flourishing and are essential to both the business of health care 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 expressions of oneself, has never been more important.

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