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Racism in Nursing Practice

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Work Environment

Diversity, equity, and inclusion (DEI) touches every part of a healthcare organization, acknowledges the value of many voices, and holds the well-being of nurses as central to a positive clinical environment. Data indicates that nurse retention at an organization is associated with how nurses 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. Organizations have a responsibility to mitigate barriers hindering these values and must respond to acts of overt and covert racism as part of systemic change needed to address health disparities, especially in marginalized communities (Caldwell et al., 2021).

Racism in the nursing practice environment is overt when BIPOC (Black, Indigenous, and people of color) 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 have resulted in barriers hindering progression within the profession. Microaggressions convey negative messages about distinctive groups of people (Sue, 2010; Torino et al., 2019). These acts can result in lowered self-esteem, high anxiety, many levels of depression, fear, and isolation if not addressed. 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).

Health care organizations must foster foundational values that support a zero-tolerance culture for racism. Organizational leadership and support are key if institutions are to truly fulfill an anti-racist mission (Rasmussen & Garran, 2016). 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 & Malcolm, 2021). Hospital leadership and nurse managers have a responsibility to address racism and racist behaviors within their organization by implementing a clear, outlined plan for mitigation. Colleagues and hospital administration cannot ignore, dismiss, or explain away such occurrences. If disruptive behaviors like

racism are not addressed, nurses may experience role conflict and a sense of betrayal, which may serve to compound moral distress (Stone & Ajayl, 2013). 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, 2018.

A study among health care leaders found that only 8% of individuals on hospital boards and executive leadership positions are Black, 3% are Hispanic, and 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 can have widespread influence on a healthcare system, and nurses need to be cognizant of its impact. Described as a disruptive behavior in some literature, racism and its impact threaten not only patient safety but also the well-being of nurses and their ability to perform competently in their jobs. Consequences of disruptive behaviors in nursing can include decreased morale, effects on retention, burnout, and, indirectly, effects on patient safety. In 2009, The Joint Commission 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 (The Joint Commission, 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

27% FELT THERE WAS A LINKAGE WITH PATIENT MORTALITY

(Rosenstein & O'Daniel, 2008)

Dual Harm

Racism is an assault on the human spirit (Defining Racism, 2021) from the interplay (intersection) of biases, discriminations, classism, colorism, micro- and macro-aggressions, and the legacy of historical trauma. Dual harm is a relatively new concept in nursing, adapted from psychology's use of it to describe the phenomenon that people who are harmed by others are at risk for also harming themselves and harming others. They experience a dual harm, or harm to others (Slade, 2019). Nursing has used the term to acknowledge that race-based harm to racialized BIPOC nurses also harms the non-BIPOC nurse. Dual harm is much more multifocal, however, than this. 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) directing patient care of historically marginalized, racialized BIPOC patients by guiding assessment and treatment decisions, promoting racialized stereotypes, and severely limiting patient accessibility to quality health care; and (3) directly harming historically marginalized BIPOC nurses through internalizing racial stereotypes, stigmas, and racist labels, causing moral distress, job dissatisfaction, and career invisibility and stagnation. Harm to any of these three aspects of the patient care system affects the other parts of it, causing harm to all and to the system itself.

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 often occur at higher rates, beginning earlier and treated later than in their white counterparts, with poorer outcomes (Ignaczak & Hobbes, 2020). In addition, risk assessments that are based on a faulty belief that different races have intrinsically different biology contribute to faulty diagnoses and treatment (Bailey, Feldman & Bassett, 2021).

Nurses who are racialized (racializing is 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, ¶ 7), and increased willingness to leave the profession (AMN Healthcare, 2019). Subsequently, when racialized nurses leave the profession, they take with them their informed perspective, their expertise, and their contributions to patient care, which affects the patients and the profession alike.

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 toward 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 anti-racism 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 anti-racism frameworks for use in curriculum design, which includes the use of self-awareness and self-examination, with real-world situations and case studies for discussion and resolution at all education levels. These and other anti-racism 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

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 BIPOC nurses were segregated within the profession and its opportunities. Our pursuit of excellence must not be impeded by race or any aspect of identity.

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

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 anti-racism 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) **Monitor and increase BIPOC hires** from internships, fellowships, workforce development programs.

c) **Designate a DEI officer** to oversee strategy and serve as a specific employee resource.

Worksite Policy

Organizations operate through rules and procedures that maintain coherence related to a specific agenda. Needed in nursing today is an accountability agenda that speaks to the reality of BIPOC-specific issues. Failure to incorporate 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) **Implement Operational definitions** related to the issues and meaningful to the setting that is 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

Burnout in nursing is a well-documented subject. It is the major cause of nurses leaving a particular position, institution, or the profession. Studies report that 31.5% of nurses left their job because of burnout in 2018, compared to approximately 17% of nurses in 2007 who cited burnout as the reason for leaving (Wheeler et al., 2021). Occupational stress, subsequent compassion fatigue, and 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 have further complicated matters. A study comparing understaffing of nurses in New York and Illinois found increased odds of burnout amid high patient volumes and pandemic-related anxiety (Lasater et al., 2021).

NURSES LEFT THEIR JOB BECAUSE OF BURNOUT

2007	2018
17%	**31.5%**

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 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.

An often-cited 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 et al., 2021).

The unspoken truth experiences of racism were discussed. Multiple personal accounts told of missed promotions, inappropriate co-worker behaviors and managers that have 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 and 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 noncontextual, and accompanying interpretive statements provide more specific guidance in the application of each provision, including values and obligations that 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 this is not a comprehensive list, relevant Code provisions include the following: **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 to 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 the importance of 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 to oneself. **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 also to 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 the Code of Ethics for Nurses with Interpretive Statements. 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 the 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 from patients and require support from nursing colleagues, management, and leadership to mitigate potential harm. Finally, assuring efforts to establish and implement equitable policies and practice, and professional opportunities for all nurses is a necessary part of establishing a culture and workplace where all nurses are treated fairly.

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Ophelia M. Byers, DNP, APRN, WHNP-BC, NEA-BC, CPXP; Joyce J. Fitzpatrick, PhD, MBA, RN, FAAN; Patricia E. McDonald, PhD, APRN; Germaine C. Nelson, DNP, MBA, RN, NEA-BC, CEN, CPXP. Giving while grieving: Racism-related stress and psychological resilience in Black/African American registered nurses. Nursing Outlook 2021.

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National Commission to Address Racism in Nursing – Practice Workgroup

Workgroup Chair:

Debra A. Toney, PhD, RN, FAAN

Commissioners:

Willa Fuller, BSN, RN

Rhonda Anderson, DNSc(h), MPA, BS, RN, FAAN, LFACHE, FAHCT

Larlene Dunsmuir, DNP, FNP, ANP-BC

Mary Ann Fuchs, DNP, RN, NEA-BC, FAAN

Karen Daley, PhD, RN, FAAN

Subject Matter Experts:

Bobbie Bagley, BS, MS, MPH

Dr. Karen Rawls, RhD, RN

Dr. Deborah Stamps, EdD, MBA, MS, RN, GNP, NE-BC

Linda Burnes Bolton, Dr.PH, RN, FAAN

Angie Millan, DNP, RN, FAAN

Janice Linton, DNP, APRN, ANP-BC, CCRN, ACHPN

Kristin Fitchpatric, DNP, APRN, PMHNP-BC

Sarah R. Cassell, DNP, MSN, BSN, APRN, CNP

Larider Ruffin, DNP, APN, RN, ANP-BC, AGNP-C, CRNP, CTTS

Erica Joseph, PhD, DNP, APRN, PMHNP-BC, NP-C

Patricia Horton, RN, MN, MBA, CMC

Deena Nardi, PhD, PMHCNS-BC, FAAN

Cathy Hamel, MS, RN NEA-BC

Roberta Waite, EdD, PMHCNS, ANEF, FAAN

Deb Washington, PhD, RN

Guardia Banister, PhD, RN

Lisa Pacheco, MSN, RN, NEA-BC

Richard Lamphier, RN

ANA Staff:

Kendra McMillan, MPH, RN