Racism in Nursing: Practice

Work Environment

Diversity, Equity, and Inclusion (DEI) touches every part of a healthcare organization, acknowledges the value of many voices, and holds the wellbeing of nurses as central to a positive clinical environment. Nurses’ intent to stay at an organization is associated with how they perceive the value their employer, managers, and peers place on diversity and inclusion. A successful healthcare workplace must have an inclusive environment and offer safe spaces for courageous conversations where nurses can discuss racism openly and explore how unconscious bias can negatively impact their decisions. Retention and recruitment of nurses is directly related to whether the work environment is diverse and inclusive. Organizations have a responsibility to mitigate barriers hindering these values and must respond to overt racism as part of systemic change needed to address health disparities, especially in marginalized communities (Caldwell, et al., 2021).

A study among health care leaders found that only 8% of individuals on hospital boards and executive leadership positions are Black, 3% are Hispanic, 1% are American Indian or Alaskan Native. (Institute for Diversity in Health Management, Health Research & Educational Trust, 2016) A healthcare organization can improve the diversity climate by employing targeted goals to recruit and retain more historically marginalized BIPOC nurses. Targeted goals might include promoting individuals from known excluded groups into leadership positions. Investing in diverse leadership may help to cultivate a culturally responsive healthcare organization and begin to eliminate health disparities.

Racism in the nursing practice environment presents overtly when BIPOC nurses are subject to assignment changes at the request of patients and family seeking care from non-BIPOC or white nurses. Racism in nursing is also covert through microaggressions in the form of insults, slights, and presumptions of lack of competence and ability that has resulted in barriers hindering progression within the profession. In either case, the emotional harm experienced by the nurse should not be underestimated. When patients express racist behavior, nurses may experience a conflict between preserving their humanity and providing care (Vogel, 2018). Organizational leadership and support are key if institutions are to truly fulfill an antiracist mission (Rasmussen, & Garran, 2016). The American Nurses Association (ANA) recommends: “Nurse managers, supervisors, and administrators must assess policies to ensure support of inclusiveness, civility, and mutual respect, acknowledging that the lack of such policies may result in environments that fail to sustain high-quality, effective, efficient, and safe health care practices.” (ANA, 2010)

Nurse leaders are in the position to address racism, bullying, incivility, and discrimination from peers, faculty, and patients by offering tools for nurses to use when confronted by micro- and
macroaggressions such as bullying, which can result in lowered self-esteem, high anxiety, many levels of depression, fear, and isolation if not addressed. Healthcare systems can confront incivility and bullying by having nurse leaders provide education and tools to nurses that encourage them to exert upstander behavior and intervene when they witnessed bullying. Microaggressions, forms of bullying, convey negative messages about distinctive groups of people. (Sue, 2010; Torino, et al., 2019)

Disruptive behavior, such as racism, can have widespread influence on a healthcare system and nurses need to be cognizant of this issue. The impact of these disruptive behaviors threatens not only patient safety, but also the wellbeing of nurses and their ability to perform competently in their jobs. Hospital leadership and nurse managers must demonstrate a concern for the frequency of disruptive behaviors and implement a clear outlined plan to address them. Colleagues and hospital administration cannot ignore, dismiss, or explain away such occurrences. If disruptive behaviors are not addressed, nurses may experience role conflict and a sense of betrayal, which may serve to compound moral distress (Stone & Ajayi, 2013).

Health care organizations must foster foundational values that support a zero-tolerance culture for racism. The following is an example of how one large multi-site healthcare system has a zero tolerance for disruptive behaviors and the actions of nurse managers to observe and mitigate incivility. This organization expects nurse managers to be on their units and observe behaviors, especially at shift change. The nurse managers watch for nonverbal signs, such as raising eyebrows, making faces, etc., and stress a team (all of us) instead of an individual issue. Nurse managers are expected to mitigate disruptive behaviors such as nursing refusing to work with a particular nurse, ignoring a call to help with a patient that requires multiple nurses, and ostracizing a nurse without explanation. To support ‘zero tolerance’ the healthcare system put in place several strategies for nurse managers to follow: observe staff in action, conduct new nurse surveys to understand engagement (do you always feel welcome?). Nurse managers also set clear expectations with nursing teams about behaviors that are acceptable and those that are not acceptable. The also stress the importance of all nurses finding out facts of a complaint before reacting. The healthcare systems stress the importance of education of all nurses about appropriate behaviors. One nurse manager addresses appropriate behaviors during her monthly meetings where she dedicates 30 minutes to this discussion. “Nurse leaders are part of the access and delivery of equitable health care regardless of location of the care provided. As such, nurse leaders have a role in recognizing and mitigating care inequities. Nurse leaders must be continually aware of triggers that indicate when they should take action and counter bias by interrupting a situation.” (Stamps, 2021)

Consequences of disruptive behaviors in nursing can lead to decrease in morale and affect retention, cause burnout, and can indirectly affect patient safety. In 2009 the Joint Commission (JC) instituted a leadership standard mandating that facilities seeking accreditation institute
policies to address disruptive behaviors among healthcare workers. Disruptive behaviors include overt and covert actions that are displayed by any healthcare worker and that threaten the performance of the healthcare team (TJC, 2008). Most frequently reported behaviors include emotional-verbal abuse. Disruptive behaviors threaten patient well-being due to a breakdown in communication and collaboration (Longo, 2010). In a study of 4,539 healthcare workers, 67% felt there was a linkage between disruptive behaviors and adverse events, 71% felt there was such a linkage with medication errors, and 27% felt there was a linkage with patient mortality (Rosenstein & O’Daniel, 2008).

Health care institutions must view racism as a preventable harm and address it with the same fervency devoted to other preventable harms that have been prioritized for decades. Prior attempts to address racism in health care, institutions have not resulted in sustained cultural change because conscious and unconscious racial biases have not been addressed (Watson and Malcolm, 2021).

Dual Harm

Racism is an assault on the human spirit (Defining Racism, 2021) from the interplay (intersection) of biases, discriminations, classism, colorism, micro and macroaggressions, and the legacy of historical trauma. Racism causes dual harm for both the nurse and the patient, in at least three dimensions of health care: (1) impacting patient care, thought processes, and communications of all healthcare providers to each other, their patients, and themselves; (2) influencing patient care of historically marginalized, racialized patients by guiding assessment and treatment decisions, promoting racialized stereotypes, and severely limiting patient accessibility to quality health care; (3) harming historically marginalized nurses through internalizing racial stereotypes, stigmas and racist labels, causing moral distress, job dissatisfaction, and career invisibility and stagnation.

It is a core nursing responsibility to protect the humanity, dignity and human rights of all patients and colleagues, yet harm persists from an ethical practice and patient safety perspective. According to all nine precepts of the ANA Code of Ethics, (Brunt, 2016) as ethics are breached, patients and families suffer. This is especially true for the historically marginalized with chronic health conditions such as hypertension, asthma, diabetes, heart failure, kidney disease and COVID 19 (Williams et al., 2010; Webb Hooper et al., 2020). In the BIPOC population, these conditions are often at higher rates, beginning earlier and treated later than their White counterparts, with poorer outcomes (Ignaczzak & Hobbes, 2020). In addition, risk assessments that are based on a faulty belief that different races have intrinsically different biologies contribute to faculty diagnoses and treatment (Bailey, Feldman, and Bassett, 2021).

Nurses who are racialized (the act of grouping marginalized populations or people together under a racial category or racist ideology/ism (Racialize, 2021) experience racism as an
historical trauma originating from suppression and oppression, White privilege, and the
systemic racism embedded in the mainstream culture. As one BIPOC nurse educator stated,
“with an...overwhelming sense of solitude...the struggle to see my own reflection or likeness in
the nursing professorate has been particularly sobering” (Thompson, 2021, p. A1). The same
pervasive racism within nursing, characterized by bias, microaggressions, white privilege and
bullying (Dawson, 2021) is also implicated in the health inequities faced by the patients BIPOC
nurses care for. This dual harm from racial trauma is also implicated in moral injury, described
as “damage to our very souls” (Khan, 2021), and increased willingness to leave the profession
(AMH Healthcare, 2019).

Racism is a preventable harm and can be mitigated by intentional actions to change belief
systems and social and organizational practices that contribute to dual harm from structural
racism, which is invisible unless one looks for it, as it is ingrained in the structures, beliefs,
policies and practices of our healthcare system (Nardi et al., 2020). Policies must be in place for
responding to inappropriate behavior towards historically disadvantaged nurses and patients.
Protocols that follow root cause and debriefing processes for harmful behavior scenarios should
be developed, tested and taught, with expectations for their proper use made clear to all who
manage or teach nurses in all levels and areas of nursing practice. Nursing practice begins with
education, including an antiracism curriculum that prepares students at all levels and specialties
for the care of an increasingly diverse population in the U.S. Educators must familiarize
themselves with the antiracism frameworks for use in curriculum design, with real world
situations and case studies for discussion and resolution at all education levels. These and other
antiracism actions must be in place to prevent entrenched and pervasive dual harm to nurses
and their patients in all areas and levels of healthcare

Inequity of Policy, Practice, Opportunity
In 1987 The Hudson Institute created a stir with its report Workforce 2000: Work and Workers
for the 21st Century (1987, Johnson & Packer). There are two trends from that report that
inform the issues of diversity, equity and inclusion today. Standing in the timeline of 1987, the
writers accurately forecasted that by end of the 20th century the workforce would disrupt what
was then the status quo by becoming older more female and more disadvantaged. “Only 15%
of the new entrants to the labor force by the year 2000 would be native white males compared
to 47% in that category today.” (p. xiii) One other anticipated trend highlighted that service
industry jobs would hold a commanding position and would require a more educated workforce
operating at a higher skill level. The report recommended that policy makers had several tasks
before them; two of which were: the integration of Black and Hispanic workers fully into the
economy and the improvement of educational preparation of all workers. What were once
1987 probabilities are now social realities.
The Covid Pandemic is rightly considered an epoch in human history. The “before times” are a line of demarcation for current attention to calls for change related to social justice, social inequities and systemic and structural racism. The designation of systemic racism as a public health crisis is singularly significant. Whether declared a “serious public threat” by the CDC and the AMA or a “public health crisis” by the APHA, strong appeals for change that is intentional through strategy, policy, advocacy and leadership is at the forefront of insistence for substantive change. What is now in place for the health services workforce, its leadership and its care design has failed to yield what is expected. Inequities, inequalities, disparities that exemplify race-based differences in data related to morbidity and mortality rates have become intolerable. What is especially insupportable is the availability of evidence establishing the issues (Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, 2003) effective interventions (In the Nation’s Compelling Interest: Ensuring Diversity in the Health-Care Workforce, 2004) and Organizational design to address a multicultural society in need of health services (Culturally and Linguistically Appropriate Services, 2000).

Dr. Martin Luther King spoke of the concept he called gradualism. The word connotes the many slow small steps taken to reach a large, visionary goal. Bias and discrimination have haunted nursing since the days when minority nurses were segregated within the profession and its opportunities. One fellowship expressed the inclusive vision for nursing as the individual experience of the Our pursuit of excellence not impeded by race or any aspect of identity. That this pursuit was for the benefit of the common good and to enable those who come together for the acquisition of knowledge, skills and competencies, the opportunity to pursue their own vision of practice from a position of superior performance. That the goal of such excellence welcomed innovative thinking informed by a broad range of values, beliefs and ethical principles. (Hausman Fellowship) The ultimate goal is the intentional creation of a positive academic and employment environment for the BIPOC professional.

The following recommendations are suggested as an outline for the way forward in addressing diversity, equity and inclusion in the nursing workforce, the work environment in which care is delivered and the learning environment in which nursing education is delivered.

**Nursing Education and its Learning Environment**

Holistic Admission and Learning Environment

a) Factor in social determinants of educational preparation for college such as BIPOC dominant public-school systems, housing and food stability, school to prison pipeline ethos, etc as part of a holistic admission process

b) Establish Peer Support Group as part of school infrastructure for the BIPOC student to provide psychological and emotional support and safe space to discuss race-based challenges in campus life (AHANA, African, Hispanic, Asian, Native American)
c) Designate a DEI Ombudsman as part of School Leadership to monitor equity in school policies, review and intervene in individual problem

d) Provide expertise based Mentoring specific to the racial identity needs of the BIPOC student

e) Require DEI Training for Faculty and School Leadership

f) Track attrition and admission data for BIPOC students

BIPOC Workforce Recruitment, Retention and Career Progress

a) Establish curriculum for the non-BIPOC leader that teaches management skills needed for a multicultural workforce. This should include pointers on antiracism practices, managing raced based conversations to avoid “tip toeing” behavior, communication triggers in a diverse environment, culture-based interpretations of valued organizational behaviors to increase recognition of the BIPOC employee with potential, etc

b) Mentoring and Career Progression of Diverse staff. Track employees who have received awards, lead projects, participate in committees, pursue education in a particular area, support for BIPOC principle investigators, demonstrate behaviors that show a strong desire for success.

c) Monitor and increase BIPOC hires from internships, fellowships, workforce development programs.

d) Establish Employee Resource Affinity Groups aligned with Human Resources. This group helps build resumes by providing event planning skills, project management experience, presentation skills, finance management etc. It also provides safe space for transparency related to work life in the white dominant organization for the BIPOC professional.

e) Designate a DEI officer to oversee strategy, serve as a specific employee resource

Policy

Organizations operate through rules and procedures that maintain coherence related a specific agenda. Needed in nursing today is an accountability agenda that speaks to the reality of BIPOC specific issues. The incorporation of that reality into policy, procedures and practices that govern decision making is the long-standing lag in bringing change to problems of bias, discrimination and racism in the profession. Implementing strategies designed to address the presence and effects of racism requires the following actions:

a) Implementing Operational definitions related to the issues and meaningful to the setting committed to dismantling racism.

b) Set up an organizational plan with buy in from leadership, staff and employees with built in accountability for outcomes

c) Establish DEI as a programmatic approach with a line item in the organizational budget to make the work sustainable.

Nursing Burnout
Burn out in Nursing is a well-documented subject. It is the major cause of Nurses leaving a particular position, institution, or our profession. Studies report that 31.5 percent of nurses left their job because of burnout in 2018. Compared to approximately 17% of nurses in 2007 cited burnout as the reason for leaving. (JAMA, 2021) In Nursing occupational stress, and subsequent compassion fatigue, moral distress are factors for all nurses. Factors that ultimately contribute to individual burnout. Despite this evidence, little has changed in health care delivery and the role of registered nurses. The prolonged COVID – 19 Pandemic, Social Injustice, and the Nursing shortage has further complicated matters. A study comparing understaffing of nurses in New York and Illinois was associated with increased odds of burnout amidst high patient volumes and pandemic-related anxiety. (Lasater, BMJ Qual Saf)

We can extrapolate findings from the fields of Psychology and Sociology to understand the impact of racism on BIPOC nurses given the limited number of studies on racism in nursing. Racism presents itself in different forms: Individual, Interpersonal, Institutional, and structural. For anyone experiencing racism, it can be a chronic source of psychological and physiological distress. We know mental and physical stress leads to burnout. Burnout brought on by racism.

A well sited study by Brondolo et al., 2009 found that participants experienced repeated exposure to racism, as often as weekly. Additionally, the study showed that participants experienced racism regardless of socioeconomic status, which supports the assertion that professionals/persons with higher education (e.g., nurses) are not exempt from exposure to racism. The study also found that Black/African American participants experienced more lifetime, i.e. chronic, exposure to racism than others. (Byers, Nursing Outlook)

The unspoken truth. During the ANA Commission on Racism in Nursing’s open forum, real life experiences of racism were discussed. Multiple personal accounts of missed promotions, inappropriate co-workers, and managers has driven many BIPOC nurses to burnout.

Organizational leaders should understand that burnout tends to increase liability exposure, reduce patient satisfaction levels, and heighten reputational risk. Mitigation of stress (Burnout) in the workplace improves job satisfaction, retention, and patient outcomes.

**Breach of Ethical Obligations**

The Code of Ethics for Nurses with Interpretive Statements (ANA, 2015) serves as the foundational ethical standard for values, norms and obligations of the nursing profession. By its very nature, racism is antithetical to the ethical ideals of the profession in its inherent perpetuation of disrespect, unfairness and harm. Code provisions and interpretive statements articulate explicit requirements for all nurses at the levels of individual as well as collective activities. As moral agents obligated by the Code in their practice, nurses have the responsibility to uphold these established and non-negotiable professional standards.
The nine Code provisions are broad and non-contextual, and accompanying interpretive statements provide more specific guidance in the application of each provision, including values and obligations which apply to all nurses – regardless of role, setting, or type of practice. Numerous provisions and associated interpretive statements articulate values and obligations that directly prohibit individual racist behaviors and attitudes as well as systematic racial inequities and injustice.

Although not a comprehensive list, relevant Code provisions include: Provision 1 – The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person. Respect for human dignity and rights must underlie all nursing practice and be extended to all persons regardless of individual differences and in every professional relationship; Provision 5 – The nurse owes the same duties to self as others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth. While this provision speaks primarily to extending the same duties to ourselves as others, the principle of according moral respect and dignity to all human beings regardless of personal attributes or life situation is at its core. It also speaks to striving for personal growth and excellence in nursing practice by routinely evaluating personal performance and learning about concerns, controversies and ethics relevant to standards of professional practice as well as themselves; Provision 6 – The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care. Obligations under this provision relate not only to doing what is right, but doing no harm and treating people fairly – including professional colleagues – and the necessity for all nurses to help construct environments that foster ethical practice and professional fulfillment.

The realities and impact of racism in the workplace as described by nurses who have directly experienced it are reflected throughout this Commission’s Report. Racism in the workplace contributes to preventable harm, moral distress and discrimination which the Code obligates nurses to advocate against. Nurse perpetrators as well as enablers of racism undermine respect and human dignity of BIPOC nurses who strive to provide safe, effective care to their patients. BIPOC nurses may also experience racist behaviors and attitudes emerging from patients and require support from nursing colleagues, management and leadership to mitigate potential harm. Finally, assuring efforts to establish and implement equitable policies, practice and professional opportunities for all nurses are a necessary part of establishing a culture and workplace where all nurses are treated fairly.
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