



National Commission to Address
Racism in Nursing

Report Series

Racism in Nursing



- 1 The History of Racism in Nursing: A Review of Existing Scholarship
- 2 Systemic Racism in a Contemporary Society
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Report #1 of 6

The History of Racism in Nursing: A Review of Existing Scholarship



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The History of Racism in Nursing: A Review of Existing Scholarship

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Introduction

History matters. Beyond George Santayana's oft-repeated cliché that "those who cannot remember the past are condemned to repeat it," history – or more correctly, the stories we tell about our history – frames how we think about ourselves now and the possibilities we can imagine for our future.¹ These stories have their own power. They create a shared sense of identity. They can remain essential yet change over time in small but powerful ways to incorporate new questions and new issues. And they can construct meanings that sometimes bridge even if they cannot destroy divides based on what scholars have described as "positionality": where one stands vis-a-vis backgrounds, assigned roles, social constructs, political capital, and sheer ambition.

We acknowledge our own positionality. We are both white women. We are also, respectively, the director of the Eleanor Bjoring Center for Nursing Historical Inquiry at the University of Virginia and the director of the Barbara Bates Center for the Study of the History of Nursing at the University of Pennsylvania. As such, we are experts in broad areas of the history of nursing and healthcare as well as in the narrower areas of our own expertise. We believe deeply in the power of history and historical analysis; we believe both give scholars and readers the distance of time to step back and reflect upon difficult and contentious issues. Historical concepts and methods reflect the complexity and interconnectedness of critical political, social, and cultural issues that cannot be reduced to single variables. They attend to the importance of context and causality. They link ideas and actors in interpretive narratives of meaning; as such, there can be no overarching "story" but, rather, different ones that privilege different perspectives.² And, most important, they encourage formulation of judgments and assessments of significance.³

G. Rumay Alexander, Katie Boston-Leary, and Cheryl Peterson, representing the National Commission to Address Racism in Nursing, commissioned this essay. The timeline they presented that would best enable this essay to move the Commission's work forward precluded original research. We have thus constructed what we call an historiographical essay. This established form of essay reviews relevant published historical research that addresses issues central to examining the issue of racism in nursing. The research we review focuses primarily on issues of structural and systemic racism that have affected nursing: "forms of racism that are pervasively and deeply embedded in and throughout systems, laws, written or unwritten policies, entrenched practices, and established beliefs and attitudes that produce, condone, and perpetuate widespread and unfair treatment of people of color."⁴ This scholarship centers on the experiences of nurses who identified as

1 George Santayana, *The Life of Reason* (New York: Scribner's, 1905), p. 284.

2 Patricia D'Antonio, Cynthia Connolly, Barbra Mann Wall, Jean C. Whelan, Julie Fairman, "Histories of Nursing: The Power and the Possibilities," *Nursing Outlook* (2010) 58(4): 207-213.

3 Patricia D'Antonio, "Conceptual and Methodological Issues in Historical Research," in Sandra Lewenson and Eleanor Herrmann (eds.), *Capturing Nursing History: A Guide to Historical Methods* (New York: Springer Publishing, 2007) pp. 11-23. This chapter draws heavily on John Gaddis' *Landscape of History: How Historians Make Sense of the Past* (New York: Oxford University Press, 2002).

4 Paula A. Braverman, Elaine Arkin, Dwayne Proctor, Tina Kauh, and Nicole Holm, "Systemic and Structural Racism: Definitions, Examples, Health Damages, and Approaches to Dismantling," *Health Affairs* (2022) 41(2): 171-178.

Black, Asian, Native American, or Latino – populations that have been historically racialized in the U.S. That is, they have been treated as distinct racial groups (regardless of ethnicity), constructed in structural opposition to the category of “white,” even as the meanings ascribed to these categories as well as the culturally determined parameters of these categories have shifted over time and across place.⁵ Because of this racialization, Black, Asian, Native American, and Latino nurses have faced structural and systemic racism that influenced their access to educational and professional opportunities and to institutional power in nursing and healthcare. They have also been approached as monolithic populations and actors, with too often insufficient attention to how the intersections of class, religion, place, access, and ambition differentially shaped individual experiences.⁶

We acknowledge the importance of topics and themes raised during the public comment period: the role of historically Black colleges and universities in nursing education and practice; the global histories of nursing, particularly those in Asia, the Middle East, and Africa; the experiences of Alaska Native nurses as well as Asian and Pacific Islander nurses in the U.S.; and the role of leadership and missions for nurses of color in those organizations that have emerged since the 1970s. Regrettably, these are topics for which richly contextualized historical studies do not yet exist. Most histories of nursing and healthcare published by 2021 cover events and actors up to the 1960s. The changes are attendant upon what historians now call “the long Civil Rights era” and acknowledge the groundwork laid by Black professionals in the 1950s are only now the subject of sustained historical analysis.

Our essay acknowledges these limitations. It moves forward in historical time to explain the evolution of relevant questions and issues. At times, it segues into earlier periods and other areas of significant historical research to explicate important themes. And it ends with suggestions for further areas for research that might help nurses understand the complex and complicated dimensions of racism in nursing. But we must begin with nursing’s own origin story.

5 See, for example, Roberts (2011). For an overview of the effects of systemic racism on Latino communities in the U.S., see Viviana López and Samantha Vargas Poppe, “Toward a More Perfect Union: Understanding Systemic Racism and Resulting Inequity in Latino Communities.” UnidosUS Position Paper, April 2021. Available at https://www.unidosus.org/wp-content/uploads/2021/08/unidosus_systemicracismpaper.pdf (accessed March 27, 2022).

6 Karen Flynn’s *Moving Beyond Borders* provides a model for analyzing the influence of multiple and intersecting subjectivities on the experiences and identities of nurses. Flynn examines the intersections of family of origin, religion, cultural values, hard work, education, family commitments, activism, and migration, as well as the impact of race, class, gender, and sexuality on the lived experiences, subjectivities, and identities of Black Canadian and Caribbean nurses. Karen Flynn, *Moving Beyond Borders: A History of Black Canadian and Caribbean Nurses in the Diaspora* (Toronto: University of Toronto Press, 2010).

Nursing's Origin Story

Florence Nightingale lies at the heart of Western nursing's historical story. We begin here not to reify but rather to critique the central place that Nightingale – and whiteness – have occupied in the history of American nursing. That story can be summarized as follows: The educated daughter of Britain's elite struggles against the conventions of her mid-19th-century time and place and achieves fame for her skilled care of her countrymen fighting in the Crimea. The epidemiological and sanitary science that underpins her ideas about proper nursing care strengthens her reputation. A grateful British public raises the funds that eventually lead to the establishment of the iconic St. Thomas' Training School for Nurses in London.⁷ An attentive northern American public, looking for innovations as it begins planning for the care of the sick and wounded during its own Civil War, adopts the architectural and environmental prescriptions for healthy institutional healing set forth in her *Notes on Hospitals*.⁸ And American women, most of them white and middle class, stream to the war's battlefield waving serialized newspaper copies of *Notes on Nursing* as testament to their own ability to nurse.⁹

Notions of class ran through these origin stories. Lest anyone miss the deeply held ideas about the importance of social hierarchies embedded in Nightingale's ideas about nursing, her *Notes on Nursing for the Labouring Classes* detailed the actual skills and techniques working-class women needed to show to their middle-class women employers who learned such supervisory skills from reading *Notes on Nursing*.¹⁰ The emerging leaders of nursing in the United States eschewed such obvious class distinctions. They, for example, never imported the two-tiered training model at St. Thomas', which had one program for "ladies" and another for those who needed to earn their living. Rather, their rhetoric stressed the need for the "right kind of woman" to enter nursing and enshrined the respectable middle-class virtues of honesty, faithfulness, truthfulness, obedience, and loyalty into the training of most other women who sought to become nurses.¹¹

Whiteness, by contrast, was so embedded in these stories it needed no explication for generations. This began to slowly change in the 1960s and 1970s. The shortage of nurses in Britain led to the immigration of nurses of color from its former colonies, most notably in South Africa and the Caribbean. These nurses found their own Crimean heroine in Mary Seacole, a British-Jamaican "doctress" who, when first the government and later Nightingale refused her offer of service, established her own "hotel," which provided health, healing, and social services for British soldiers. A statue to honor Seacole's contributions to the British army and empire stands today outside St. Thomas' Hospital in London.¹²

7 There is a vast body of literature on Florence Nightingale. We recommend the most recent and authoritative biography by Mark Bostridge which also grapples both with the extensive historiography and with Nightingale's social, political, and cultural impact. See *Florence Nightingale: The Woman and Her Legend* (New York: Farrar, Straus, and Giroux, 2008).

8 Florence Nightingale, *Notes on Hospitals. Being Two Papers Read Before the National Association for the Promotion of Social Science, at Liverpool, in October 1858*.

9 Florence Nightingale, *Notes on Nursing* (Harrison of Pall Mall, 1859). For an analysis of the impact of both *Notes on Hospitals* and *Notes on Nursing*, see Patricia D'Antonio, *American Nursing: A History of Knowledge, Authority and the Meaning of Work* (Baltimore: Johns Hopkins University Press, 2010) pp. 5-7.

10 Florence Nightingale, *Notes on Nursing for the Labouring Classes* (London: Harrison, 1861).

11 D'Antonio, *American Nursing*, pp. 28-53.

12 Seacole describes her service in the Crimea in her book, *Wonderful Adventures of Mrs. Seacole in Many Lands* (London: James Blackwood, 1987). See also https://en.wikipedia.org/wiki/Mary_Seacole, retrieved October 13, 2020.

This story, as we now acknowledge, obscures as much as it clarifies in other areas as well. It silences the longer history of nursing by religious orders such as Catholic nuns and Protestant deaconesses.¹³ It also renders men – with their long history of nursing not only in the military but also during disasters and pandemics – invisible.¹⁴ It is tempting to speculate about an overarching history of nursing that decenters Nightingale, gender, and class. That work has yet to start. But we have made some progress.

In the United States, Mary Elizabeth Carnegie's *The Path We Tread: Blacks in Nursing 1854-1984* sought to provide the first correction to a white nursing story in 1986. Carnegie, a pathbreaker herself as the first Black nurse to serve as a voting member of a state board of nursing, the first Black editor of the prestigious journal *Nursing Research*, and the first Black president of the American Academy of Nursing, wanted to correct two problems. First, she lamented a tradition in nursing of rendering the historical contributions of Black nurses invisible; beyond a rudimentary knowledge that Mary Mahoney held the title of America's first trained Black nurse, few white nurses and perhaps only a slightly larger number of Black nurses had any knowledge about the role Black nurses played in the history of the discipline. Her book presents carefully constructed accounts of the heretofore invisible contributions of Black nurses to the educational institutions, practice initiatives, policy legacies, and professional associations that determined the history of the discipline.¹⁵

Carnegie's second critique – that historians of Black Americans, in general, and Black women, in particular, ignored the experiences of nurses – was answered several years later with Darlene Clark Hine's *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950*. If Carnegie, revered and respected among nurses when she wrote *The Path We Tread*, would venture a lack of knowledge as a reason for the invisibility of Black nurses, Hine, an historian of Black professionals, more forthrightly labeled this same phenomenon as racism. In her analysis, enduring racism structured the American healthcare experience and the role of institutions and disciplines within it. It demanded separate hospitals, medical schools, and nursing schools (including nurse training schools at Black hospitals and collegiate nursing programs at historically Black colleges and universities). It perpetuated separate organizations and health initiatives. And it demanded a “relentless” struggle among Black nurses and their leaders in the National Association of Colored Graduate Nurses (NACGN) to constantly push for recognition, and later, integration into the white body of American nursing.

13 Sioban Nelson, *Say Little: Do Much: Nursing, Nuns and Hospitals in the Nineteenth Century* (Philadelphia: University of Pennsylvania Press, 2001); Barbra Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1965-1925* (Columbus: Ohio State University Press, 2005).

14 D'Antonio, *American Nursing*, pp. 1-27.

15 Mary Elizabeth Carnegie, *The Path We Tread: Blacks in Nursing 1854-1984* (Philadelphia: J. B. Lippincott, 1986).

Hine's story is one of "seemingly endless confrontation" as Black nurses sought access to the education, the resources, and the recognition they and their community of patients deserved.¹⁶ They found power and some successes within their segregated orbits of Black hospitals and training schools and, Hine argues, experienced a stronger sense of responsibility to the Black communities that supported them than did their white colleagues. Black nurses found a little more freedom from the structures of segregation in the northern part of the United States than they did in the Jim Crow South. But even in parts of the more progressive North, the prerogatives of whiteness took precedence over even stellar class, education, and work experiences. As D'Antonio notes, a 1931 survey of Black nurses' career opportunities in New York City, one of the more progressive of all Northern cities vis-a-vis race, revealed those opportunities to be "confined to members of their own race because of race prejudices." A venerable institution such as the Henry Street Visiting Nurse Association might pay a Black nurse the same salary as a white one, but it could only assign her to Black families; the idea of a Black woman giving orders to a white mother breached entrenched racial norms. Not surprisingly, many talented Black nurses left nursing for other opportunities.¹⁷

Historians have traced how Black Americans resisted, challenged, and, at times, achieved within the broader social and political structures of racism. Racism, as the Swedish economist Gunnar Myrdal wrote in 1944, was the central "American dilemma." His enormously influential book, *An American Dilemma: The Negro Problem and American Democracy*, prescribed initiatives that would improve the circumstances of Black Americans and/or decrease the prejudices of white Americans. Scholars have identified Myrdal's analysis as central to the eventual success of the landmark *Brown vs. Board of Education*, which led to school desegregation, affirmative action programs, and the mixed legacies of urban renewal and "wars" on poverty that addressed what we now call the social determinants of health.¹⁸

An American Dilemma, however, was written for white audiences; Black activists would have found little that was new in these recommendations. Those who were more conservative, such as Frederick Douglass, had long promoted the value of education and economic self-sufficiency. Those who were more progressive, such as W.E.B. DuBois, looked to remedy underlying social and political structures. Black Americans involved in a then-segregated healthcare enterprise hewed to a more pragmatic course. Perhaps nowhere can this be more clearly seen than in the experiences of Black nurses during wartime.

16 Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950* (Bloomington: Indiana University Press, 1989), p. ix.

17 D'Antonio, *American Nursing*, pp. 74-76.

18 Gunnar Myrdal, *An American Dilemma: The Negro Problem and Modern Democracy* (New York: Harper & Brothers, 1944).

Racism and War

In every war since America won its independence, many Black Americans held to the belief that if they demonstrated their patriotism and service – even if in a rigidly segregated military structure with their own regiments – a grateful nation would repay its debts with steps toward a more inclusive and participatory place for them within its democratic framework. Black Americans – from the Civil War through the Spanish-American War through World Wars I and II – found themselves deeply disappointed in the post-war years, as did Black nurses. During the Civil War, before the establishment of training schools, Black women with hard-won knowledge and nursing experiences found themselves relegated to positions as cooks, cleaners, and laundresses as middle-class white women used their prerogatives of race and class to assume positions of direct patient care.¹⁹ The short-lived Spanish-American War in 1898 coincided with the growth in the numbers of white trained nurses in the United States; now, the segregated nursing corps could maintain their power by discounting the valid knowledge and experiential claims of Black women as “unscientific” despite the widely held belief (later disproven) that only Black women had the necessary immunity to yellow fever, endemic in the battlefields of Cuba.²⁰ The Army Nurse Corps inducted a very small number of trained Black nurses to nurse prisoners of war and the few Black soldiers injured or sickened in the line of duty; the Army, supported by nursing leadership, claimed it did not have the resources to maintain segregated accommodations believed necessary for the maintenance of discipline and harmonious relations.²¹

Yet Black nurses never assumed the position of passive observers. By World War II they had developed an organizational infrastructure through state chapters of the NACGN, key political allies in the Black press and among Black clergy, and some influential allies among leading white politicians and public health nurses. Under the inspired, but very carefully calculated, leadership of Mabel Staupers and Estelle Massey Riddle, the NACGN laid the groundwork to finally and fully desegregate the Army Nurse Corps. As documented by Hine, they found their moment in 1944 when, in the face of an acute shortage of white military nurses, pending federal legislation proposed the drafting of white nurses. With what Hine describes as a “flawless sense of timing and political maneuvering,” Staupers focused public opinion on the systematic exclusion of thousands of well-trained Black nurses who stood willing and ready to serve. The Army Nurse Corps formally desegregated within days; the Navy Nurse Corps quickly followed.²²

19 Jane Schultz, *Women at the Front: Hospital Workers in Civil War America* (Chapel Hill: University of North Carolina Press, 2004).

20 Charles McGraw, “Every Nurse Is Not a Sister: Sex, Work, and the Invention of the Spanish-American War Nurse,” PhD dissertation, University of Connecticut, 2005, Chapter 2.

21 There is a large body of literature on nursing in World Wars I and II. For a comprehensive overview, see Mary Sarnecky, *A History of the Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999).

22 Hine, *Black Women in White*, pp. 171-186. Quote on page 181.

We know how this story ended. In 1946, the segregated boards of both the American Nurses Association (ANA) and the NACGN endorsed the principle of one integrated professional organization for all nurses. And on January 26, 1951 – with great fanfare – the NACGN formally dissolved. This was, Staupers acknowledged, a leap “of great faith.”²³ Yet the rewards of faith can be complicated. As Charissa Threat argues in *Nursing Civil Rights*, Black women’s gains in the military came at men nurses’ expense. Men nurses had been simultaneously championing their own right to serve in the military nursing corps. But in the complicated matrix of gender and race within the military establishment, gender trumped race: It was easier to imagine Black women nurses touching men’s bodies than it was men nurses doing the same.²⁴ Only in 1955 were men nurses authorized to serve in the Army Reserve Nurse Corps; only in 1966 were men authorized to serve in the regular Army Nurse Corps.

Language suffered. What did it mean to speak of “integration” as many Black nurses did? What did it mean to speak of “desegregation,” the language of many white nurses? This remains an understudied area. One might posit that the elusiveness of definitional clarity allowed a space, of sorts, where different nurses of different backgrounds with different ambitions could coalesce around a meaningful way forward. One could also argue that it created some of the seeds of profound dissatisfaction that was one of a constellation of factors that led Black nurses to re-create their own National Black Nurses Association in 1971.

And while the story of the ANA and the NACGN is important, the ANA was, in fact, a constituent association of states, not individual members. The most significant battles for desegregation took place, then, in the individual states, in general, and in the Southern states, in particular. To date, the only such historical study we have is that of Patricia D’Antonio’s of North Carolina, in large part because of the extant midcentury records of both the white North Carolina State Nurses Association (NCSNA) and the State Association of Negro Registered Nurses (SANRN). In this telling, the early post-war leadership of the NCSNA took note of two important changes: that more and more of the ANA’s leadership were actively entertaining the idea of desegregation, not just the “more liberal” members; and that Florida had just enacted a seemingly sensible plan where it simply dropped “white” from its bylaws and hoped no Black nurses would appear where they were not wanted.

23 D’Antonio, *American Nursing*, pp. 131-133. Quote on page 103.

24 Charissa Threat: *Nursing Civil Rights: Gender and Race in the Army Nurse Corps* (Chicago: University of Illinois Press, 2015).

Negotiations between the NCSNA and the SANRN lasted several years, until a mutually agreeable plan was reached. Like what little we know of other states' agreements, it presented no immediate threat to white supremacy and to the Jim Crow laws that supported it: Black nurses agreed to a higher membership fee structure than many could afford and to educational activities in desegregated venues but social ones in venues that prohibited Black patrons. Some SANRN members, D'Antonio suggests, might well have chafed at their subordination to the norms of their social, political, and disciplinary worlds. But these Black nurses had looked beyond their nursing worlds to their place in their broader communities. They did accept a compromise that their physician colleagues in North Carolina had refused. In exchange, they claimed the achievement of being "the first" among peer physicians, clergy, teachers, and social workers. The Black nurses who had claimed membership in the SANRN cheered the 1949 press release that proclaimed, "Nurses Make Historic Decision." Their neighbors in the white Georgia State Nurses Association refused desegregation until they were threatened with expulsion from the ANA in 1961 if they refused to do so.²⁵

To decenter whiteness in nursing's origin stories is also to acknowledge the systematic ways in which ways of knowing that fell outside of Western biomedical frameworks have been historically excluded from formal nursing education. For this, it is necessary to go back to the period of enslavement. It is in this period that historians have located the roots of the racialized and classed hierarchies that came to characterize first trained and then professional nursing in the U.S., and it is in this period that Black women's knowledge, skills, and experiences were devalued and the parameters of racial exclusion in nursing were first established.

²⁵ D'Antonio, *American Nursing*, pp. 131-157.

Nursing and the Era of Enslavement

In the antebellum American South, enslaved women performed the majority of nursing work on plantations. They provided nursing care to sick and injured enslaved people housed in plantation hospitals (“sick houses”). They provided healing and nursing care within enslaved communities, integrating traditional healing knowledge and practices, handed down from older community members, with Indigenous and European medical knowledge and practices. As Sharla Fett describes in *Working Cures*, “Enslaved women grew herbs, made medicines, cared for the sick, prepared the dead for burial, and attended births.”²⁶ As healers and caregivers, enslaved nurses were highly valued by and provided essential care to their families and communities.

Enslaved women also cared for the children and family members of enslavers, attending births and providing childcare, sick care, and elder care.²⁷ They “fed and washed patients, administered medicines, dressed wounds, changed beds,” doing so “in close confines with abusive slaveholders.”²⁸ Enslaved women were also required to wet-nurse (breastfeed) their enslavers’ infants, often to the detriment of their own children. As Stephanie Jones-Rogers has documented, “white mothers’ desires and demands for enslaved wet nurses transformed bondwomen’s ability to suckle into a largely invisible, yet skilled form of labor, and created a niche sector of the slave market.”²⁹ As Jones-Rogers argues, “white mothers were crucial to the commodification of enslaved women’s reproductive bodies, their breast milk, and the nutritive and maternal care they provided to white children.”³⁰ This was just one of the ways, Jones-Rogers argues in *They Were Her Property*, that “white women actively participated in the slave market, profited from it, and used it for economic and social empowerment.”³¹

The skilled health work that enslaved women performed “required experience and expertise as well as close observation and innovation,” while also being “fatiguing, repetitive, and dirty.”³² “Daily sickcare,” Fett argues, “thus represented both skilled labor and an area of ‘superexploitation’ for enslaved women.”³³ Yet enslavers devalued the nursing and doctoring work of enslaved women, ignoring or obscuring the complexity of that work, even as they depended on it. Southern whites, R.J. Knight explains, “often characterized enslaved women as superstitious, uninformed, and injurious.”³⁴ This echoed language that white physicians, public health officials, and nurses would again leverage in the early 20th century to denigrate the skilled and essential care of Black midwives, a point to which we will return.

26 Sharla M. Fett, *Working Cures: Healing, Health, and Power on Southern Slave Plantations* (Chapel Hill: University of North Carolina Press, 2002), p. 5.

27 Fett, *Working Cures*, pp. 111-141; R. J. Knight, “African Americans, Slavery, and Nursing in the US South,” *Nursing Clio*, January 7, 2021, <https://nursingclio.org/2021/01/07/african-americans-slavery-and-nursing-in-the-us-south/#post-27607-footnote-ref-9>, retrieved December 13, 2021; on enslaved wet nurses, see Stephanie E. Jones-Rogers, “[S]he could ... spare one ample breast for the profit of her owner: white mothers and enslaved wet nurses’ invisible labor in American slave markets,” *Slavery and Abolition* (2017) 38(2): 337-355, and Emily West with R. J. Knight, “Mothers’ Milk: Slavery, Wet-Nursing, and Black and White Women in the Antebellum South,” *Journal of Southern History* (2017) LXXII (1): 37-68.

28 Knight, “African Americans, Slavery, and Nursing.”

29 Jones-Rogers, “[S]he could ... spare one ample breast for the profit of her owner.”

30 Jones-Rogers, “[S]he could ... spare one ample breast for the profit of her owner.”

31 Stephanie E. Jones-Rogers, *They Were Her Property: White Women as Slave Owners in the American South* (New Haven: Yale University Press, 2019). Quotation from book’s summary: <https://yalebooks.yale.edu/book/9780300251838/they-were-her-property/>. Retrieved December 13, 2021.

32 Fett, *Working Cures*, p. 112.

33 Fett, *Working Cures*, p. 112.

34 Knight, “African Americans, Slavery, and Nursing.”

In *Medical Bondage*, Deirdre Cooper Owens powerfully underscores the contradictions that characterized 19th century racial science and the violence it wrought.³⁵ As Cooper Owens details, enslaved women also served as surgical assistants and nurses for physicians such as J. Marion Sims, who performed brutal experimental surgeries on enslaved women. But even as white physicians assumed that enslaved women were intellectually inferior, using their perceived intellectual and biological differences as justification for their enslavement and for the violence enacted upon them in the name of medical experimentation, they nevertheless relied on enslaved women to work as nurses and surgical assistants – work which required high levels of skill and in which intelligence and judgment were valued. Collectively, this scholarship on the nursing work of enslaved women highlights, as R.J. Knight recently summed up, that the work of enslaved nurses “encompassed exploitation and power as much as intimacy and care, forced labor as well as free, and has served both communities and regimes.”³⁶

The contradictions that characterized enslaved women’s care work had implications for the development of trained nursing after emancipation and the Civil War. In the late 19th century, as Charles McGraw has argued, “wage-earning nurses, irrespective of race or training, contended with the occupation’s deep roots in Black women’s domestic labor under slavery.” And it was a strategy by white nurses “to erect a racial barrier between skilled nursing practice and general domestic labor, with Black women relegated to the latter.”³⁷ So too, Black medical leaders worked to sever the link between nursing and domestic servitude, establishing their own barriers in which the experience and expertise of nurses who had worked for years were dismissed in favor of training young women with no prior experience. As both Darlene Clark Hine and McGraw have detailed, prominent Black physician Daniel Hale Williams, who founded both the Provident Hospital and Nurse Training School in Chicago in 1891 and Freedmen’s Hospital Nurse Training School in Washington, D.C., in 1894, “sought to sever nursing ... from the taint of slavery and working-class servitude.”³⁸ He did so by “castigat[ing] the legacy of Black women’s health work,”³⁹ even as he used that legacy to simultaneously extoll “Black women as natural nurturers.”⁴⁰ When Williams arrived at Freedmen’s Hospital in Washington, D.C., he disbanded the Howard University Medical Department Training School, which had admitted not only young student nurses but also “all working-class nurses employed at Freedmen’s Hospital as well as other ‘old women nurses’ who sought technical certification.” The new Freedmen’s Hospital nursing school would admit only young student nurses, while “experienced practitioners who continued to draw on the rich traditions of enslaved healers found no place in his narrative or his training school.”⁴¹

35 Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2017).

36 Knight, “African Americans, Slavery, and Nursing.”

37 McGraw, “Every Nurse Is Not a Sister,” p. 96.

38 McGraw, “Every Nurse Is Not a Sister,” p. 128.

39 McGraw, “Every Nurse Is Not a Sister,” p. 128.

40 Hine, *Black Women in White*, p. 12.

41 McGraw, “Every Nurse Is Not a Sister,” p. 128.

These moments signaled the transformation in what counted as legitimate knowledge and the basis for claims to expertise in nursing – a transformation that was infused with meanings of race and class. No longer would experience and experiential knowledge serve as the basis for claims to legitimacy and expertise in nursing; instead, legitimate knowledge and claims to expertise were to be based on “proper character” and the acquisition and utilization of biomedical knowledge instilled through nursing education.

Similar contradictions and racialized exclusions were operative in the early 20th century campaign, led by physicians, public health officials, and public health nurses, to eliminate traditional or lay midwives. As historians of midwifery have detailed, through the late 19th century, the majority of childbirths were attended by midwives, many of whom were Black, Indigenous, or immigrant women. Most midwives, including enslaved women, drew upon traditional healing knowledge and practices passed down through generations to provide birthing care within their communities. Other midwives learned their practice through apprenticeship either to local physicians or experienced midwives in their community. In the early 20th century, however, as childbirth became medicalized, physicians emerged as the primary birth attendants and childbirth moved from the home to the hospital. In the early 1900s, midwives delivered approximately 50% of all births in the U.S. By 1930, however, the number of midwife-attended births in the U.S. had decreased to 15%.⁴²

These early decades of the 20th century also witnessed high rates of maternal and infant mortality. Obstetricians and public health and social welfare reformers blamed the high mortality rates on midwives, despite convincing evidence from several research studies that midwife-attended births accounted for fewer maternal deaths than those attended by general practitioners, who were typically poorly trained in obstetrical techniques. Public health nurses joined obstetricians in a campaign to eliminate traditional midwives, calling Black, Indigenous, and immigrant midwives incompetent, unsanitary, and dangerous. As part of the broader reform effort to reduce infant and maternal mortality rates, Congress passed the Sheppard-Towner Act of 1921. One of the provisions of this act provided federal funding to states to establish midwifery training and licensure. This regulatory initiative targeted Black midwives in the South, who represented the largest group of unregulated birth attendants. State health departments established midwifery classes taught by public health nurses, many of whom had far less experience attending births than the midwives they were training. To be licensed, midwives were required to attend this training and submit to supervision by public health nurses.⁴³

⁴² See, for example, Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920* (Cambridge: Harvard University Press, 1995); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York: Oxford University Press, 1986).

⁴³ Leavitt, *Brought to Bed*; Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana: University of Illinois Press, 1994); Jenny M. Luke, *Delivered by Midwives: African American Midwifery in the Twentieth-Century South* (Jackson: University Press of Mississippi, 2018).

And yet, even as states engaged in the “racialized marginalization” of midwives, they nevertheless remained dependent on their skilled labor given the dearth of physicians and public health nurses, particularly in rural and other underserved areas. In this way, state health departments sought at once to restrict and regulate and to appropriate the knowledge and practice of midwives.⁴⁴ Even as government-funded research in the 1930s continued to document the better birth outcomes achieved by midwives compared to physicians, reformers continued to blame Black, Indigenous, and immigrant midwives for the country’s high maternal and infant mortality rates. Throughout the segregated South, however, Black midwives continued to provide essential care to Black families, especially in rural communities that lacked access to physicians or public health nurses.

Since the 1990s, a body of literature on the history of Black midwives, centered on the narratives and experiences of the midwives themselves, has been produced. This includes Gertrude Fraser’s *African American Midwifery in the South*, Jenny Luke’s *Delivered by Midwives*, and a handful of biographies by Black midwives, including Margaret Charles Smith’s *Listen to Me Good*, which was written in collaboration with Linda Janet Holmes; Onnie Lee Logan’s *Motherwit*; and Claudine Curry Smith and Mildred H.B. Roberson’s *My Bag Was Always Packed*.⁴⁵ Collectively, these works emphasize the skill, knowledge, and expertise that characterized the work of Black lay midwives, and the vital role they “played in the reproductive experiences of southern women, both Black and white.”⁴⁶ Fraser’s work also reveals the contradictions and ambivalences that characterized the place of the Black lay midwife in rural Virginia, and, more broadly, the South throughout the 20th century, reflecting both the praise and denigration given their work. Other scholars who have examined the emergence of nurse-midwifery in the mid-20th century have made clear this history’s imbrication with the decline of Black lay midwives.⁴⁷ At the same time that public health officials, physicians, and nurses sought to regulate and restrict the practice of midwives, public health nurses recognized that professional midwives in Britain and Europe contributed to low maternal and infant mortality rates in those countries. They thus worked to establish nurse-midwifery as a new nursing specialty in which nurses (the overwhelmingly majority of whom were white women) would be trained in both nursing and the practice of midwifery. The first nurse-midwifery training programs were established in the mid-1920s and

44 Lena McQuade-Salzfass, “An Indispensable Service: Midwives and Medical Officials after New Mexico Statehood,” in Laurie B. Green, John McKiernan-González, and Martin Summers (eds.), *Precarious Prescriptions: Contested Histories of Race and Health in North America* (Minneapolis: University of Minnesota Press, 2014), pp. 115-141, quotation from p. 128.

45 Gertrude J. Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge: Harvard University Press, 1998); Luke, *Delivered by Midwives*; Margaret Charles Smith and Linda Janet Holmes, *Listen to Me Good: The Story of an Alabama Midwife* (Columbus: Ohio State University Press, 1996); Onnie Lee Logan as told to Katherine Clark, *Motherwit: An Alabama Midwife’s Story* (New York: E.P. Dutton, 1989); Claudine Curry and Mildred H. B. Roberson, *My Bag Was Always Packed: The Life and Times of a Virginia Midwife* (Bloomington: 1st Books, 2003).

46 Fraser, *African American Midwifery in the South*, p. 1.

47 See, for example, P. Mimi Niles and Michelle Drew, “Constructing the Modern American Midwife: White Supremacy and White Feminism Collide.” *Nursing Clin*, October 22, 2010, <https://nursingclio.org/2020/10/22/constructing-the-modern-american-midwife-white-supremacy-and-white-feminism-collide/>. Retrieved December 13, 2021.

early 1930s, and their growth continued over the ensuing decades. Some of these programs, such as the Frontier Nursing Service, explicitly excluded Black nurses, while other programs heavily restricted access to Black nurses and other nurses of color.⁴⁸ Ultimately, the increased regulation of traditional midwives by state health departments and the emergence and increasing role of nurse-midwives in the mid-20th century contributed to the demise of traditional Black, Indigenous, and immigrant midwives.

The contradictions that characterized enslaved women's nursing work not only influenced the development of trained nursing and the campaign against lay midwives, but also continue to influence 21st century characterizations of nursing and care work. As Fett argues, the "Contradictions between skill and servitude in slave women's sick care reveal similarities across time and space among societies that relegate hands-on care of the sick to subordinate groups of women ... classifying hands-on care of the sick or elderly as 'menial' tends to obscure the complex nature of the work performed."⁴⁹ In short, the ongoing marginalization and devaluing of the hands-on body work of nursing care in the 21st century is deeply rooted in the era of enslavement.⁵⁰

The era of enslavement was also a time when physicians and scientists, many of them enslavers, constructed a racial science premised on the belief that women and men of African descent, as well as Indigenous people, were biologically and medically different from white people. As Dorothy Roberts has detailed, 18th century European "biologists were preoccupied with classifying all earthly creations, whether plants, insects, or animals, into a natural hierarchy. Their chief scientific method was taxonomy: observing, naming, and ordering the world by partitioning living things into biologically different types. Applying this method to human bodies, naturalists made race an object of scientific study and made European conquest and enslavement of foreign peoples seem in line with nature."⁵¹ Not solely a European exercise, however, as Rana Hogarth has documented in *Medicalizing Blackness*, "many physicians who worked and settled in the Greater Caribbean," beginning in the 18th century, "took to trying to make sense of the apparent differences

48 On the history of certified nurse-midwifery, see Katy Dawley, "Origins of Nurse-Midwifery in the United States and its Expansion in the 1940s." *Journal of Midwifery and Women's Health* (2003) 48(2): 86-95; Arlene Keeling, *Nursing and the Privilege of Prescription, 1893-2000* (Columbus: Ohio State University Press, 2007), pp. 49-71

49 Fett, *Working Cures*, pp. 112-113. And on the history of nurse-midwifery and the resurgence of lay midwives after World War II, see Wendy Kline, *Coming Home: How Midwives Changed Birth* (New York: Oxford University Press, 2019).

50 Janette Dill, Odichinma Akosionu, J'Mag Karbeah, Carrie Henning-Smith, "Addressing Systemic Racial Inequity in the Health Care Workforce." *Health Affairs Blog*, September 10, 2020.

51 Dorothy Roberts, *Fatal Invention: How Science, Politics, and Big Business Re-Created Race in the Twenty-First Century* (New York: The New Press, 2011), p. 28.

they observed between Black and white people's bodies during times of sickness. Their efforts helped to sanction the objectification, exclusion, and subjugation of Black people for generations to come." This objectification also, Hogarth argues, "became an essential component to the development of the medical profession in the Americas."⁵² And in the 1840s and 1850s, leading American physicians, naturalists, and ethnologists were engaged in a project to "classify and rank groups on the basis of innate physiological and temperamental differences." They did so through the development of taxonomies based on the measurement of skulls and the characterization of facial features (physiognomy), and through theorizing about human origins. These taxonomies "predictably reinforced the idea of Black inferiority and the immutability of racial types."⁵³ The creation and maintenance of racialized hierarchies were used to justify the institution of slavery. They also underwrote – and were fundamental features of – European and American colonialism and imperialism. To see the employment of racial hierarchies and their genocidal implications, we need to look no further than Nightingale's own writings about and involvement in the British imperial project.⁵⁴ So too, however, they are manifest in nursing's role in American imperialism, including colonialism as it was exercised in Cuba, Puerto Rico, the Philippines, and Hawaii; American imperialist projects in post-World War I eastern and central Europe and Asia; and the settler colonialism that has always characterized and continues to characterize the United States' relationship to Native nations.

52 Rana A. Hogarth, *Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780-1840* (Chapel Hill: University of North Carolina Press, 2017), pp. 1-2.

53 Martin Summers, "Suitable care of the African American when afflicted with insanity." *Bulletin of the History of Medicine* (2010) 84(1): 58-91, quotation from p. 67.

54 Natalie Stake-Doucet, "The racist lady with the lamp," *Nursing Clio*, November 5, 2020, <https://nursingclio.org/2020/11/05/the-racist-lady-with-the-lamp/>. Retrieved November 8, 2021.

Nursing and Colonialism in the Indigenous United States

The United States is a settler colonial society. Settler colonialism is the process by which a nation “strives for the dissolution of native societies” and “erects a new colonial society on the expropriated land base.”⁵⁵ As the anthropologist Patrick Wolfe argues, settler colonialism employs a “logic of elimination” that “destroys to replace,” the “primary motive” for which is “access to territory.” As Wolfe puts it, “settler colonizers come to stay: invasion is a structure not an event.”⁵⁶ The federal government’s relationship with Native nations has been and continues to be a settler colonial one.⁵⁷

Historians have documented the deep entanglement of medicine in settler colonial projects. As Maureen Lux explains in *Separate Beds*, “According to non-Native observers, the susceptibility of Aboriginal bodies to diseases associated with contact showed that they were unable to survive independently in the changing conditions of European global expansion. In such a view, Aboriginal populations around the world consistently showed themselves, through their bodies, to need and deserve colonization. That it was through colonization and the associated dual mechanisms of ‘civilization’ and medicine that these Indigenous populations could ultimately be saved. Both the diseases and their cures justified colonization in a perfectly circular logic.”⁵⁸ Following this logic, missionaries, physicians, and other settler agents used medical practices to surveil, categorize, and eradicate Indigenous bodies in pursuit of Indigenous territories.⁵⁹ Settler agents and the policies and practices they implemented also worked to eliminate Indigenous healing practices and to disparage and even criminalize Indigenous healers. In *Colonizing Bodies*, for example, Mary-Ellen Kelm documents the ways in which Indigenous bodies were materially affected by settler colonial policies in Canada during the 20th century. These included policies that “placed restrictions on fishing and hunting, allocated inadequate reserves, forced children into unhealthy residential schools, and criminalized Indigenous healing.” In doing so, Kelm demonstrates the ways in which settler colonial processes sought to “pathologize” Indigenous bodies and “institute a regime of doctors, hospitals, and field matrons, all working to encourage assimilation.” These settler colonial processes, as Kelm makes clear, created Indigenous ill-health.⁶⁰

55 Patrick Wolfe, “Settler Colonialism and the Elimination of the Native.” *Journal of Genocide Research* 8, no. 4 (2006): 387-409, quotation from p. 388.

56 Wolfe, “Settler Colonialism and the Elimination of the Native,” p. 388.

57 For a comprehensive history of the Indigenous United States, see Roxanne Dunbar-Ortiz, *An Indigenous Peoples' History of the United States* (Boston: Beacon Press, 2015).

58 Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920-1980s* (Toronto: University of Toronto Press, 2016), p. 197.

59 Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (Vancouver: University of British Columbia Press, 1999); Warwick Anderson, *The Cultivation of Whiteness: Science, Health, and Racial Destiny in Australia* (Durham: Duke University Press, 2006); Seth Archer, *Sharks Upon the Land: Colonialism, Indigenous Health, and Culture in Hawai'i, 1778-1855* (New York: Cambridge University Press, 2018).

60 Kelm, *Colonizing Bodies*. Quotation from book’s summary, <https://www.ubcpress.ca/colonizing-bodies>. Retrieved December 13, 2021.

There is a particularly robust body of scholarship on the historiography of medicine, settler colonialism, and Indigenous health in First Nations. In a valuable survey of this literature, Mary Jane Logan McCallum highlighted four key arguments stemming from this body of scholarship: “first, that Indigenous people are not ‘naturally unhealthy’ or ‘susceptible’ to disease; second, that ill health is not just a matter of germs but also of colonial policies and practices of the Canadian government; third, that Canadian medicine served colonialist agendas that included at different times the elimination, coercion, and assimilation of Indigenous people; and, last, that Indigenous medicine was never fully replaced by an allopathic bio-medical model.”⁶¹ While McCallum, and the scholarship she engages, is focused on the settler colonial policies and practices of the Canadian government, these same arguments are equally important to the history of settler colonialism and Indigenous health in the U.S. There are relatively few contextualized historical studies, however, that examine the intersections of medicine and settler colonialism in the Indigenous United States, and fewer still that focus on the role of nursing in the settler colonial project.⁶²

Before discussing this scholarship, we provide some very brief background on U.S. colonial policies and practices as they relate to Indigenous health. Throughout the 19th century, Indigenous health systems coexisted with Western medicine within many Native American communities. Native American women and men played important roles as healers. Women, for example, often possessed healing expertise related to plant-based medicine, and also provided vital care within their communities as midwives. When the federal government established the Bureau of Indian Affairs (BIA) in 1824, it tasked Protestant missionaries with responsibility for American Indian healthcare.⁶³ While the federal government “could claim to be fulfilling its treaty promises of healthcare for American Indians,” for missionaries, medicine was an important evangelizing tool, a means by which they hoped to convert American Indians to Christianity.⁶⁴ As part of this, missionaries and physicians sought to dissuade Native Americans from using Indigenous healing practices and to instead convince them to accept Western medical practices. As several historians have demonstrated, however, many Native American communities pursued a pluralist approach to healthcare, making use of Western medicine to treat some bodily ills, while continuing to rely on Indigenous healers and healing practices for many of their other health needs.⁶⁵

61 Mary Jane Logan McCallum, “Starvation, Experimentation, Segregation, and Trauma: Words for Reading Indigenous Health History,” *Canadian Historical Review* (2017) 98(1): 96-113, quotation from p. 100.

62 See David S. Jones, *Rationalizing Epidemics: Meanings and Uses of American Indian Mortality since 1600* (Cambridge: Harvard University Press, 2004); David H. DeJong, *If You Knew the Conditions: A Chronicle of the Indian Medical Service and American Indian Health Care, 1908-1955* (Lanham: Lexington Books, 2008); Brianna Theobald, *Reproduction on the Reservation: Pregnancy, Childbirth, and Colonialism in the Long Twentieth Century* (Chapel Hill: University of North Carolina Press, 2019); Paul Kelton, *Cherokee Medicine, Colonial Germs: An Indigenous Nation's Fight Against Smallpox, 1578-1824* (Norman: University of Oklahoma Press, 2015); Robert Trennert, *White Man's Medicine: Government Doctors and the Navajo, 1863-1955* (Albuquerque: University of New Mexico Press, 1998).

63 Initially, the BIA was established within the War Department, but in 1849 it was transferred to the newly created U.S. Department of the Interior. From that time through the mid-20th century, the name of the BIA changed several times. For the sake of simplicity, we will use BIA throughout this document, recognizing that this was not always the name it was known by.

64 Christin L. Hancock, “Health Vocations: Field Nursing and the Religious Overtones of Public Health,” *Journal of Women's History* (2011) 23(3): 113-137, quotation from pp. 115-116.

65 Trennert, *White Man's Medicine*; Wade Davies, *Healing Ways: Navajo Health Care in the Twentieth Century* (Albuquerque: University of New Mexico Press, 2001); Kelton, *Cherokee Medicine, Colonial Germs*; Margaret J. Flood, “Simple Medicines: Land, Power, and Health in the Nineteenth Century Ojibwe Western Great Lakes.” PhD dissertation, University of Minnesota, 2021.

In the late 19th century, the rapidly deteriorating health of Native Americans prompted the BIA to establish the field matron program. Established in 1890, the field matron program was intended to bring to Native American “women and their domestic world the benefits of modernity and Anglo-American culture.”⁶⁶ Initially the field matron’s primary role was to ‘civilize’ Indian women through white domesticity.⁶⁷ As Lisa Emmerich has described, field matrons offered to Native American women cooking classes, religious services, and child care seminars not only to provide “practical help in adapting to ... reservation life,” but also “to emphasize the superiority of Anglo-American models of femininity, wifehood, and motherhood.”⁶⁸ As American Indian health continued to deteriorate in the early 20th century, the BIA expanded the responsibilities of field matrons to include rudimentary healthcare, supplying them with basic medical supplies but not formal training.⁶⁹ The expansion of the field matron’s responsibilities, however, did little to stem the ongoing deterioration of American Indian health. This was at a time when tuberculosis had replaced smallpox as the largest health threat to American Indians, and trachoma, a highly infectious eye disease that caused severe pain and eventual blindness, was also pervasive. Malnutrition facilitated the spread of disease. In the 1920s, amid growing criticisms of the Indian Service, the secretary of the interior launched an investigation of the administration of Indian Affairs. Lewis Meriam led the team that gathered data on almost 100 Indian reservations. The resulting Meriam Report was especially critical of the Indian Medical Service, citing, in particular, the Indian Medical Service’s failure to adequately combat tuberculosis and trachoma, and the abysmal and deteriorating state of Indian health on many reservations. In response, and heeding the recommendation of the Meriam Report, the BIA began the process of creating a more professional health program, the centerpiece of which was public health nursing.⁷⁰

Much of the historical scholarship on nursing, colonialism, and Indigenous health in the U.S. has focused on the role of public health nurses who worked under the auspices of the BIA field nursing program in the 1930s. These field nurses, the overwhelming majority of whom were white, middle class, and born in the U.S., sought to “inculcate Euro-American attitudes and values” as they provided much-needed health services on American Indian reservations.⁷¹ The field nurses pursued an assimilationist strategy that sought to eliminate Indigenous beliefs and healing practices and replace them with allopathic medical care premised on the biomedical model.

66 Lisa E. Emmerich, “Right in the Midst of My Own People: Native American Women and the Field Matron Program.” *American Indian Quarterly* (1991) 15 (2): 201-216.

67 Hancock, “Healthy Vocations,” p. 116.

68 Emmerich, “Right in the Midst of My Own People.”

69 Hancock, “Healthy Vocations.” pp. 115-116.

70 Theobald, *Reproduction on the Reservation*, p. 71, and Hancock, “Healthy Vocations,” p. 116.

71 Emily K. Abel and Nancy Reifel, “Interactions Between Public Health Nurses and Clients on American Indian Reservations during the 1930s.” *Social History of Medicine* (1996) 9(1): 89-108, quotation from p. 93.

In the late 1990s, historian Emily Abel and public health scholar Nancy Reifel published a series of articles that examined the history of the BIA field nursing program from the perspective of the field nurses and their Native American clients.⁷² In their co-authored article, Abel and Reifel examined the interaction between BIA field nurses and their clients on two Sioux reservations in South Dakota during the 1930s. Their analysis drew upon “the accounts of the nurses, including letters, memoirs, and above all their monthly and annual reports” to the BIA, as well as 23 oral history interviews conducted by Abel and Reifel with elderly residents of the reservations in the early 1990s who were able to recall their experiences with the field nurses.⁷³ Abel and Reifel found that field nurses – like their colleagues in medicine and public health – frequently described their Indigenous clients as “‘ignorant,’ ‘primitive,’ ‘prejudiced,’ and ‘superstitious.’ Most nurses insisted that American Indians were capable of reason but had to be taught how to exercise it ... the nurses denied the possibility that American Indians could be active participants in the construction of meaning and knowledge.” Indeed, field nurses dismissed the value of Indigenous ways of knowing and healing. Further, the field nurses assumed that “American Indians would follow a linear progression from understanding the rules of health to the eradication of all traditional practices.”⁷⁴ The field nurses provided a range of health services that included “screening for such conditions as trachoma, tuberculosis, and sexually transmitted diseases, providing immunization, delivering home care, and placing clients in institutions for sickness [particularly, tuberculosis] and childbirth. Most nurses insisted, however, that education was their primary focus.”⁷⁵ Health education was the vehicle by which the field nurses sought to conform Native Americans “to Euro-American standards of ‘right living’ to promote health.”⁷⁶ This included concepts of cleanliness, personal habits and hygiene, diet, parenting, and sexual relationships. Nevertheless, Abel and Reifel argue, Native American clients asserted their own agency in their interactions with field nurses: “Sioux people viewed the nurses as resources to be used strategically and selectively. Those who accepted nurses’ services did so because the services addressed specific needs the clients themselves defined as important. Most disregarded the health education program insofar as it assumed the superiority of Euro-American values.”⁷⁷

Other scholars have gone on to provide further analysis of the BIA field nursing program. Christin Hancock has drawn connections between the field nursing program and “the same assimilation-style health practices begun generations earlier by missionaries and field matrons.”⁷⁸ Hancock sees the persistence of a proselyting mission in the work of the field

72 Emily K. Abel, “We Are Left So Much Alone to Work Out Our Own Problems: Nurses on American Indian Reservations During the 1930s.” *Nursing History Review* (1996) 4: 43-64; Abel and Reifel, “Interactions Between Public Health Nurses and Clients”; Nancy Reifel, “American Indian views of public health nursing, 1930-1950.” *American Indian Culture and Research Journal* (1999) 23(3): 143-154.

73 Abel and Reifel, “Interactions Between Public Health Nurses and Clients,” p. 89.

74 Abel and Reifel, “Interactions Between Public Health Nurses and Clients,” p. 94.

75 Abel and Reifel, “Interactions Between Public Health Nurses and Clients,” p. 96.

76 Abel and Reifel, “Interactions Between Public Health Nurses and Clients,” p. 96.

77 Abel and Reifel, “Interactions Between Public Health Nurses and Clients,” p. 90.

78 Hancock, “Health Vocations,” p. 113.

nurses, whose program of health education centered on “the gospel of health” and the “counsel of ‘right living.’”⁷⁹ Hancock also makes clear the harm and ill-health perpetuated by the “racial, cultural, and religious prejudices” of the field nurses, as well as the biomedical framework that shaped their approach to illness, health, and health education, all of which “contributed to the prioritization of individual causes of sickness and disease over socioeconomic ones.”⁸⁰ During home visits, in particular, field nurses “underscored the importance of individual health and hygiene, largely holding women accountable for tribal health.”⁸¹ Field nurses “viewed Indian homes as health hazards that were in perpetual need of public health education.” In these visits – and at the core of their health education work – field nurses emphasized the importance of “personal hygiene, sanitation, diet, and pre-natal and infant care.” But in “targeting Indian women, field nurses emphasized individual hygiene rather than social or environmental causes of illness.” In this way, field nurses held American Indian women – rather than the structural impacts of colonialism and racism – “personally responsible for the health and wellness of their families.”⁸²

Hancock’s analysis, like that of Abel and Reifel, builds upon primary sources that center both non-Native and Native voices. Hancock uses the writings of the white field nurses, together with oral histories of Native women that are part of the Doris Duke American Indian oral history project conducted in the 1960s and 1970s. It is in the responses of Native American women to field nurses that Hancock elaborates on the agency and power of Native American women in these encounters. As Hancock notes, though “their responses to field nurses varied, American Indian women regularly negotiated the presence of western health care.” Echoing the earlier work of Abel and Reifel, Hancock highlights the agency that Native American women maintained in their encounters with field nurses, accepting services that were useful to them and rejecting that which “they deemed unnecessary or even offensive.”⁸³ For example, even when Native American women used some of the medical care provided by field nurses, “they typically maintained their own health regiments [sic] as well, in the process of preserving cultural power unavailable to western medical providers.” This included their reliance on handmade herbal remedies; American Indian “women historically maintained responsibility for gathering, preparing, and administering herbs.”⁸⁴ And while Native American women selectively accepted the services of field nurses, Hancock asserts, field nurses also “frequently became students of Native women,” learning about Indigenous beliefs and practices.⁸⁵ As Hancock explains, the home visits “allowed field nurses into the intimate spaces of Indian women’s lives” while also providing “the backdrop for education in Native customs. Some field nurses found themselves and their rigid ideas on Western medicine transformed by the experience.”⁸⁶

79 Hancock, “Health Vocations,” p. 114.

80 Hancock, “Health Vocations,” p. 115.

81 Hancock, “Health Vocations,” p. 119.

82 Hancock, “Health Vocations,” pp. 120-121.

83 Hancock, “Health Vocations,” p. 122.

84 Hancock, “Health Vocations,” p. 124.

85 Hancock, “Health Vocations,” p. 122.

86 Hancock, “Health Vocations,” p. 125.

As Hancock's work and other scholarship on the BIA field nursing program make clear, "While field nurses brought some important medical services to American Indians on reservations ... they were also white women expected to instill in American Indian women a hunger for middle-class Anglo-American expectations of personal hygiene and domestic cleanliness." And in doing so, "field nurses defined health and healthful living in ways that often conflicted with tribal customs, emphasizing individual responsibility over socioeconomic causes of illness. Although providing some relief to impoverished reservation communities, field nurses performed their work within a long established colonial context." So too, the "heavy emphasis on personal hygiene targeted Indian women, making them largely responsible for the poor health and disease that affected entire reservations." Doing so "obscured the reality of the socioeconomic conditions on reservations" and diverted attention – and accountability – from the impact of colonial practices and policies on Indigenous ill-health.⁸⁷ Ultimately, Hancock concludes, "field nurses, and their public health agenda, relying as it did on an ideology that presumed western medical authority, contributed, even unwittingly, to the ongoing hegemonic colonization of Native North Americans."⁸⁸

Nevertheless, as Native studies scholars and historians have demonstrated, Native American communities continued to assert agency over their individual, community, and tribal health, and in many communities, Indigenous health practices and healers persisted. For example, in *My Grandfather's Knocking Sticks*, Brenda Child highlights the centrality of Ojibwe women's labor and healing practices to life on Ojibwe reservations in Minnesota during the early 20th century. Child writes that even as government physicians trivialized the medical expertise of Ojibwe women, women persisted in their healing work. While physicians blamed American Indian families – women, in particular – "for the dismal state of health in Indian communities," disparaging the Ojibwe method of health and wellness and asserting Western ideas and approaches to health and disease, Ojibwe people were "relentlessly pragmatic." As Child explains, on the Red Lake reservation in northern Minnesota, Ojibwe people "accepted western medicine, adding it to their long-standing repertoire of Indigenous healing." The government physician for the reservation "misinterpreted the willingness of Ojibwe people to visit the doctor as a sign of cultural submission," when it was anything but.⁸⁹ As Child describes, "In Ojibwe Country," there remained "a dynamic network of women who specialized in plants and their healing properties."⁹⁰ Ojibwe women participated in considerable labor and utilized healing expertise, working with plants and medicines, to provide care to their families and other community members. Brianna Theobald has similarly described Crow men and women in the early 20th century selectively using the medical services provided by the federal government while also utilizing Crow healing systems. As Theobald explains, while many Crow men and

87 Hancock, "Health Vocations," p. 128.

88 Hancock, "Health Vocations," p. 128.

89 Brenda J. Child, *My Grandfather's Knocking Sticks: Ojibwe Family Life and Labor on the Reservation* (St. Paul: Minnesota Historical Society Press, 2014), p. 138.

90 Child, *My Grandfather's Knocking Sticks*, p. 144.

women “had grown accustomed to using the Crow reservation hospital for at least some purposes,” much to the chagrin of government employees, “an individual’s use of the hospital did not signify repudiation of Crow healers. Crows accepted western medicine selectively and generally did not view the two healing systems as mutually exclusive.”⁹¹

A handful of scholars have centered on the experiences of Native American nurses, detailing the motivations of Native women to pursue nursing careers, the barriers and discrimination they experienced as they did so, and the vital contributions of Native American nurses to Indigenous health and healing. In *African American and Cherokee Nurses in Appalachia*, Phoebe Pollitt documents the experiences of several Eastern Band of Cherokee Indian women who trained as registered nurses and practiced in the Qualla Boundary in Appalachia during the early and mid-20th century.⁹² In 2016, Barbara Charbonneau-Dahlen and Karine Crow provided “A Brief Overview of the History of American Indian Nurses.”⁹³ Their article summarizes both the discrimination experienced by Native American nurses and the important contributions made by individual Native American nurses during the 20th century. For example, Charbonneau-Dahlen and Crow summarize the barriers – as well as opportunities – encountered by Native American women seeking to pursue careers in nursing. Congress’ passage of the Indian Child Removal Act in 1880 mandated that all Native American children attend boarding schools in an assimilationist strategy to eliminate Indigenous beliefs, customs, and practices and inculcate in students Euro-American beliefs and values. The BIA instituted a standardized – and gendered – curriculum across all American Indian boarding schools, which combined academics with vocational training.⁹⁴ For girls, this meant various forms of domestic labor and, potentially, some rudimentary nurse training.⁹⁵ Among the many harms the boarding schools caused to children, one was that they exposed children to infectious diseases. The schools were often overcrowded and poorly maintained, with inadequate sanitation, and children were malnourished, all of which contributed to the spread of infectious diseases, particularly tuberculosis and trachoma. Given the high rates of illness in these schools, Charbonneau-Dahlen and Crow explain, boarding school infirmaries and hospitals “functioned as a pre-nursing training facility for American Indian female students while in high school.” The training experience gave these Native American students hands-on experience providing basic care to their fellow sick students and also prepared them to enter nursing schools after graduating from high school.⁹⁶ In *My Grandfather’s Knocking Sticks*, Child writes about the experiences of Lutiana LaVoye, an Ojibwe woman from the Great Lakes area. At 19 years old, LaVoye, a recent graduate of the Haskell Indian Boarding School in Lawrence, Kansas, worked as a “volunteer nurse” in military hospitals in the

91 Brianna Theobald, “Nurse, Mother, Midwife: Susie Walking Bear Yellowtail and the Struggle for Crow Women’s Reproductive Autonomy.” *Montana Historical Society* (2016) 66(3): 17-35, quotation from p. 20.

92 Phoebe Pollitt, *African American and Cherokee Nurses in Appalachia: A History, 1900-1965* (Jefferson, North Carolina: McFarland & Company, 2016), pp. 92-110.

93 Barbara Charbonneau-Dahlen and Karine Crow, “A Brief Overview of the History of American Indian Nurses.” *Journal of Cultural Diversity* (2016) 23(3): 79-90.

94 Charbonneau-Dahlen and Crow, “Overview,” 2016, p. 80. On the history of boarding schools, see for example, Brenda J. Child, *Boarding School Seasons: American Indian Families, 1900-1940* (Lincoln: University of Nebraska Press, 1998); and Margaret Jacobs, *White Mother to a Darker Race: Settler Colonialism Maternalism, and the Removal of Indigenous Children in the American West and Australia, 1880-1940* (Lincoln: University of Nebraska Press, 2009).

95 Theobald, “Nurse, Mother, Midwife,” p. 21.

96 Charbonneau-Dahlen and Crow, “Overview,” p. 80.

Washington, D.C., area during the influenza epidemic of 1918. LaVoye likely received rudimentary nurse training at the boarding school.⁹⁷

Native American women who sought to enter nursing schools in the late 19th and early 20th centuries encountered discrimination. They were barred from many of the first nursing schools, and Charbonneau-Dahlen and Crow note that the first Native American students graduated from nursing schools in the late 1880s. When the Hampton Training School for Nurses was established at the Hampton Institute in 1891 as a Black nurse training program, the school also admitted Native American students.⁹⁸ Their article includes a list of the Native American women who attended the Hampton Institute between 1879 and 1924, drawing upon data originally compiled by Jon Brudvig.⁹⁹ In 1930, Clarence Salsibury, MD, a Presbyterian missionary, established the first accredited American Indian school of nursing, on the Navajo reservation in Ganado, Arizona, in 1930.¹⁰⁰ And in 1935, the commissioner of Indian affairs, John Collier, secured funds to establish a nurse training course at the Kiowa Indian Hospital in Oklahoma. The course was not accredited, “however, and effectively prepared students to work as aides in government hospitals, where they remained near the bottom of hospital hierarchies.”¹⁰¹ By 1941, “only eighty-nine of the more than eight hundred nurses in the Indian Service were of Native descent.”¹⁰²

As Hancock notes in her essay on the BIA field nursing program, although the majority of BIA field nurses were white women, in the context of the early 1930s’ Indian New Deal, “official OIA [Office of Indian Affairs] policy encouraged the recruitment of American Indians to fill positions” in Indian Service programs. However, throughout the 1930s, the number of American Indian women hired as field nurses remained very low. Moreover, “American Indian women were heavily concentrated in ‘aide’ and ‘assistant’ roles, meaning that their work was typically directed and supervised by non-Native health workers.”¹⁰³ This created similar dynamics to those established in other colonial contexts (see below), in which Black and Indigenous nurses, and other nurses of color, were marginalized in low-status, low-paying subordinate positions within the nursing hierarchy, subject to supervision by white middle-class nurses.

Brianna Theobald has detailed the career of Susie Walking Bear Yellowtail.¹⁰⁴ Yellowtail was born in 1903 in Pryor, Montana, on the Crow reservation. As a child, Yellowtail first attended the Catholic boarding school at Pryor, and then transferred to the government boarding school at Crow Agency.¹⁰⁵ At the age of 16, she left Montana to attend the Bacone Indian School in

97 Child, *My Grandfather's Knocking Sticks*, pp. 150-159.

98 Charbonneau-Dahlen and Crow, “Overview,” p. 81.

99 Charbonneau-Dahlen and Crow, “Overview,” pp. 82-87.

100 Jim Kristofic, *Medicine Women: The Story of the First Native American Nursing School* (Albuquerque: University of New Mexico Press, 2019).

101 Theobald, “The History-Making Work of Native Nurses.” *UNC Press Blog*, October 14, 2019. Available at <https://uncpressblog.com/2019/10/14/brianna-theobald-the-history-making-work-of-native-nurses/>. Retrieved December 13, 2021.

102 Theobald, “Nurse, Mother, Midwife,” p. 23.

103 Hancock, “Healthy Vocations,” p. 126.

104 See both Theobald, “Nurse, Mother, Midwife,” and Theobald, *Reproduction on the Reservation*.

105 Theobald, *Reproduction on the Reservation*, p. 73.

Oklahoma. In the early 1920s, she traveled to the East Coast. With the assistance of a Baptist sponsor, Yellowtail “enrolled in the nursing program at Franklin County Memorial Hospital in Greenfield, Massachusetts, before going on to Boston City Hospital School of Nursing.” In 1927, when Yellowtail graduated from the school, along with five other classmates (all of whom were white), “she became the first Crow registered nurse and one of the first Native American registered nurses.”¹⁰⁶ A year later, Yellowtail joined the Indian Service, returning to the Crow Agency, where she worked as a supervisory nurse at the hospital.¹⁰⁷ Yellowtail stayed at the hospital for only a few months, resigning after she married. But as Theobald explains, Yellowtail’s decision to resign “stemmed in part from her deep frustration with the hospital’s white employees.” Her experience “convinced her that Crows commonly endured mistreatment at the reservation hospital. Yellowtail later recalled that she ‘went to bat’ for mistreated patients.”¹⁰⁸ Several years later, Yellowtail returned to the Crow hospital to give birth to her second child, where she experienced first-hand mistreatment at the hands of the government physician. But even before her experiences as a patient, Yellowtail’s experiences working at the reservation hospital transformed her into a “political activist.”¹⁰⁹

Theobald builds on the work of historian Cathleen Cahill, who in *Federal Fathers and Mothers* demonstrated the ways in which 20th century Native Americans turned positions within the federal Indian Service into “politicized sites of resistance,” countering the federal government’s intentions and expectations.¹¹⁰ Theobald shows this to be no less true for Native American women like Susie Yellowtail who worked as nurses within the Indian Health Service (IHS). Some of Yellowtail’s superiors deemed her a “troublemaker,” and she was unable to secure health-related employment on the reservation throughout the 1930s.¹¹¹ In part to mitigate their potential for disruption, Theobald explains, the BIA preferred not to assign Native American nurses within their home communities, sending them instead to hospitals on other reservations. However, for tribal leaders, the employment of tribal members at local hospitals was viewed as a matter of self-determination.¹¹²

After resigning from the Crow Indian Hospital, Yellowtail continued both her health work and her political activism –which were, Theobald makes clear, integrally connected. In particular, Yellowtail began serving as a midwife for women in Wyola and throughout the Little Big Horn valley. As Theobald explains, Yellowtail “had delivered a number of babies during her employment at Indian Service hospitals, and after 1930, she had also given birth herself, which

¹⁰⁶ Theobald, *Reproduction on the Reservation*, p. 74.

¹⁰⁷ Theobald, “Nurse, Mother, Midwife,” p. 23.

¹⁰⁸ Theobald, “Nurse, Mother, Midwife,” p. 25.

¹⁰⁹ Theobald, “Nurse, Mother, Midwife,” p. 25.

¹¹⁰ Cathleen Cahill, *Federal Fathers and Mothers: A Social History of the United States Indian Service, 1869-1933* (Chapel Hill: University of North Carolina Press, 2011), p. 113, as quoted in Theobald, *Reproduction on the Reservation*, p. 80.

¹¹¹ Theobald, *Reproduction on the Reservation*, p. 80.

¹¹² Theobald, *Reproduction on the Reservation*, p. 80.

many Crows still viewed as a prerequisite for midwifery. She combined her Western medical training with birthing knowledge she had learned from women in the Yellowtail family, in order to provide women with safe childbirth experiences outside the government hospital. According to Yellowtail, by mid-decade, many women avoided the hospital out of fear of the doctors, “who were known to perform involuntary or forced sterilizations.”¹¹³ In 1934, Yellowtail was herself sterilized without consent during a gynecological procedure performed by a government physician at the Crow Indian Hospital. As Theobald explains, “Considered in context, Yellowtail’s midwifery constituted an act of resistance” to the sterilization abuses in the Crow Indian Hospital.¹¹⁴

Yellowtail continued to work as a midwife throughout the 1940s and into the 1950s. She also served on the tribe’s committees on health and education. In her role on the health committee, she acted as “patient advocate and government watchdog.” In the late 1950s, as Theobald explains, the health committee “distributed a circular encouraging Crows to report all hospital-related complaints to the committee and to bring a committee member to serve as a witness to doctor visits.” Then in 1961, Yellowtail was appointed by President John F. Kennedy to the Surgeon General’s Advisory Committee on Health, a position she held through the Johnson and Nixon administrations. In this capacity, Yellowtail traveled “throughout Indian Country, investigating reservation health conditions, and making recommendations for improvement.” As she traveled throughout the West, Yellowtail “came to realize the patterns of abuse and neglect at the Crow Indian Hospital were not unique.” In the early 1960s, she helped found the Native American Nurses Association (later renamed the American Indian Nurses Association), an organization of Indigenous nurses whose professional experiences had alerted them to the coercive sterilization practices that occurred in government hospitals and the poor treatment Native patients received from government and contract health workers.¹¹⁵

Theobald’s examination of Yellowtail’s life and career is part of a broader analysis in which she traces the reproductive histories of generations of Native American women from the 19th through the early 21st centuries, “focusing attention on what women said and did.”¹¹⁶ Yellowtail is just one of the Native women on whose words, actions, and experiences Theobald centers in *Reproduction on the Reservation*. Theobald does so by drawing upon the writings, speeches, and stories held in tribal archives; oral histories with Crow individuals; and bureaucratic records, sociological and anthropological studies, and activist literature.¹¹⁷ In doing so, Theobald shows that Native American women “navigated

113 Theobald, *Reproduction on the Reservation*, p. 97.

114 Theobald, “Nurse, Mother, Midwife,” p. 34.

115 Theobald, “Nurse, Mother, Midwife,” p. 34.

116 Theobald, *Reproduction on the Reservation*, p. 10.

117 Theobald, *Reproduction on the Reservation*, pp. 14-15.

pregnancy and birthing ... in myriad ways.”¹¹⁸ For some Native American women, this meant incorporating “field matrons, nurses, physicians, and even hospitals into their reproductive lives on Native terms.” For example, “women who chose or felt pressured to give birth in a hospital continued to consult midwives before and during pregnancies and after their deliveries,” while women “who might have acted as midwives in other circumstances also accompanied women to the hospital, where their efforts to serve as patient advocates and authorities on birthing were met with varying degrees of success in different contexts.”¹¹⁹ In other words, “Native women have displayed fortitude and creativity in navigating the federal government’s often contradictory demands on their bodies and behaviors and in meeting their perceived parturition and childbirth needs in evolving historical contexts.”¹²⁰ Theobald also shows that since at least the 1930s, Native American women “worked to secure the best possible care for Native women,” “advocated for women’s health and the health and well-being of their communities by pressuring federal agencies to uphold Native ‘treaty rights,’” demanded that Native American women receive services comparable to those given white women with private insurance, and “demanded that government health workers provide culturally appropriate care.”¹²¹ Theobald’s work also highlights the “network of Native nurses and other health professionals who assumed roles as watchdogs and patient advocates in colonial medical institutions” and who, in the 1970s and 1980s, struggled alongside Women of All Red Nations, a Native American women’s organization, for Native women’s reproductive autonomy.¹²²

Collectively, the scholarship on nursing and colonialism in the Indigenous U.S. makes clear the ways in which nursing has been integral to settler colonialism. It also highlights the colonial context in which Native American people have experienced and still today experience health, illness, and healthcare. This literature also emphasizes the agency and power that Native American people maintained as they negotiated health and healthcare. And it emphasizes the vital work that Native American nurses have done to resist, contest, and navigate colonial healthcare institutions, and to advocate for the health and healthcare of Native American people.

118 Theobald, *Reproduction on the Reservation*, p. 10.

119 Theobald, *Reproduction on the Reservation*, p. 11.

120 Theobald, *Reproduction on the Reservation*, p. 12.

121 Theobald, *Reproduction on the Reservation*, p. 13.

122 Theobald, *Reproduction on the Reservation*, p. 13.

Nursing and American Imperialism Beyond the Continental U.S.

Over the past decade, a small but growing number of scholars have begun to explore and problematize nursing's role in American imperialism. The first scholar to critically address the intersections of nursing and imperialism was Catherine Ceniza Choy. In *Empire of Care*, Choy uses oral histories of Filipino nurses in New York City as well as official government documents to demonstrate that the history of U.S. colonialism in the Philippines indelibly shaped the development of professional nursing in the Philippines, while also explaining the expansive transnational network of Filipino nurse migration in the decades after World War II. Choy argues that the migration of these nurses from the Philippines transcended economic self-interests – that it was, instead, deeply rooted in an exploitative form of American imperialism that began with that country's self-conscious adoption of a distinctly American hospital, healthcare, and nurse training system.¹²³ As Choy explains, the Americanized nursing programs were important sources of educational and social mobility for Filipino women. With support from philanthropic foundations like the Rockefeller Foundation and Daughters of the American Revolution, the American colonial government established the pensionado program, which “sponsored members of the Filipino elite at universities and colleges in the US to prepare them to assume top positions in American-established institutions in the Philippines.” For the Filipino women who participated in the program, argues Choy, “study in the U.S. became a prerequisite for social and occupational mobility in the nursing profession in the Philippines,” and it also “created the professional and social foundations that enabled the Filipino nursing labor force to work and study in the U.S.”¹²⁴

As Choy makes clear, the history of colonialism in the Philippines is key to understanding why, by the late 1960s, Filipino nurses constituted the overwhelming majority of foreign-trained nurses who entered the U.S. through the government's Exchange Visitor Program (EVP). Congress established the EVP in 1948, and between 1956 and 1969, over 11,000 Filipino nurses participated in the program.¹²⁵ Participants of the EVP came to the U.S. for up to two years to work and study in sponsoring institutions, which provided them with a monthly stipend. The ANA and individual hospitals were among the several thousand sponsoring U.S. agencies and institutions. While Filipino nurses had their own reasons for participating in the program, U.S. hospitals “used exchange nurses as an inexpensive labor supply to alleviate growing nursing shortages in the post-World War II period.”¹²⁶ As Choy details, Filipino nurses were routinely exploited by the hospitals that sponsored them: “Some hospital administrators took advantage of the exchange status of Filipino nurses by assigning them the work of registered nurses and compensating them with minimal stipend. Other American hospital administrators abused the educational and professional component of the EVP by assigning Filipino exchange nurses the

123 Catherine Ceniza Choy, *Empire of Care: Nursing and Migration in Filipino American History* (Durham: Duke University Press, 2003).

124 Catherine Ceniza Choy, “Exported to Care: A transnational history of Filipino nurse migration to the United States,” in Nancy Foner, Rubén G. Rumbaut, and Steven J. Gold (eds.), *Immigration Research for a New Century: Multidisciplinary Perspectives* (New York: Russell Sage Foundation, 2000), pp. 113-133.

125 Choy, *Empire of Care*, p. 65.

126 Choy, *Empire of Care*, p. 78.

work of nurse's aides."¹²⁷ Congress' passage of the Immigration and Nationality Act in 1965 further encouraged the recruitment of foreign-trained nurses by American hospitals. With ongoing shortages of healthcare professionals, and concerns that those shortages would be exacerbated following the implementation of Medicare and Medicaid, foreign-trained nurses were in particularly high demand, and large numbers of Filipino nurses immigrated to the U.S. in response. Indeed, as Choy notes, by 1967, "the Philippines became the world's top sending country of nurses to the United States."¹²⁸

In the 15 years since the publication of Choy's groundbreaking work, a handful of scholars have begun to interrogate the logics of imperialism, professionalization, and racialization that were at work as nurses participated in the U.S.'s other colonial projects, each of which was a product of the 1898 Spanish-American War.¹²⁹ As Choy demonstrated for the Philippines, nursing imperialism was premised on the superiority of American nursing and with it, Euro-American values. In this rendering, white American nurses saw themselves as a civilizing force that would – along with the larger colonial missions – “civilize” colonial subjects and prepare them for “self-rule.”¹³⁰ As Winifred Connerton argues, by embodying the “‘benevolent’ approach of American colonialism,” American nurses “were the personal face of America in their contact with patients at the bedside and in the clinic.”¹³¹ Connerton's work shows that American nurses who went to Puerto Rico as members of the Army Nurse Corps, as colonial service workers, and as Protestant missionaries after the Spanish-American War participated in the U.S. government's colonial project to Americanize and “modernize” Puerto Rico. The U.S. colonial government and missionary administrators “needed trained nurses to effectively run their public health and hospital facilities,” and they – along with the American nurses they hired – “believed in the power of nursing training to ‘improve’ Puerto Rican society.”¹³²

127 Choy, “Exported to Care,” pp. 122-123.

128 Choy, “Exported to Care,” p. 127.

129 See, for example, Winifred C. Connerton, “American Nurses in Colonial Settings: Imperial Power at the Bedside,” in D’Antonio, Fairman, and Whelan (eds.), *Routledge Handbook on the Global History of Nursing* (New York: Routledge, 2013), pp. 11-21; Winifred Connerton, “Working Toward Health, Christianity and Democracy: American Colonial and Missionary Nurses in Puerto Rico, 1900-30,” in Helen Sweet and Sue Hawkins (eds.), *Colonial Caring: A History of Colonial and Post-Colonial Nursing* (Manchester: Manchester University Press, 2015), pp. 126-144; Ellen Walsh, “Called to Nurse: Nursing, Race, and Americanization in Early 20th-Century Puerto Rico,” *Nursing History Review* (2018) 26: 138-171; Laura R. Prieto, “Dazzling Visions: American Women, Race, and the Imperialist Origins of Modern Nursing in Cuba, 1898-1916,” *Nursing History Review* (2018) 26: 116-137; Jean J. Kim, “Professionalizing ‘Local Girls’: Nursing and U.S. Colonial Rule in Hawai‘i, 1920-1948,” in Laurie B. Green, John McKiernan-González, and Martin Summers (eds.), *Precarious Prescriptions: Contested Histories of Race and Health in North America* (Minneapolis: University of Minnesota Press, 2014), pp. 143-165.

130 Choy, “Exported to Care,” p. 118.

131 Connerton, “American Nurses in Colonial Settings,” p. 11.

132 Connerton, “Working Toward Health, Christianity and Democracy,” pp. 126-127.

Intersections of Imperialism and Racism in Latino Nursing

But to be sure, the development of professional nursing in Puerto Rico was not simply the product of colonial imposition. Rather, as Ellen Walsh's research on the Protestant missionary project in Puerto Rico shows, some Puerto Ricans supported the U.S. colonial project of modernization – though they didn't adopt it wholesale but instead adapted it to their own ends.¹³³ As they did so, Puerto Rican nurse leaders contributed to the racialization of nursing education in Puerto Rico. Although the racial classifications, and the social hierarchies that resulted from them, were different in Puerto Rico than on the mainland, “features identified as African consigned Puerto Ricans to a lower position on the spectrum.” As Walsh explains, “imperialist and local ideologies of white racial superiority” converged in the development of nursing education in Puerto Rico “to Afro-Puerto Ricans' disadvantage.”¹³⁴ Segregation was commonly practiced in Puerto Rico under the U.S. colonial government. For example, the Presbyterian Hospital training school excluded Afro-Puerto Rican candidates, and many of the “best” institutions around the island would not hire Afro-Puerto Rican nurses. However, “racist policies were not universally adopted throughout the island.”¹³⁵ The fact that de jure segregation was not operative in Puerto Rico had implications for the professional standing of Puerto Rican nurses in the U.S. Despite, as Walsh argues, “imperial ideologies that discursively darkened all Puerto Ricans,” the Association of Registered Nurses of Porto Rico (ARNPR), which was founded in 1916, was accepted into the ANA just four years later (at a time, of course, when African American nurses were excluded – by law in the South and by custom in other parts of the country – from the ANA and other majority-white nursing organizations and nursing schools). This, in turn, helped the ARNPR and its leaders “build critical professional networks” with nurses on the mainland.¹³⁶

American nursing was also integral to the U.S. imperialist project in Cuba, which in turn was shaped by the intersections of both Cuban and U.S. racial hierarchies. As Laura Prieto has documented, “The exclusion of Afro-Cuban women followed that of African American women nurses in the early phase of U.S. occupation.” Although Americanized nursing in Cuba offered expanding opportunities for some Cuban women, “modern nursing was an American export bounded by racial exclusion and suffused with an imperialist ideology.”¹³⁷ As in Puerto Rico, “race had its own complicated history in Cuba.”¹³⁸ Racial classifications in Cuba “attempted to affix an identity based on degree of African ancestry and skin color,” doing so along “multiple color lines.”¹³⁹ The U.S. occupation exacerbated the racism that was already operative in Cuba whereby “The island's elites were already predisposed to regard people of African descent as inferior and perhaps even a danger to the republic. Thus they eagerly worked to ‘white’ and even Anglo-Americanize Cuba.” In Cuba, as it was in Puerto Rico, race was classed. As Prieto continues, “over time even Black Cuban elites separated themselves from the poorer, less educated Afro-Cuban masses. Thus, across races, Cuban elites found American imperialist views of race ideologically

133 Walsh, “Called to Nurse,” p. 139.

134 Walsh, “Called to Nurse,” p. 156.

135 Walsh, “Called to Nurse,” p. 161.

136 Walsh, “Called to Nurse,” p. 161.

137 Prieto, “Dazzling Visions,” pp. 117-118.

138 Prieto, “Dazzling Visions,” p. 121.

139 Prieto, “Dazzling Visions,” p. 122.

persuasive as well as strategically useful, since they needed to persuade the United States of Cuba's fitness for political autonomy in order to end U.S. occupation."¹⁴⁰ As Prieto argues, "From the U.S. perspective, Cuba's readiness for independence was contingent upon establishing 'racial exclusion' and segregation By this thinking, Black nurses were unsuitable exponents of the 'modern' nursing the United States hoped to inculcate in its possessions."¹⁴¹ The ideology of racial hierarchy and white racial superiority marked American nursing's imperialist project in Cuba in other ways. White American nurse leaders, Prieto argues, saw Cuban nursing as a "tabula rasa," whereby Cuba's "Native women [were] in need of tutelage, like the Cuban people as a whole." In this rendering, "The white corps of American nurses thus saw Cuban women as a decidedly inferior," and yet also "malleable-redeemable."¹⁴² But as in Puerto Rico, "not all Cuban women seemed equally eligible" for "modern" nursing; "Afro-Cuban women were unwelcome as potential nurses The very insistence on making nursing a *respectable* profession, one that would 'entice and charm' more elite women, meant excluding Black women."¹⁴³ In this way, "the U.S. occupation of Cuba brought about the racial cleansing of the American nurse corps *and* the racialized foundation of nursing training for Cuban women. White American women alone would uplift their Cuban sisters to the standards of professionalism."¹⁴⁴

But the Latino experience in the United States is not, of course, limited to Puerto Rico and Cuba. What historians have called the "Spanish Borderlands" – the intersections of a strong Latino presence and culture with the expanding frontiers of an Anglo-dominated United States in what is now New Mexico, Arizona, and California – have been described as places of violent political and social conflict but also hard-won interdependence and mutuality.¹⁴⁵ They lament, however, that little has been done as yet of the day-to-day experiences of women; gender studies have largely focused on Hispanic women in the Americas and in Europe.¹⁴⁶ Barbara Brush and Antonia Villarreal have started to address this discrepancy with their brief biography of Ildaura Murillo-Rohde, who struggled to include Hispanic nurses within the ANA's administrative structure before finally founding, with like-minded colleagues, the National Association of Hispanic Nurses in 1976.¹⁴⁷ D'Antonio has described some of the health experiences of Puerto Ricans migrating to New York City in the 1920s and 1930s – individuals and families whose valid citizenship claims were seen even by rather progressive public health nurses as tenuous, complicated, and preferably ignored. Furthermore their health needs – complicated by the discrimination they experienced in where they might live, work, and educate their children – were not well suited

140 Prieto, "Dazzling Visions," pp. 122-123.

141 Prieto, "Dazzling Visions," p. 125.

142 Prieto, "Dazzling Visions," p. 127.

143 Prieto, "Dazzling Visions," p. 128.

144 Prieto, "Dazzling Visions," p. 127.

145 Vicki Ruiz, "Why Latino History Matters to US History," *Japanese Journal of American Studies*, 20, 2009: 7-26.

146 Sueann Caulfield, "The History of Gender in Historiography of Latin America," *Hispanic American Historical Review*, 813, 2001: 449-499.

147 Barbara Brush and Antonia Villarreal, "Heading the Past, Leading the Future," *Hispanic Health Care International*, 12 (4), 2014: 159-160.

to the increasing dominance of an acute health care system.¹⁴⁸ And Lena McQuade-Salzfass has documented the experiences of parteras – or Spanish-speaking midwives – and the symbolic role they played in New Mexico after it became a state in 1912. In the post-statehood period, McQuade-Salzfass argues, “midwifery came to symbolize all that was different about New Mexico in the United States.”¹⁴⁹

Like other states in the early 20th century, New Mexico passed a series of midwifery laws that required lay midwives, including parteras, to register with the public health department, attend birth education classes led by public health nurses and physicians, and restrict the scope of their practice. The midwifery licensing laws placed reproductive healthcare practices under the purview of the state public health department and “rendered certain birth practices and practitioners illegal.”¹⁵⁰ Parteras who violated the laws – who practiced without certification or engaged in practices that were prohibited, such as performing any internal exams – could be and were prosecuted. The implementation and enforcement of the state’s midwifery laws depended on the state health department recruiting qualified public health nurses to work in the state. As McQuade-Salzfass shows, however, their recruitment efforts centered on perpetuating “the notion that New Mexico was an exotic, foreign space greatly in need of Americanization.” And according to the director of child hygiene and public health nursing, moreover, New Mexico was “a region where white, female nurses endowed with the ‘pioneer spirit’ performed ‘greatly needed’ work educating ‘the most ignorant’ New Mexicans who clung to ‘age-old superstitions’ and ‘believe[d] in their medicine women rather than in modern methods.’” In the context of the U.S. government’s recent colonization of the region and subsequent incorporation of New Mexico as a state, McQuade-Salzfass explains, “descriptors such as ‘superstitions’ evoked the Indigenous and Catholic health practices of Nuevomexicanos and racialized people of Spanish Mexican descent.” In this way, the regulation of midwifery was cast as a means by which New Mexico would “be brought within national norms,” including the norms of Euro-American reproductive health¹⁵¹ Nevertheless, throughout the first half of the 20th century, the public health department relied on the indispensable labor of parteras, who provided vital reproductive healthcare, “primarily to rural, economically impoverished Nuevomexicanas and their families, who often had no other access to physicians or hospitals well into the 20th century.”¹⁵² Ultimately, McQuade-Salzfass argues, the midwifery laws and policies “reveal much about the consolidation of racialized and gendered health hierarchies in early twentieth-century New Mexico and the centrality of reproduction to demarcating national belonging.”¹⁵³

148 Patricia D’Antonio, *Nursing with a Message: Public Health Demonstration Projects in New York City* (New Brunswick: Rutgers University Press, 2017).

149 McQuade-Salzfass, “An Indispensable Service,” p. 118.

150 McQuade-Salzfass, “An Indispensable Service,” p. 129.

151 McQuade-Salzfass, “An Indispensable Service,” p. 132.

152 McQuade-Salzfass, “An Indispensable Service,” p. 123.

153 McQuade-Salzfass, “An Indispensable Service,” p. 136.

Imperialist Legacy

The role of nursing in American imperialism was not restricted to its immediate colonial/territorial interests. As Julia Irwin has demonstrated in *Making the World Safe*, the thousands of U.S. nurses who volunteered to work as instructors in nursing schools and staff public health agencies in Europe, Asia, and the Caribbean in the wake of World War I were not only motivated by the desire “to tackle world health issues,” but also by the conviction “that the spread of U.S. professional nursing ideas stood to modernize the world.”¹⁵⁴ The American nurses who volunteered with the American Red Cross, as Irwin shows, “carried their experiences and assumptions about health, race, and civilization with them.” As they sought to implement these ideals via the establishment of nursing schools and public health campaigns in eastern and central Europe, Asia, and the Caribbean, these white nurses (the American Red Cross barred African Americans from serving overseas)¹⁵⁵ “shared a modernizing impulse that ordered the world’s people according to hierarchy of levels of development and progress – they defined certain populations as easy and willing to reform and others as more difficult. And they believed all populations could be improved if the U.S. took the lead in educational and environmental interventions.”¹⁵⁶

But it wasn’t just that the logics of racial and cultural hierarchies informed and underpinned nursing’s role in American imperialism overseas; American imperialism also contributed to the racialization of nursing in the U.S. As Choy did for the history of Filipino nurse migration to the U.S., Sujani Reddy has demonstrated the intersections of American imperialism, professionalization, and racialization in the history of Indian nurse im/migration to the U.S. In *Nursing and Empire*, Reddy shows that the emergence of transnational immigration of Indian nurses during the Cold War decades was rooted in the U.S. imperialism of the pre-World War II decades, led by the Rockefeller Foundation, and Christian medical missionaries prior to that. She also explains the ways in which foreign nursing labor was racialized in the U.S. during the Cold War decades.¹⁵⁷ Foreign-trained nurse graduates – the overwhelming majority of whom were nurses from the Philippines, India, and other parts of the so-called Third World – “faced stigmatization as a ‘cheap(er)’ solution to recurrent crises in what was cast as a chronic nursing shortage.”¹⁵⁸ This stigmatization was rooted in the long history of racial exclusion in U.S. immigration policy whereby migrants from a legislatively defined “Asiatic Barred Zone” had been ineligible for both immigration and naturalization since the early 20th century. “‘Foreign’ was thus a racially loaded category that would mark Indian nurses in a way that did not apply to their white American or European immigrant counterparts.”¹⁵⁹ As foreign-trained nurses

154 Julia F. Irwin, “Nurses Without Borders: The History of Nursing as U.S. International History.” *Nursing History Review* (2011) 19: 78-102.

155 Julia F. Irwin, *Making the World Safe: The American Red Cross and a Nation’s Humanitarian Awakening* (New York: Oxford University Press, 2013), pp. 101-102.

156 Irwin, “Nurses without Borders.”

157 Sujani Reddy, *Nursing and Empire: Gendered Labor and Migration from India to the United States* (Chapel Hill: University of North Carolina Press, 2015), pp. 9-10.

158 Reddy, *Nursing and Empire*, p. 12.

159 Reddy, *Nursing and Empire*, p. 154.

they were subject to increased testing and regulation, which caused “some to experience forms of downward mobility, including employment in nursing’s nonprofessional ranks where Third World and especially African American labor was disproportionately concentrated.” Even when they were hired into the professional nursing ranks, Reddy found that most Indian nurses “found their labor relegated to the shifts, units, and hospitals least able to retain their white colleagues.”¹⁶⁰

What sets the work of Choy and Reddy apart is that through their use of oral histories, their analysis centers on the experiences and perspectives of Filipino and Indian nurses within the matrix of American imperialism and the professionalization and racialization of American nursing. As the scholarship of Choy and Reddy make clear, nursing’s role in American imperialism is integral to understanding the increasingly important role – and racialized experiences – of foreign-trained nurses in the Cold War decades. As both scholars demonstrate, in the decades after World War II, as U.S. hospitals confronted ongoing – and growing – nursing shortages, foreign-trained nurses assumed increasing importance in the U.S. nursing labor market. But as they did so, their entrance served to reinforce racialized hierarchies in U.S. nursing *and* contributed to racialization of nurse im/migrants from the Philippines, India, and other parts of Asia as “foreign” and thus always “other.” For Reddy, the racialization of foreign-trained nurses cannot be understood apart from the racial dynamics of the white-Black binary that had constituted American nursing since the introduction of trained nursing in the late 19th century. As Reddy argues, for example, “the relative immobility” of African American nurses in the post-World War II U.S. “must be understood as part of the conditions of possibility for Indian nurses’ advancement.” While many Indian nurses who had been relegated initially to the roles of nurse’s aide or licensed practical nurse (LPN) could, eventually, “move further up the occupational ladder,” oftentimes their Black colleagues continued to face barriers to occupational mobility. But at the same time, white nurses denied Indian nurses “full access to the privileges of whiteness.” In this way, discrimination was “a multifaceted phenomenon, flowing both up and down the nursing hierarchy,” positioning “Indian nurses on both the perpetuating and receiving ends of racism.” While Indian im/migrant nurses troubled the Black/white binary in American nursing, Reddy argues, the question of “who/what are they within this racialized field” was answered by their racialization as “foreign.”¹⁶¹

¹⁶⁰ Reddy, *Nursing and Empire*, pp. 12-13.

¹⁶¹ Reddy, *Nursing and Empire*, p. 178.

As this scholarship on the role of nursing in American imperialism makes clear, then, the racialization of professional nursing that was central to America's colonialist projects was also integrally connected to the racialization of professional nursing in the U.S. In particular, the intersections of imperialism and racialization in nursing's professional project were inextricably contextualized within the dynamics of the Black-white binary that was operative in American nursing not only during the years of Jim Crow segregation but also in the decades thereafter. And as the work of Choy and Reddy makes clear, this history has implications for understanding the experiences of Filipino, Indian, and other foreign-trained nurse migrants and immigrants in the U.S. in the 21st century, as well as the intersectional imprint of racism and colonialism on the attitudes, practices, and policies of professional nursing organizations, including the ANA, toward foreign-trained migrant and immigrant nurses of color.

While Choy and Reddy's publications are the first book-length analyses of not only America's nursing imperialism but also the transnational place of nursing in a global world, they should not be the last. New studies should analyze the subject and, more concretely, explore how this history helps us make sense of the activism of California's Filipino nurses, particularly in this time of COVID-19, as well as how we can reconcile a subtext of exploitation with the fact that one of the first presidents of National Nurses United is a Filipino nurse. And what of other underrepresented groups? What kinds of colonialist, imperialistic, or transnational concepts might help us understand the experiences of Hispanic, Asian, Pacific Islander, and men nurses?

The Limits of Integration and the Need for Activism

By the 1970s, it was clear that the gains of the Civil Rights Movement, including the integration of the ANA, had its limits. Even after civil rights legislation in the 1960s dismantled the legal system of segregation and made racial discrimination in education and employment illegal, practices of racial exclusion in nursing and higher education continued. As Darlene Clark Hine wrote in 1989, “The end of overt discrimination and segregation ... did not mean the eradication of more subtle and sophisticated forms of institutional racism.”¹⁶² As Hine explained, “In the twenty years following the dissolution of the NACGN and the ostensible integration of Black nurses into the ANA, only imperceptible improvements had been registered in the actual status of Black women within the profession.”¹⁶³ For example, the ANA had effectively denied Black nurses leadership positions. As of 1970, there had never been a Black president or vice president of the ANA, and “few Black nurses won appointment to committees or commissions or were invited to present papers at the annual conventions.”¹⁶⁴ The 1970s was also characterized by ongoing inequities in nursing and higher education. The majority of Black nurses graduated from practical nursing and associate degree programs, which subsequently limited their opportunities for career advancement, leadership, and faculty positions, all of which required, at minimum, a bachelor of science in nursing (BSN) degree. For example, in 1972, of the 2,735 African American students who graduated from U.S. nursing schools, 61% graduated from associate degree programs, 21% from diploma programs, and only 17% from BSN programs. Of the total number of students graduating from BSN programs that year, 5% were African American.¹⁶⁵ This reflected broader trends in higher education in which Black students were overrepresented in community colleges and heavily underrepresented in four-year colleges and universities. These trends, which were a product of ongoing racial discrimination, meant that in 1965, when the ANA attempted to establish the BSN as the minimum credential necessary for entry into professional nursing practice, it effectively discriminated against Black nurses who already faced substantial barriers to higher education in nursing.

Majority-white organizations were also failing to address the health needs of people of color, particularly low-income people of color. For example, in 1969, nurse leader Rhetaugh Dumas wrote in the *American Journal of Nursing* that the “social destructive force of poverty” is “one of the most serious hazards to the survival and health of man.” For people of color, she continued, “the problems of poverty are precipitated and compounded by racism and other forms of prejudice and discrimination.”¹⁶⁶ For Dumas, nursing shared responsibility for effecting change in the healthcare system “to make health services more responsive to the needs of the poor.”¹⁶⁷ In the early 1970s, members of the Committee on Nursing in a Society in Crisis also called on nurses to reorient their priorities and focus their attention on the “interrelationship of sociopolitical issues and nursing” – particularly racism and poverty – so as “to plan and take part in changing the health care system.”¹⁶⁸

¹⁶² Hine, *Black Women in White*, p. 191.

¹⁶³ Hine, *Black Women in White*, p. 192.

¹⁶⁴ Hine, *Black Women in White*, p. 192.

¹⁶⁵ Marion Altenderfer, *Minorities and Women in the Health Fields: Applicants, Students, and Workers, Department of Health, Education, and Welfare* (Bethesda: Government Printing Office, 1975), pp. 43-46.

¹⁶⁶ Rhetaugh G. Dumas, “This I believe ... about Nursing and the Poor.” *Nursing Outlook* (September 1969): 47-49, quotation from p. 47.

¹⁶⁷ Dumas, “This I believe,” p. 47.

¹⁶⁸ Carolyn Sullivan, Janice Robinson, and Janice Ruffin, “Nursing in a Society in Crisis.” *American Journal of Nursing* (1972) 72(2): 302-304.

As Hine and Gloria Smith have each detailed, following the ANA's 1970 annual convention, more than 150 Black nurses began meeting to "discuss ways in which to better articulate the health needs of the Black community and to share frustrations with their lack of mobility in the health-care system."¹⁶⁹ Under the leadership of Lauranne Sams, a group of Black nurses organized a new independent professional association, the National Black Nurses Association (NBNA). Established at the end of 1971, the NBNA published a set of 10 objectives to improve the health and healthcare of Black Americans and to promote the professional development of Black nurses. The NBNA was to be an advocate for Black patients, acting as a "change agent in restricting existing institutions and/or helping to establish institutions to suit the needs of Black people." The NBNA would serve as "the national body to influence legislation and policies that affect Black people and work cooperatively and collaboratively with other health workers to this end." The NBNA also sought to "conduct, analyze, and publish research to increase the body of knowledge about health care and health needs of Blacks" and would establish "standards and quality education of Black nurses on all levels by providing consultation to nursing faculty and by monitoring the proper utilization and placement of Black nurses." The NBNA would also work to increase the recruitment of Black people into nursing and would be "the vehicle for unification of Black nurses of varied age groups, educational levels, and geographic location to ensure continuity of our common heritage." The NBNA recognized that such research and advocacy – led by Black nurses – was integral to improving the health and healthcare of Black Americans.¹⁷⁰

Black nurses were not the only nurses to organize at this time. Nurses from diverse populations began taking on larger roles in meeting the health needs of their communities and promoting greater leadership and influence in nursing education and the nursing profession itself. The reasons that led different communities of nurses to organize were varied and represented the complex developments and intersections that shaped the experiences of different populations of nurses. In 1974, for example, a group of Hispanic nurses who felt the ANA was not being responsive to the needs of Hispanic nurses met at the ANA Convention with the intent of establishing a Hispanic Nurses Caucus of the ANA. As noted earlier, the group, which included Ildaura Murillo-Rohde, struggled to include Hispanic nurses within the ANA's administrative structure. After two years, in 1976, the group instead established the National Association of Spanish-Speaking/Spanish-Surnamed Nurses, which was renamed the National Association of Hispanic Nurses in 1979.¹⁷¹

169 Hine, *Black Women in White*, p. 192; Gloria R. Smith, "From Invisibility to Blackness: The Story of the National Black Nurses' Association." *Nursing Outlook* (1975) 23: 225-229.

170 Smith, "From Invisibility to Blackness," p. 227.

171 See <https://www.nahnnet.org/history>. Retrieved December 14, 2021.

In 1972, Native American nurses organized the American Indian Nurses Association (AINA). They did so to raise awareness of and work to address health disparities; to increase the number of Native American nurses; to sensitize “non-Native medical providers to tribal histories and cultures”; and to advocate for “greater opening to Native healing practices.”¹⁷² Susie Yellowtail, who was one of AINA’s founding members, asserted, “It is time... for our own people to work with Indian people, because few non-Indian people know what makes us tick.”¹⁷³

Brianna Theobald has written that sterilization abuse was also among the AINA’s earliest priorities. In *Reproduction on the Reservation*, Theobald recounts the important role that Community Health Representatives, a program launched by the IHS in the late 1960s, played in alerting the IHS to concerns about sterilization abuse in its facilities. Community health representatives were “Native women and men who acted as health aides and served as liaisons among patients, local health committees, and providers.”¹⁷⁴ In their conversations with women about their reproductive healthcare, community health representatives in Wisconsin identified differential rates of sterilization procedures in different institutions and discovered that some institutions lacked transparency in their sterilization protocols, and they reported their concerns to the IHS.¹⁷⁵ Also, in 1974, a study by Connie Pinkerton-Uri, a Choctaw and Cherokee physician, found that 1 in 4 American Indian women had been sterilized without consent at an IHS hospital in Claremore, Oklahoma. Pinkerton-Uri initiated the research after an unnamed 26-year-old Native American woman entered her physician’s office in Los Angeles in 1972 requesting a “womb transplant.” The woman had received a hysterectomy six years earlier when she was struggling with alcoholism; now sober and married, the woman wanted to begin a family. Pinkerton-Uri realized the woman had not understood the nature or implications of her earlier hysterectomy. The following year, Theobald writes, “Pinkerton-Uri had visited the IHS hospital in Claremore, Oklahoma, at the invitation of more than a dozen nurses who were protesting discriminatory labor practices and poor patient care.” At Claremore, Pinkerton-Uri “encountered what she characterized as a ‘sterilization factory.’”¹⁷⁶ Pinkerton-Uri reported her findings to the IHS and to congressional legislators. Theobald explains that it was pressure from Uri-Pinkerton, Native American nurses, and others that led congressional members to call on the Government Accounting Office (GAO) to investigate sterilization practices at IHS facilities in New Mexico, South Dakota, Oklahoma, and Arizona. The 1976 GAO report confirmed that IHS had performed 3,406 sterilizations between 1973 and 1976. Although the GAO found no evidence of forced or coerced sterilizations, the report identified inconsistencies in the informed consent process. It is telling, however, that investigators did not interview any of

172 Theobald, “The History-Making Work of Native Nurses.” See also, Rosemary Wood, “American Indian Nurses’ Association Begins Recruitment Project.” *The Oklahoma Nurse* (September-October 1974), pp. 2-3.

173 Yellowtail, quoted in P. Arnold, “Indian nurses hold national conference.” *The American Nurse* (1975) 7(6): 8.

174 Theobald, *Reproduction on the Reservation*, p. 155.

175 Theobald, *Reproduction on the Reservation*, p. 155.

176 Theobald, *Reproduction on the Reservation*, p. 157.

the women who had been sterilized. Theobald explains that Native American nurses came together to establish the AINA because their “professional experiences had alerted them to the coercive sterilization practices that occurred in government hospitals and the poor treatment Native patients received from government and contract health workers.”¹⁷⁷ Native American nurses and other health professionals fought alongside other Native American women activists to protest the sterilization abuses experienced by Native women in IHS facilities and to demand Native American women’s reproductive autonomy.

Also in the 1970s, as Catherine Ceniza Choy has detailed, the “exploitive recruitment practices” of Philippine and U.S. recruitment agencies, “controversial licensing examinations, and a growing awareness of their complex and unique situation in the United States motivated Filipino nurses to organize.”¹⁷⁸ But Filipino nurses differed in their criticisms of recruitment practices and licensing examinations, which led to the development of three different national organizations representing Filipino nurses in the U.S.: the National Federation of Philippine Nurses Associations in the United States (later renamed the National Organization of Philippine Nurses Associations in the United States and then the Philippine Nurses Association of America), the National Alliance for Fair Licensure of Foreign Nurse Graduates, and the Foreign Nurse Defense Fund.¹⁷⁹ The existence of “multiple Filipino nurses’ organizations in the United States,” Choy argues, “reflected their diverse and competing interests within the United States.”¹⁸⁰ (Reddy has likewise described the impact of the controversial licensing requirements and recruitment practices on Indian nurses who im/migrated to the U.S. in the late 1960s and 1970s.¹⁸¹)

As both Choy and Reddy have detailed, changes in immigration practices in the late 1960s and 1970s intersected with changing approaches to the licensing requirements for foreign-trained nurses. Use of the EVP decreased and was replaced by the increasing use of the H-1 visa, a temporary visa for professional workers. The activism of Filipino nurses had led to nursing being designated as a preferred profession for the H-1 visa. Through the late 1960s, the overwhelming majority of foreign-trained nurses who im/migrated to the U.S. were able to practice as registered nurses without having to take the state licensing exams required of U.S. nurses. Instead, they were able to practice through the endorsement of their employees or through reciprocity, which was often granted to Filipino nurses who had a license to practice as a registered nurse in the Philippines. “As the permanence of immigrants within the U.S. market became more apparent,” Reddy argues, “U.S. nursing leaders pushed states to require that foreign nurse graduates take the State Board Test Pool Examination (SBTPE) in order to practice as an RN.”¹⁸²

¹⁷⁷ Theobald, “Nurse, Mother, Midwife,” p. 34.

¹⁷⁸ Choy, *Empire of Care*, p. 166.

¹⁷⁹ Choy, *Empire of Care*, pp. 166-185.

¹⁸⁰ Choy, *Empire of Care*, p. 167.

¹⁸¹ Reddy, *Nursing and Empire*, pp. 160-164.

¹⁸² Reddy, *Nursing and Empire*, p. 160.

American nurse leaders argued that requiring foreign-trained nurses to pass the SBTPE would ensure the competency of foreign-trained nurses, thereby safeguarding U.S. nursing practice and, ultimately, patient care. The SBTPE was developed by the National Council of State Boards of Nursing, which until 1978 was part of the ANA. The exam was composed of five test areas – medical, surgical, psychiatric, obstetric, and pediatric nursing. To take the exam, foreign-trained nurses needed to possess both an occupation visa and proof of their licensed status as registered nurses in their country of origin. The majority of foreign-trained nurses who took the SBTPE, however, failed. A 1976 national report cited a failure rate of 77%.¹⁸³ As Choy discusses, there were several factors that contributed to nurses failing the SBTPE at such high rates. In addition to the fact that the examination could induce anxiety and fear in test-takers, many of whom hadn't been in school for many years, "Filipino nurses' comparatively limited training in psychiatric nursing in the Philippines resulted in difficulty passing that area of the SBTPE," and "Some Filipino nurses also claimed that the multiple-choice format of the examination was confusing."¹⁸⁴ Furthermore, recruiters and hospitals that hired foreign-trained nurses did not always inform nurses of the testing requirements. The consequences of failing the SBTPE could be devastating. For H-1 visa holders, whose visa status was tied to their ability to work as registered nurses, failing the SBTPE could lead to their visa being revoked and to their deportation. Reddy also recounts the exploitative work conditions that some nurses who failed the SBTPE faced as hospitals reliant on their labor continued to hire them but did so 'under the table' and assigned them work as nurse's aides.¹⁸⁵

The high SBTPE failure rates led the ANA Commission on Nursing Services to issue a 12-point platform at the ANA's 1974 convention that, as Choy describes, had two objectives: "to remove the preferential status of foreign nurses in U.S. immigration policies, and to support the authority of state nurses associations to evaluate foreign-trained nurses" via the SBTPE.¹⁸⁶ As Choy continues, "The ANA Commission claimed that 'many foreign graduates are *not prepared to work* in roles expected of them, ... some employers place foreign nurse graduates in roles for which they are *unprepared*, [and] United States professional schools of nursing cannot provide sufficient education programs to foreign nurses with *academic deficiencies*.'" The ANA Commission also "characterized the presence of foreign-trained nurses in the United States as detrimental because they accepted 'salaries lower than the acceptable rates for U.S. nurses' and they were 'attracted to areas where US nurses cannot find employment.'"¹⁸⁷

183 Tomoji Ishi, "Class Conflict, the State, and Linkage: The International Migration of Nurses from the Philippines," *Berkeley Journal of Sociology* (1987) 32: 290, cited in Choy, *Empire of Care*, p. 169.

184 Choy, *Empire of Care*, p. 170.

185 Reddy, *Nursing and Empire*, p. 161.

186 Choy, *Empire of Care*, p. 172.

187 American Nurses Association, "Proposed Resolutions," 10, cited in Purita Falgui Asperilla, "Problems of Foreign Educated Nurses and Job Satisfaction of Filipino Nurses," as cited in Choy, *Empire of Care*, p. 172; emphasis added by Choy.

This platform, however, was defeated by another group of ANA members, which included Clarita Miraflor, president of the Philippine Nurses Association of Chicago, who “characterized the resolution as nativist and racist.”¹⁸⁸ Miraflor was joined by other ANA members in proposing an alternative resolution. This resolution “highlighted the role that U.S. hospital recruiters played in the problems of foreign-trained nurses in the United States,” and “called for the ANA to collaborate with the International Labor Organization and World Health Organization in the elimination of misleading US recruitment practices.” This resolution also called for the creation of a prescreening examination for foreign-trained nurses that they would need to pass before arriving in the U.S. This alternative resolution passed, and in 1977, the ANA and the National League for Nursing co-sponsored the establishment of the Commission on Graduates of Foreign Nursing Schools (CGFNS), which would be responsible for overseeing “the implementation and administration of the prescreening examination, known as the CGFNS examination.” This examination was composed of a nursing competency section, which included the five areas covered by the SBPTE examination, as well as an English-language competency section. The CGFNS administered the first CGFNS examination in 32 cities around the world on October 4, 1978.¹⁸⁹

Although the CGFNS did lead to dramatically increased rates of testing success for foreign-trained nurses, the CGFNS examination was also controversial. As Choy describes, “While individual American nurses interpreted the CGFNS as beneficial to foreign-trained nurses and detrimental to U.S. nurses, some Filipino nurses took the opposite view, characterizing the Commission and its use of the CGFNS examination as ‘anti-Filipino.’”¹⁹⁰ Filipino nurses’ dissatisfaction led to the formation of three U.S. national organizations, each with “distinct agendas and interpretations of the 1970s controversy regarding licensure of foreign-trained nurses.”¹⁹¹ In 1979, local Philippine Nurses Association chapters throughout the U.S. formed a new national U.S. nursing organization, the National Federation of Philippine Nurses Associations in the United States (later, the National Organization of Philippine Nurses Associations in the United States, NOPNAUS). As Choy explains, “While H-1 visa nurses’ problems and the CGFNS controversy were the immediate concerns that motivated formation” of the National Federation, “its formation was also linked to the transnational origins of these local chapters and the changing relationship between them and the PNA [Philippine Nurses Association] in the Philippines.”¹⁹² In 1977, “over one hundred Filipino nurses

188 Choy, *Empire of Care*, p. 172.

189 Choy, *Empire of Care*, pp. 173-174.

190 Choy, *Empire of Care*, p. 175.

191 Choy, *Empire of Care*, p. 176.

192 Choy, *Empire of Care*, p. 176.

and community activists formed the National Alliance for Fair Licensure of Foreign Nurse Graduates.”¹⁹³ The NAFL-FNG “demanded an end to what they considered to be a culturally biased nursing licensure examination.”¹⁹⁴ And finally, also in the late 1970s, Filipino nurses organized the Foreign Nurse Defense Fund, “which defended the rights of foreign nurses in the United States through the use of civil rights legislation.” This included accusing the National League for Nursing “of violating state and federal civil rights through its development of a ‘racist and discriminatory’ licensing examination.” The Foreign Nurse Defense Fund also accused government officials from the Department of Health, Education, and Welfare and the Immigration and Naturalization Services “of ‘criminal conspiracy’ through their use of SBTPE as a basis for deportation of foreign nurses in the United States.”¹⁹⁵ In 1982, the National Council of State Boards replaced the SBTPE with the National Council Licensure Exam (NCLEX). But the CGFNS remained in place, and passage of both the CGFNS and NCLEX examinations are required for foreign-trained nurses to practice as registered nurses in the U.S. Although the NAFL-FNG and Foreign Nurses Defense Fund had dissolved by the mid-1980s, the NOPNAUS continued and was renamed the Philippine Nurses Association of America in 1987.

193 Choy, *Empire of Care*, p. 181.

194 Choy, *Empire of Care*, p. 176.

195 Choy, *Empire of Care*, p. 183.

Conclusion

As is readily apparent, our historiographic review of relevant literature is only as robust as the interests and questions of scholars who champion particular topics and forms of analyses. This, as we mentioned in the beginning, necessarily limits what this essay can and cannot accomplish in terms of the history we attempt to tell. And, as we also mention, this history (as are all forms of data analysis in the discipline) is necessarily framed by our positionality. But we would never claim it is the only or the definitive story. And we look forward to more to come.

We also note that the vast majority of these scholars do not share nurses' disciplinary backgrounds. That is not, we emphatically state, necessarily problematic; all scholars must share similar methodological training, epistemological stances, and commitments to standards of reasoned arguments. But we do believe it suggests a dearth of disciplinary scholars who may ask different kinds of questions and who can seek to repair the vast holes that exist in the historical literature when we seek to address the roots of racism in nursing. History has simply not been valued as a way of knowing in the discipline, and we now experience the results of an over-reliance on biomedical paradigms when we seek to explore one of the most important issues facing the discipline. There are simply too many questions still left unanswered.

We always look to doctoral students who chose to study history when we think about the future. As D'Antonio writes in a forthcoming essay in *Nursing Inquiry*, Natalie Stake-Doucet's indictment of Florence Nightingale as the "racist lady with the lamp" in *Nursing Clio* has created a profound sense of dislocation among champions of both the discipline and its iconic heroine.¹⁹⁶ Historians have long recognized that Nightingale represented a global, colonizing healthcare project that created a powerful place for middle-class white women at the apex of a racialized hierarchy. But we are now being asked to consider the long-term, certainly structural but too often hidden implications of her successful crusade. We know how, to paraphrase Joan Lynaugh and Claire Fagin, a group of clinicians of the wrong gender, from the wrong class, and with the wrong educational background transformed the historical experience of health and illness.¹⁹⁷ We now ask: What cost came from the implicit dominance of whiteness? And we wonder: How might such answers to these new questions help at least crack the historically persistent structural barriers that invite some into the nursing enterprise, leave others out, and create nearly insurmountable hurdles for those that construct different meanings about the discipline's work and place in the world?

Recovering and highlighting the stories of these and other nurses are important. But however important, the stories themselves will not be sufficient. Stories need context; the data they provide, like all data, needs interpretation; and the process of interpretation demands frameworks that engage with new questions and new issues. To choose one example: Recent

¹⁹⁶ Stake-Doucet, "The racist lady with the lamp."

¹⁹⁷ Joan Lynaugh and Claire Fagin, "Nursing Comes of Age." *Image: The Journal of Nursing Scholarship* (1998) 20 (4): 184.

colonial and post-colonial scholarship now suggests we look for more nuanced meanings of power. This scholarship positions historical nurses and midwives as “intermediaries” who simultaneously translated official colonial directives into specific lessons and practices more easily understood by those with whom they directly worked, provided data up the proverbial chain of command about changes needed, and, in the end, shaped public health policy.¹⁹⁸ Their role in the colonial and imperialist enterprise conferred real status and authority. Can we think about underrepresented nurses as such “intermediaries” navigating and changing both from below and above the complex, subtle, and intersecting social and structural dynamics that simultaneously reinforce and sometimes change established hierarchies and systems of power? Can we think about such “intermediaries” as more actively choosing which messages to incorporate into their own practices and which to transmit? Do such intermediaries of different race, gender, and class backgrounds interpret this role differently? Stories need meanings, and meanings are what historians create.

Perhaps this might be the place to break with the historiography of this essay and to tell one particular story that may pull these themes together. This story comes from D’Antonio’s *American Nursing*, and it bears repeating. It goes as follows:

In 1923, Elizabeth Jones sought to describe nurses and nursing to the readers of *The Messenger*, a then popular and influential lay magazine. As was typical, Jones began by invoking the spirit of Florence Nightingale, in her mind “the world’s greatest nurse.” She continued by telling how this spirit inspired the next generation of American nursing leaders to establish training schools, create professional associations, and bring advances in medical science into the lives of families across the nation. The nurse, Jones wrote, was more than a teacher. She both brought advice and embodied it. She was, Jones continued, “looked upon by most of those with whom she comes in contact, as an example of a higher life.”¹⁹⁹

However important the work of nurses, Jones noted, how they did that work was even more significant. She believed a particular combination of content and character defined professional nursing. Content opened the nurse’s gaze to the life of an individual “as it really is, and not as it seems to be,” and character placed the nurse in a position of trust when dealing with “other problems besides helping to heal the diseased.” Certainly, education was important. She told her readers of the “educational unrest” nurses felt who sought more scientific knowledge about dietetics, pathology, bacteriology, and languages to care for individual patients.

198 Ryan Johnson and Amna Khalid (eds.), *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health* (New York: Routledge, 2011).

199 Elizabeth Jones, “The Negro Woman in the Nursing Profession,” *The Messenger* (July 1923) 5, p. 764.

But ultimately, she wrote, “it is not the duties we have to perform that count.” Nurses and nursing were “impressions,” or, as we might say today, representations. It was as much about how one presented oneself as what one did. As an African American nurse, Jones believed she epitomized the “New Negro Woman.” And it would be the New Negro Nurse’s professional combination of education and disciplined integrity that would force white America, however reluctantly, to acknowledge the African American nurse and through her all Black America’s “aptness and talent.” Nurses would be among the vanguard and, she concluded, “eventually [the white man] will be compelled to take us on our merits rather than on our skins.”²⁰⁰

Nursing has long simultaneously existed within complicated, conflicting, supporting, and delegitimizing communities both within and outside the discipline. We believe in the compelling need for more historical studies that elucidate the dimensions of this simultaneity and explore the strengths it brings not only to the discipline but also to the individuals, families, and communities it serves.

Still, this essay and Jones’ own story suggest ways to move forward. And we offer the following suggestions that we believe the historiography and the stories support.

We need more contextualized historical studies about the experiences of underrepresented groups in nursing.

- a. We have tended to define “underrepresented” in terms of race, class, and gender. But religion, geography, and access to resources (especially the material resources for the types of education necessary to even enter nursing) are also important.
- b. We need to know more about the intersecting variables of race, class, gender, and religion. As we seek to explicate these relationships we should also use them to avoid essentializing actors under study. While it is a necessary historiographical step to discuss “Black nurses,” for example, we should also be as aware that they are not a monolithic group.
- c. But historical studies need time as much as they do grants of monies. The members of this commission should encourage their constituent associations to support historical research.

200 Jones, “The Negro Woman in the Nursing Profession,” p.765. Darlene Clark Hine’s “Black Professionals and Race Consciousness: Origins of the Civil Rights Movement, 1890-1950,” *Journal of American History* (2003), 89(4): 1279-1294, addresses the role professional physicians, lawyers, and nurses played in setting the stage for the later Civil Rights Movement.

These studies should grapple with both complexity and also the complicity of nurses and nursing in perpetuating systems of structural racism.

- a. For example, although nursing has gained clear power and authority in its embrace of biomedical science, how does its embrace of a form of knowledge formed by hierarchies of racialized power and practices affect its work with individuals, families, and communities?
- b. Nurses and nursing must acknowledge and explore the ways in which commitments to different kinds of knowledge, education, and practices are themselves rooted in clear but unexamined racist traditions.
 - i. We point, in particular, to examining a commitment to reified forms of “standards” (e.g., examination requirements, educational credentials, and licensing and certification requirements) that have often been imbricated with systems of exclusion.
 - ii. While we acknowledge there is a body of scientific knowledge that is needed for safe, quality nursing practice, we encourage examination of how tests and standards for such concepts as “critical thinking” and “clinical reasoning” reflect and refract unspoken and unexamined knowledge hierarchies that may not best serve the discipline.

These historical studies should also locate nurses within simultaneous communities – not only of professional identity but also of community connections.

- a. Sims’ use of Black women both as nurses and as research subjects, for example, suggests that there are also more complicated forces at play.
- b. W.E.B. DuBois’ concept of a “double-consciousness” or a sense of “two-ness” among Black Americans may prove a useful framework when exploring all nurses’ sense of connection to one particular discipline and also to very different communities of identity.
 - i. These concepts also suggest that goals of representation as a method to diminish the legacy and practices of racism in nursing will be necessary but not sufficient. We will also need to increase the official and unofficial power of the many voices and experiences of individuals and groups that comprise the discipline of nursing.
- c. Our histories, though, do caution that the move into the community and primary care will not, in and of itself, solve the problems of knowledge validity and unconscious biases that nurses will inevitably carry into their patients’ homes and communities. We must be more assertive in providing the incentives and tools for nurses to acknowledge both the valuable and biased knowledge and practices they bring with them.

But we need to also acknowledge the limitations of knowledge (data) alone as a force for change. While Carnegie's *The Path We Tread* was an essential contribution to the historical literature on Black nurses, it was the activism of the later 20th century that produced substantive change. Nursing needs to confront the historical tension between its belief in education as a force for good and the need to actively engage in political and social struggles for a more just and equitable discipline and society.

History suggests that we should not be timid, and that we should forthrightly name the issue of structural racism. Language is important – and we might no longer hide behind an admittedly successful strategy that allowed many individuals their own unspoken definitions of what was to be achieved.

We do not and should not diminish nursing's successes. As this historiographical essay argues, we need to think about nursing not only as a particular form of work, but also as a form of work that carries particular meanings – ascribed to it both by those who do the work and by its larger social, political, and structural context. It also provided opportunities to many from a variety of different backgrounds seeking ways to both do good and do well. We suggest that we can claim the good ... and acknowledge the problems, especially those that coalesce around race and racism. History does not suggest this will be easy. But we will be stronger doing the work required to make this a reality.



National Commission to Address
Racism in Nursing

REPORT SERIES

Report #2 of 6

Systemic Racism in a Contemporary Society



Report #2 of 6

Systemic Racism in a Contemporary Society

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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 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 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.

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.

THE 4 I'S OF OPPRESSION

IDEOLOGICAL Oppression

INSTITUTIONAL Oppression

INTERPERSONAL Oppression

INTERNALIZED Oppression

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

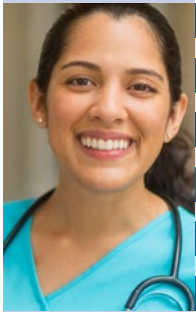
one is treated or viewed matters to every member of humanity. Thus, belonging to a profession that has the fundamental tenets of care, respect, and human rights yet treats certain members of its own in dehumanizing and structurally disadvantaging ways is hurtful. Once these acts occur, anything can be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

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.

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National Commission to Address Racism in Nursing – Contemporary Context Workgroup

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Report #3 of 6

How Does Racism in Nursing Show Up in the Education Space?



Report #3 of 6

How Does Racism in Nursing Show Up in the Education Space?

3	Introduction
4	THEME: Historical
8	THEME: Pedagogy
10	THEME: Access
13	THEME: Climate and Culture
15	THEME: Progression
18	Conclusion
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Introduction

Schools of nursing (SONs) are the front door to the nursing profession. Racial, structural, and institutional inequities that are embedded in nursing programs and schools have the most profound impact on the profession because of the expanded reach they have into the future of students who progress and those who fail, the nursing workforce, future nurse educators (NEs), and the health and well-being of our nation. It is important that NEs learn about our racist history and work to create climates and environments that are built on equity, human dignity, and equal service to all.

It starts with leadership. Once students enter our SON and programs, academic leaders must ensure that faculty are trained about the history of racism in nursing and taught how to develop curricula and course content that are pedagogically sound, are racially affirming, and promote an anti-racism ideology. Academic leaders, faculty, researchers, publishers, and social media platforms must evaluate all future publications, proposals, and communication to eliminate racist stereotyping of diverse populations. Our scholarship must be based on “biological markers” and not social constructs such as race, religion, gender, sexuality, etc. Nurse educators are compensated for their services to prepare and produce future nurses, and there is no place in the profession for structural and institutional barriers that block access and limit students and faculty progressions. Both student and faculty need support to be successful. Therefore, SON and university/college leaders will need to rethink how success is measured in both spaces.

Looking through a new lens, we invite you to review our work and provide critical feedback to inform this work and shape the future of nursing. It is our hope that you will join us in advocating for real change. Nurses cannot chart a path toward health equity until there is racial healing in the profession.

THEME: Historical

Goal statement: Recognize the roots of racism in nursing education, climates and environments that are built on equity, human dignity, and equal service to all.

Pre-19th Century

To recognize the metastatic nature of racism and how it presents in nursing today, one must painstakingly unearth the foundation that underlies the profession and dare to interrogate the racial caste system that shaped the discipline. In the early 17th century, racism emanated in the United States through a lens of white superiority that promulgated a false doctrine and erroneous rhetoric that alleged the congenital inferiority and worthlessness of individuals racially identified as Black (King, 1968). Race, a socially constructed marker, was sold as a biological construct that transcended generations (National Human Genome Research Institute, 2018). Racism became the vehicle through which discriminatory ideas, policies, practices, guidelines, and rules came together, were endorsed legally or de facto, and were driven by dominant voices across healthcare settings and the nursing discipline over multiple centuries (Hine, 1989; Carnegie, 2000). While rooted in slavery, racism is not a binary construct that exclusively encapsulates white dominance over Black disempowerment. Rather, racism continues to be operationalized by a subliminal and sometimes deliberate acceptance and propagation of negative stereotypical messages about historically racialized groups that serve to delegitimize and reduce their full humanity, limit access, fuel oppression, normalize unfair treatment, and sustain racial inequities through racist policies. It is against this backdrop that the genesis of nursing came to be.

The myth of “separate but equal” produced inequities regardless of where it was situated or when it was espoused. It was during the Crimean War in 1854 that Mary Seacole was denied an opportunity to join the team of nurses under the supervision of Florence Nightingale (Seacole, 2005). Nevertheless, Seacole cared for wounded men afflicted with diseases, although separately and without the government sponsorship afforded to Nightingale. Similarly, Jim Crow laws in the South denied access to higher education and economic mobility. However, Historically Black Colleges and Universities (HBCUs) emerged, albeit grossly underfunded, to address the inequalities related to racism. Booker T. Washington established and served as president of Tuskegee University in 1881. Tuskegee was the first HBCU and the first one to create a nursing program (Hine, 1989). Recognizing the need to create opportunities for African Americans and Blacks in the South and improve health care outcomes, HBCUs that had nursing programs began to emerge between 1890 and 1930 and included Dillard University, Florida A&M, Hampton University, and Howard University (Hine, 1989).

Racism was not unique to the South. In 1890, Emma Reynolds applied to every nurse training institution in Chicago and was denied access (Hine, 1989). Her story was not an anomaly (Carnegie, 2000). When the U.S. Supreme Court upheld the constitutionality of a state's Jim Crow law in *Plessy v. Ferguson*, in 1896, under the cloak of "separate but equal" systems, racial discrimination was affirmed in health care systems and nursing education. In the United States, beliefs that fueled segregation crossed state lines and prevented many students from accessing nursing. From 1890 to 1925, racial segregation and discrimination occurred alongside "an elite cadre of white nurse leaders" who gave "shape and guidance to the professionalization of nursing" (Hine, 1989, p. 89). The professional organizations, journals, and special body of scholarship created by white nurses were racially exclusive and reinforced the power of discrimination and segregation (Hine, 1989; Carnegie, 2000).

20th Century

In the first half of the 20th century, nursing was moving toward establishing formalized hospital-based training for nurses (Hine, 1989). The centuries-long existence of Black, Indigenous, and Latinx nurses, midwives, and other healers was systematically erased to make room for this new Victorian-era approach to nursing education, where nurses were expected to be "literate" and meet a cadre of preferred characteristics. This emerging preference for white Eurocentric attributes influenced the development of "professional" nursing standards that continue to be used to discriminate against racialized groups and perpetuate racism in nursing education (Baptiste et al., 2021; Hine, 1989; Niles & Drew, 2020; Theobald, 2020). By 1900, there were 432 nursing training schools, most of which were hospital-based programs. Hospitals and training programs for nurses remained largely segregated and rapidly overshadowed freestanding nursing programs in the United States (Hine, 1989). Though Black, Indigenous, and Latinx women had historically been responsible for nursing care in their communities, very few were admitted to nursing training schools (Hine, 1989; Moore & Drake, 2020; Theobald, 2020).

During the period from 1900 to the 1950s, nursing education continued to evolve toward a more standardized curriculum. In 1923, the Goldmark Report was published, stating that nursing education should occur in a university setting (Goldmark, 1923). As nursing education moved into academic settings, the number of advanced education programs increased, and nurses of color continued to be excluded through the racial gatekeeping that was pervasive in the beginning half of the century (Niles & Drew, 2020; Moore & Drake, 2021). Schools of nursing were not the only source of racial gatekeeping in nursing during this time. Nurses began to organize as a profession, with the first assembly of the Nurses Associated Alumnae of the United States and

Canada occurring in 1896. In 1911, the Nurses Associated Alumnae of the United States and Canada became the American Nurses Association (ANA). Once again, racialized nurses were excluded from participation. In 1916, the ANA required that nurses join the organization through their state organizations, which denied membership to Black nurses. Many states also prevented Black nurses from taking the examination to become registered nurses (Moore & Drake, 2021). Groups that were racialized were compelled to form their own professional nursing organizations. To address the specific needs of Black nurses, the National Association of Colored Graduate Nurses was formed in 1906 (Moore & Drake, 2021), and in 1916, the Association of Registered Nurses of Porto Rico was formed (Walsh, 2018).

In the 1950s and 1960s, a series of legal changes ended legal support for racial discrimination. In 1954, the U.S. Supreme Court ruled in *Brown v. Board of Education* that in the field of public education the doctrine of “separate but equal has no place” (Cornell Law School, 2020). *Brown* highlighted the nation’s racial caste system and set the stage for passage of civil rights legislation (Rothstein, 2014). As a result, de jure racial exclusion in historically white nursing institutions and organizations, which endured through the 1960s (Lewenson & Graham-Perel, 2020), eventually ended. In 1951, the National Association of Colored Graduate Nurses dissolved to integrate into the ANA (Staupers, 1961). Passage of the Immigration and Nationality Act in 1965 ended legal preference for immigrants from northwestern Europe (Masselink & Jones, 2014). Similarly, the ANA-sponsored Exchange Visitor Program, which had brought primarily European nurses to the United States before 1959, expanded to include nurses from other countries, particularly from the former U.S. colony the Philippines (Choy, 2003).

Although legal changes eventually had a significant impact on de jure racial discrimination, they had no power to abolish racist ideology in nursing and health care. Acceptance of scientific racism (beliefs in biological inferiority) contributed to nurses’ historic participation in the violation of racialized people’s human rights, such as occurred in the Tuskegee Experiment (Crenner, 2012) and the forced sterilization of thousands of racialized women in the 1960s and 1970s, and hundreds in the 2000s (Alonso, n.d.; Kardish, 2014). At the same time, scientific racism in nursing curricula and textbooks prepared a nursing workforce to deliver discriminatory care (Byrne, 2001; Jaschik, 2017), reinforcing the status quo of medical apartheid in America (Garber, 2020; Newkirk, 2016; Smedley et al., 2003). De facto racial exclusion in nursing organizations and mass human suffering caused by health injustice led to the formation of professional associations to represent the voices of racialized nurses and their communities, including Chi Eta Phi Sorority Inc., a professional nursing organization in 1932, the National Black Nurses Association (NBNA) in 1971, the National Association

of Hispanic Nurses (NAHN) in 1975 (NBNA n.d.; NAHN, n.d.), the Philippine Nurses Association of America Inc. (PNAA) in 1979, the Asian American Pacific Islander Nurses Association (AAPINA) in 1992, and NANAINA in 1993 (which unites American Indian/Alaska Native nurses and those who care for AN/Al people). Due to the ongoing lack of diversity, support, and progression in nursing, in 1998 the National Coalition of Ethnic Minority Nurse Associations (NCEMNA) was founded to provide a unified voice and force advocating for equity and justice in nursing and health care for ethnic minority populations. NCEMNA consists of five national ethnic nurse associations: AAPINA, NANAINA, NAHN, NBNA, and PNAA.

In the post-civil rights era, nursing education deployed policies that failed to readdress its white supremacist foundations, resulting in reproduction of the pre-civil rights racial hierarchy. These seemingly race-neutral approaches obscured how white supremacist power relations cultivated inequality and oppression, enabling continuation of the status quo (Koschmann, Jeffers & Heidari, 2020; Jones, 2014). Examples include accreditation standards for nursing programs that failed to mandate equity (Hassouneh, 2018) and criteria for selection of National League for Nursing Centers for Nursing Excellence that disregarded the need for anti-racist change to achieve excellence. Similarly, the American Association of Colleges of Nursing (1997) has historically expressed support for diversity, equity, and inclusion (DEI) without engaging in the substantive anti-racist policy change efforts needed to create equal outcomes across groups. Thus, the construction of standards for education and of problems and their solutions by nursing educational institutions and organizations obscured the operations of white supremacy while maintaining the status quo of racial hierarchy in the profession.

Nursing's most recent history in the 21st century reveals some progress in changing the predominantly white female leadership of the American Nurses Association and other organizations. Of the first 35 ANA presidents, two were Black women: Dr. Barbara Nichols, elected in 1978, and Dr. Beverly Malone, elected in 1996 (Waite & Nardi, 2019). The election of Dr. Ernest Grant heralded the election of the first Black male president of the ANA, in 2014. He is currently serving his second term. However, at the state level, many of the ANA's affiliate chapters have yet to elect a nurse of color as president.

THEME: Pedagogy

Nursing curricula and pedagogy have historically centered on the experiences of people who are white-identifying and failed to ensure that content and methods for teaching are racially affirming, promote an anti-racism ideology, and mitigate anti-Blackness. This is evident in the pedagogical approach used to address cultural competency, where a variety of races and ethnicities are discussed in nursing textbooks and peer-reviewed journals. It is common to see stereotypes being taught through patient-provider scenarios, case studies, and simulations, and in the clinical setting.

Nursing textbooks are commonly written without references to or input from highly skilled scholars from minoritized groups. The omission of diverse perspectives and lived experience results in educational materials that perpetuate stereotypes and nonscientific, biased beliefs about Black people. The use of race as it relates to medical diagnoses and treatment reinforces disproved notions about being Black or of African descent as a biological construct and contributes to ongoing racial disparities in health care (Bach, 2003). In fact, race is an insufficient proxy for genetic ancestry, and science has demonstrated that race is a social category with no basis in biology (Lee, 2009).

Despite the significant efforts to analyze the interlocking systems of inequitable access and discrimination in healthcare, nursing education tends not to include an anti-racism pedagogy in its curricula (Hassouneh, 2006). Nurse educators should become proficient in and knowledgeable about social determinants of health that are structurally, institutionally, and politically based as they prepare the future nursing workforce to provide culturally informed, congruent, and safe care for an increasingly diverse population.

In addition, educators play a fundamental role in the academic success of students and their ability to operationalize the profession's value of social justice. Equity pedagogy is one approach to teaching and learning that supports the academic achievement of all students. According to Banks (2006), "an equity pedagogy exists when teachers modify their teaching in ways that will facilitate the academic achievement of students from diverse racial, cultural, gender, and social-class groups" (p. 18). Effective educators learn to utilize a range of pedagogical strategies to meet the needs of a range of learners. Three examples that support the three domains of learning – cognitive, socio-emotional, and skills

and behaviors (Bloom & Krathwohl, 1956) – are (1) cooperative strategies rather than competitive strategies, to help students develop positive racial attitudes; (2) narrative pedagogy, which allows students to build on lived experiences and supports relevance; and (3) culturally responsive teaching, which is “an umbrella term for pedagogies that prepare students to support social justice in and beyond the classroom” (Day & Beard, 2019, p. 279).

Recommendations

- 1. Develop programmatic outcomes for DEI and anti-racism.**
- 2. Assess curriculum for DEI, and revise. Consider policy modification.**
- 3. Assess educational resources for bias, especially textbooks.**
- 4. Assess for, develop, and ensure access to DEI educational resources – provide supplemental DEI educational resources as needed.**

THEME: Access

Goal: To promote an equitable and inclusive academic environment (culture and climate); students, staff, faculty, and administrators need access to people, resources, and opportunities to make a meaningful impact and drive optimal success.

To promote an equitable and inclusive academic environment (culture and climate) where students, faculty, staff, and administrators are successful, each group needs access to people, resources, and opportunities. Within the academy, these groups have a synergistic relationship, meaning that the successes or challenges of one influence the other, as well as the overall mission of an institution of higher learning. Although they work together, each is discussed separately in terms of tools for success: people, resources, and opportunities.

Students

To support BIPOC (Black, Indigenous, and people of color) nursing students, we must set a standard that cultivates an environment of equitable and inclusive excellence along with purposeful development of resources that foster the success of all students (Williams, 2020). Nursing schools must be intentional and committed to cultivating an equitable and inclusive environment that affords students access to culturally proficient faculty, staff, and opportunities to achieve superior academic outcomes, reinforced by anti-racist policies and pedagogies. There should be access and opportunities for students to engage with nursing faculty with diverse experiences and role preparation such as nurse researcher and nurse executive/leader. BIPOC nursing students should also be provided with a sustainable and comprehensive safety net including elements such as mentoring, early access to financial support, current technology, mental wellness practitioners, healthy food, and safe and affordable on/off-campus housing. Access to nursing education should be financially accessible. Holistic admissions should be considered a successful strategy for developing a diverse student population with measurable diversity outcomes for students, staff, and faculty. On the national level, nursing education accrediting bodies should implement standards requiring holistic admissions review of all nursing programs with measurable diversity outcomes for students, staff, and faculty. Unlike other health profession education organizations, there are no nursing education accrediting bodies that currently require this.

Staff

Staff provide the support and infrastructure for members of the academic community when it comes to equitable and inclusive excellence. Staff are vital front-line personnel that facilitate the advancement of the academy's mission. For example, staff may be the first resource for students applying to nursing school or remaining in a program because they may be advising students. Historically, we know the discordance arising from the interactions of culturally inept staff and nursing faculty with BIPOC nursing students. Williams and colleagues (2005) describe an equitable and inclusive excellence scorecard that includes campus climate, with competent staff willing to help set the tone of the culture, commitment, and communication through the academic environment that students must navigate. Just as in other parts of the academy, staff should be empowered to bring their whole selves to work, with opportunities for success. Staff success includes access to people, resources, and opportunities to make a meaningful contribution to inclusive excellence.

Faculty

BIPOC nursing faculty members face unique challenges compared to white nursing faculty members. Therefore, an evidence-based, strategic support plan is needed to move these faculty toward success ("Three Strategies to Support Minority Faculty," 2018). The plan includes access to people, resources, and opportunities. BIPOC faculty need access to collaboration opportunities with other faculty members who share the same ethnicity and culture. These relationships provide an accepting space for faculty to share experiences and decrease feelings of social isolation while enhancing a sense of belonging. Bidirectional conversations between BIPOC faculty can help these educators express their experiences with microaggressions and bias in the workplace ("Three Strategies to Support Minority Faculty," 2018). Access to senior-level minoritized faculty and allies to promote faculty development and exposure to resources is crucial for success in the academy as teachers, scholars, and servant leaders.

Administrators

Executive leadership is critical to ensuring racism is addressed within the academy. Williams and colleagues (2005) convey that administrators are most important to cultivating and driving organizational change in the academy. They set the tone for communicating the vision, building capacity, and attracting and allocating resources to make ensure inclusivity. Depending on their role, administrators have significant responsibility in supporting academic inclusive excellence because they often control the necessary resources for student, faculty, and staff success. Not unlike other workplaces, academic administrators set the tone for the culture and climate of an organization. The optimal culture would embrace, expect, and tolerate nothing less than an inclusive environment for all stakeholders. To access people, resources, and opportunities for themselves and stakeholders, Kalargyrou and Woods (2009) stated that administrators need communication, diplomacy, and human resources skills to develop collaborative and collegial relationships among staff and faculty. Executive leadership should be accountable for strategically rooting out racism in the academy, ensuring that there is equity and reward systems throughout.

Summary

With access to people, resources, and opportunities, individuals can contribute to the academy's success while also experiencing a sense of value and belonging. All stakeholders in an inclusive academy will contribute to and expect a culture that embraces the importance of communication, diplomacy, empathy, humility, and respect.

THEME: Climate and Culture

As early as pre-school, distinct variabilities occur in school performance between minoritized groups and their peers (Voight, 2013). Almost half of all college students who enter a four-year postsecondary institution will fail to complete a bachelor's degree within six years of entering higher education (U.S. Department of Education, 2012). In addition, BIPOC nursing students face substantial racial and ethnic disparities in college persistence and degree attainment.

Climate and culture are concepts that help to describe the internal environments of organizations and institutions. Culture refers to the deeply embedded patterns of organizational behavior and the shared values, assumptions, and beliefs that members have about their organization or its work. Climate is generally thought to focus on patterns of behavior or formal activities in an institution that can be observed directly and objectively. Examples include but are not limited to certain practices, policies, procedures, and characteristics. Climate is often related to governance and decision patterns, teaching and learning processes, participant behaviors, effort and interaction patterns, and work patterns. Therefore, climate is considered to change more rapidly compared to culture.

Nora and Cabrera (1996) conducted a quantitative analysis of 831 students at a single predominantly white institution and found that students of color reported more negative campus climates, higher levels of discrimination by faculty, and greater insensitivity in the classroom than their white peers. These are common negative behaviors experienced by BIPOC nursing students enrolled at predominantly white academic institutions. Developing diverse, equitable, inclusive, and accessible environments where there is a collective sense of belonging and all individuals thrive and do their best work is critical to achieving academic nursing's goals related to diversity, equity, and inclusion. When students feel valued, respected, and welcomed by their classmates and peers, they report experiencing a stronger bond to the greater campus community. In this environment, students feel safe enough to share experiences, engage in thoughtful discussions, and offer support to others. Peers can also help buffer the effects of a negative classroom relationship with a faculty member (Sidelinger et al., 2011).

By developing a better understanding of how learning environments are impacting student success, educators can be equipped with valuable information to initiate change, target areas of growth, and, most important, improve student outcomes. Hence, the examination of climate and culture is a key element in mitigating racism in nursing education.

Recommendations to Build Inclusive Learning Environments

The National Academies of Sciences, Engineering, and Medicine (2021) recommends the following:

- 1. Assess all organizational policies for diversity, equity, and inclusion best practices.**
- 2. Build an organizational anti-racist climate by routinely assessing the perceived racial climate as well as the cultural competence of faculty, staff, and students, and promote cultural competence of faculty, staff, and students. Assess student bias against faculty of color.**
- 3. Provide anti-racism training resources and create open and safe spaces for action-oriented conversations.**
- 4. Build the infrastructure and allocate resources to support underrepresented and disadvantaged students, faculty, and staff. An example of structural resources is the existence of departmental groups and clubs that are inclusive of people of color. These groups could include faculty, staff, and students.**

THEME: Progression

Related goal: 1. Advocate for equity in educational outcomes for racially minoritized students in access, retention, and degree completion. (Student Focused)

Related goal: 2. Ensure equitable structures and opportunities that foster pathways to increase the recruitment, retention, and progression of faculty of color and leaders in schools of nursing. (Faculty and Administrator Focused)

Overview

Ensuring student, faculty, and administrator progression requires understanding of systemic patterns of disparity in order to address and eliminate barriers and remove participation gaps as part of an intentional strategy to improve student progression, faculty progression, and administrator progression (Accreditation Board for Engineering and Technology, 2021). Intentional restructuring of academic environments that focuses on transparent policies, processes, and resources provides equitable access to resources that empower students, faculty, and administrators to be successful in their progression pathways. To mitigate systemic racism embedded in nursing education, the work group focused on systems, processes, and resources that can support students' progression through their programs of study. Likewise, faculty and administrator progression can be supported by the implementation of systems, processes, and resources for role transition and role development.

Operational Definitions for Progression

- 1. Student progression is the pathway to degree or certificate completion from the point of admission through program completion. Student progression encompasses retention and focuses on *how* students proceed through programs of study. Student progression includes systems, processes, and resources that assist students through their programs of study.**
- 2. Faculty progression is the pathway to role acquisition and includes systems, processes, and resources that support faculty success for transition in the faculty role. Faculty progression starts on the first day of employment and proceeds throughout the employment period.**
- 3. Administrator progression is the pathway to role acquisition and includes systems, processes, and resources that support administrator success for transition in the administrative role. Administrator progression starts on the first day of employment and proceeds throughout the employment period.**

Resources

Resources to support student progression include, but are not limited to, robust orientation/mentoring processes, holistic admission/transfer pathways, targeted and intentional engagement/socialization (internal and external), faculty and peer mentoring, academic strengthening mechanisms, comprehensive student support services, flexible learning options, and nonacademic support (e.g., fiscal and childcare). Resources to support faculty and administrators include, but are not limited to, adoption of comprehensive onboarding processes, engagement/socialization (internal and external), peer mentoring, professional development for role development, academic support, leadership support, and other support (e.g., childcare).

Recommendations

In addition to implementation of the resources identified previously, schedule regular review (monitoring) of systems, processes, and resources for student, faculty, and administrator progression to identify implicit bias, and take measures to correct biases. Engage college/university leaders, faculty, staff, and students in conversations directed toward addressing explicit and implicit bias and anti-Blackness, and to foster inclusiveness. Encourage faculty to discuss equity in student resources and faculty resources that are linked to success, as well as academic equity and access to resources. Provide faculty and administrator development to prepare faculty and administrators for implementation of learning experiences that decrease non persistence in students. Maximize educational capacity by establishing partnerships with communities of interest to build collaborative initiatives that engage students, faculty, and administrators. Implement reporting systems for students, faculty, and administrators' documentation of aggressions and microaggressions for investigation. Establish workload policies that provide equitable research opportunities and leadership opportunities for faculty and administrators. Remove barriers to research tracks. Additional recommendations are listed in Table 1 – Student Systems, Processes, and Recommendations and Table 2 – Faculty and Administrator Systems, Processes, and Recommendations.

Table 1. Student Systems, Processes, and Recommendations

Systems	Processes	Recommendations
Student Admission (inclusive of transfer pathways and matriculation); Advisement	Marketing/Advertisement Orientation/Mentoring	Engagement/Socialization Strategic Internal/External Partnerships (e.g., sororities and fraternities) Faculty Mentoring Peer Mentoring Affinity Groups
Instructional Modalities	Flexible Learning Academic Support	Flexible Learning Options Retention/Learning Specialist/ Inclusion Liaison/Engagement Specialist for Academic/Content Support Referrals to Community Support Administrative Support Adjunct/ Visiting Faculty
Nonacademic Support	Nonacademic Student Support	Foundations Scholarships Population-Specific Grants Grant Writers Childcare Referrals to Community Support

Table 2. Faculty and Administrator Systems, Processes, and Recommendations

Systems	Processes	Recommendations
Employment/Hiring	Onboarding Mentoring	Engagement/Socialization Peer Mentoring (faculty/administrator and organizational leadership; inclusive of the tenure process)
Professional Development (role, research, specialty, and leadership)	Professional Development Selection	Professional Development (role, research, specialty, and leadership) Faculty/Administrator Fellowships
Support (academic and other); Use of Supportive Services	Support (academic and other)	Administrative Support Grant Writers Teaching/Learning Centers for Excellence Childcare
Promotion/Tenure; Participation in Pre-Promotion/Tenure Workshops and Mentoring	Promotion/Tenure	Mentors, Mentoring of Minority Faculty Including Scholarship and Orientation to the Academic Culture by Minority Scholars Administrative Support Teaching/Learning Centers for Excellence Development Funds for Grant Writing, etc. Research Funds

Conclusion

We need leaders to commit to “real change” who are ready to view their systems from the edge of chaos, not just to innovate, but to eliminate. Diversity among leaders is needed to break down racial barriers. Leadership and educators must be representative of the nursing students for whom we are trying to break down barriers. Our call to action is that academic leaders move beyond hiring DEI officers and seek to mandate the implementation of anti-racist environments and create a sense of belonging among faculty and students. Belonging is defined as the ability to be one’s authentic self both professionally and personally with respect to culture and the lived experience without being labeled as aggressive while others are considered compassionate. The work assigned to these positions appears to focus on “training” around the concepts of diversity, equity, and inclusion, and, to a small extent, tolerance. Diversity is the “low-hanging fruit” of the analytical profile of differences in the organization. It is easy to measure and is ideal for developing dashboards that are then translated to mean organizational excellence (Dawson, 2021). On the other hand, equity is about fairness and justice in the workplace, ensuring that every person is going to have access to and receive the resources and support they need to achieve and be their best self (DeConinck, 2010). It is about the impartiality of decision-makers and leaders in the organization.

Organizations must perform the baseline work to identify leaders’ “workaround” practices. This may mean evaluating and addressing organization equality and equality practices, which is different from the social policy view of equality that focuses on equality among race, ethnicity, gender, and other societal or human characteristics. Organizational equality and equity together describe a state of being treated equally in pursuit of professional status, progression in one’s career, promotional opportunities, compensation, rights to share in nonmonetary benefits, and the right to have more than just a seat at the table, but to also be heard. SONS should include internal and external comparison and assessment of their policies and practices. For example, they should examine why most major universities consider a 70-point earned grade to be a passing C, while many programs with a large minority student population require 75 points or higher to receive a C grade, or in the worst case they consider a C a failing grade, thereby increasing the time to reach graduation and the economic debt of these students.

Finally, there is the question of inclusion, or, as some authors and organizations are defining their culture, of “belonging.” Glassdoor Team (2021) defined belonging as the ability to be one’s authentic self both professionally and personally with respect to culture and lived experiences. It is the ability of the organization to support and allow the individual to show up and connect with its mission, vision, and values without being asked to change to fit who the organization thinks the individual should be. The lack of BIPOC health professionals is compounding the nation’s persistent racial and ethnic health disparities. We recommend that predominantly white institutions implement sustainable measures that foster equitable access for BIPOC nursing students and educators to have a curriculum and a faculty workplace environment that does not attend to the social construction of difference with nonoppressive standards.

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Report #4 of 6

How Racism Shows Up in Policy



Report #4 of 6

How Racism Shows Up in Policy

- 3** Introduction
- 5** Key Themes — Policy
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Introduction

AUTHOR'S NOTE: The commission's four work groups (education, practice, research and policy) were tasked with identifying three to five key themes that reflect how racism is present in the assigned area.

Policies — a set of ideas or plans that guide programs or thinking at the organization or government level — are ever present in our daily lives, guiding or putting boundaries around our actions and decisions both at home and most certainly in the workplace. The question under consideration is how racism within the nursing profession shows up in the sphere of policy development and implementation. Consider the following:

- How do policies impact the ability of someone to enter the nursing profession?
- How do policies either promote or prevent someone from thriving within the nursing profession?
- How are the development and implementation of policies informed by a broad array of stakeholders who are impacted by those policies?
- What are the potential unintended consequences when policies are made absent broad stakeholder input?

Fundamentally, it is necessary to consider how policies — both historical and those under development — may perpetuate racism within nursing. The focus of this document is not on specific policies but on three key themes that contribute to and perpetuate racist policies and two conditions that influence the outcome of the policymaking process. Other documents that are part of this series cover specific policy concerns that may be present in the areas of nursing education, practice and research.

Dr. Ibram X. Kendi (p.274, 2019) defines a racist policy as “any measure that produces or sustains racial inequity between racial groups. By policy, I mean written and unwritten laws, rules, procedures, processes, regulations and guidelines that govern people.” Because of biases that are brought to any policymaking endeavor, Kendi further notes that “there is no such thing as a nonracist or race-neutral policy.” Unfortunately, the nursing profession is no different from other professions that are steeped in policies that have racist legacies or current thinking that perpetuates decisions and actions that harm nurses of color. Nursing’s professional code of ethics, “Code of Ethics for Nurses With Interpretive Statements” (ANA, 2015), calls on each of us individually and as a collective to:

- Practice with compassion and respect for the inherent dignity, worth and unique attributes of every person.
- Promote, advocate for and protect the rights, health and safety of patients.
- Establish, maintain and improve the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.
- Collaborate with other health professionals and the public to protect human rights, promote health diplomacy and reduce health disparities.
- Articulate nursing values, maintain the integrity of the profession and integrate principles of social justice into nursing and health policy.

(Provisions 1, 3, 6, 8 and 9)

Key Themes — Policy

While not all-encompassing, the three overarching themes discussed below exemplify key challenges related to racism and policy. The nursing profession has been a participant — whether knowingly or unknowingly — in creating and implementing policies that have perpetuated racism and created inequities across all aspects of the profession and those we serve.

THEME 1

Racism is perpetuated through the systemic and structural nature of policy.

THEME 2

The application and implementation, whether through explicit or unwritten rules, can aggravate the racist impact of any policy.

THEME 3

Policies typically reflect the voices in the room. Lack of diversity or only token representation of individuals of color or representatives from impacted communities preserves a singular point of view: that of the dominant culture making the policies.

Nursing in the U.S. has a legacy of policies that grew out of Eurocentric thinking plus our country's own racial history. As part of broader society and systems, nursing has contributed to the hardwiring of biases and other norms into policies that have harmed nurses of color and patients, families and communities, nor has nursing challenged the larger system or entities that established the policies that resulted in racism. Nursing has also established policies that may have been well intentioned but likely resulted in marginalizing nurses of color. For example, the policy position of baccalaureate as the required degree for entry into nursing practice had an underpinning in evidence but did not take into account the impact that this policy had on nurses of color who were interested in entering the profession. One likely consequence of this policy position was the marginalization of community colleges and other educational avenues, while at the same time university-based education was not fully accepting of students of color.

“It is not that [racism] is always overt. It's more of institutional, structural and cultural racism that exists in nursing.”

Anonymous Quote, 2021 Racism Survey

“The power in nursing is primarily held by middle-aged to old white women who have just recently begun to consider racism in nursing care. There are racist principles that have been carried down through history and never challenged.”

Anonymous Quote, 2021 Racism Survey

One of the challenges and barriers identified during listening sessions convened in 2021 by the National Commission to Address Racism in Nursing described how racist thoughts “transcend into acts of discrimination and oppression that results in disparities in advancement, lack of inclusion in decision-making processes and inequities in compensation.” Policies intended to be applied regardless of race are placed into the hands of leaders, managers, employers and others whose own biases can impact the application of the policies. Other barriers include criteria and processes that are thought to be necessary yet tend to exclude or are a deterrent to a nurse of color successfully navigating the policy.

“Why should any Black nurse go back for a Ph.D. or D.N.P. degree [when they] will never get hired or promoted even with a D.N.P. degree or Ph.D.?”

Anonymous Quote, 2021 Listening Session

“I feel that I have been overlooked for promotions that have been extended to white counterparts who were less experienced and educated. It’s discouraging to feel left out and not appreciated because of race.”

Anonymous Quote, 2021 Racism Survey

Having the right voices and subject matter experts at the policymaking table has long been a challenge for the nursing profession. Not only is it necessary to include a broad variety of voices at the table, but sufficient representation is also needed to avoid tokenism and the expectation that one individual can and should represent the entirety of a profession or race and ethnicity.

These are just a few of the challenges associated with an equitable policymaking process. The goal must be the systematic evaluation and revision of existing policies, the development of new policies and the implementation of all policies that adhere to principles of antiracism, inclusion, equity and social justice.

Overarching Contexts

Policymaking is ultimately about leadership, power and decision-making authority. Who has the power to decide that a policy is needed and subsequently determine who is in the room to contribute to the development of the policy? And who decides what the final policy will be? There are policies that nursing controls and there are policies developed by others that govern what nurses do. As a profession, nurses and nursing must commit to engaging in a fully informed policymaking process that is inclusive and not only considers but also prioritizes equity and justice. Two key conditions that contribute to the success or failure of the development and implementation of antiracist policies are leadership and culture.

Nursing leaders are essential to either creating a culture of inclusion or advocating for different approaches to policymaking that creates an open and trusted environment. The “Future of Nursing 2020-2030” report (NAM, 2021) notes that nurse leaders must play an important role in dismantling structural and cultural racism while addressing discrimination based on identity.

Culture or the environment in which the policy is being developed will also impact the drive for antiracist policies. An environment of openness and trust and a sense of belonging will foster engagement in the policymaking process.

All nurses are called to engage in policymaking and to be advocates. This advocacy extends to addressing existing policies and new policies under development, and to actively engage with the way policies are being made with the voices at the table.

“We also have to create avenues for others, recognizing the value and worth of what we bring. Experience is a formidable teacher.”

Anonymous Quote, 2021 Listening Session

Conclusion

Each of the three themes identified have a positive, antiracist alternative. Achieving the alternatives rests on all of us. Nursing leaders have a significant obligation to create a culture that engages in significant inquiry while policies are being developed to ensure a full exploration of potential consequences that may result from implementing those policies. More importantly, nurse leaders must engage with nurses — particularly nurses of color — to ensure that all points of view are welcomed into the discussion and heard. Ultimately, nurse leaders and nursing must be held accountable for the policies that govern nursing practice and the profession.

Affirmative Key Themes — Policy

- | | |
|----------------|---|
| THEME 1 | Equity and justice can be perpetuated through the systemic and structural nature of policy. |
| THEME 2 | The application and implementation of any policy are equitably administered as measured by equal outcomes across groups. |
| THEME 3 | Diversity of people and thought, plus the equitable inclusion of all stakeholders, will broaden the policymaking lens and support the development of antiracist policies. Every effort must be made to amplify the voices most impacted by those policies. |

Finally, nursing leaders, nurses and the collective nursing profession must commit to rooting out racism within existing policies and advance new policies that affirmatively address past harms while also advancing the needs of the profession, patients, families and communities. Tools grounded in a framework of equity and justice are also needed to guide the development and implementation of antiracist policies within the profession.

“As nurses, we need to unlearn much of what we thought we knew about racism and get comfortable being uncomfortable about our profession and our own way of being ... [we] need to see nursing through a new lens and be open to what we might see versus stating that racism does not exist.”

Anonymous Quote, 2021 Racism Survey

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National Commission to Address
Racism in Nursing

REPORT SERIES

Report #5 of 6

Racism in Nursing Practice



Report #5 of 6

Racism in Nursing Practice

- 3** Work Environment
- 5** Dual Harm
- 7** Inequity of Policy, Practice, Opportunity
- 7** BIPOC Workforce Recruitment, Retention and Career Progress
- 7** Worksite Policy
- 8** Nursing Burnout
- 9** Breach of Ethical Obligations
- 11** References

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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National Commission to Address
Racism in Nursing

REPORT SERIES

Report #6 of 6

Racism in Nursing Research Themes



Report #6 of 6

Racism in Nursing Research Themes

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Thematic Discussions on How and Where Racism Shows Up in Nursing Research

Racism has negatively impacted nurses, nurse researchers, the nursing profession, and patient outcomes. Over the past decade, the growth in Ph.D.-prepared compared to DNP-prepared nurses has been slower, particularly among Black, Indigenous and people of color (BIPOC) nurses, which has implications for nursing research since Ph.D.- and DNP-prepared nurses are needed as nursing faculty and contributors to research addressing health inequities (National Academies of Science, Engineering, and Medicine, 2021). Despite a growing number of nurses from racial and ethnic minority groups attaining doctoral degrees, the lack of diversity in leadership – especially at the executive level – or at decision-making tables has created systemic and institutional barriers for aspiring and seasoned nurse researchers from minoritized groups. According to a study by the National Institute of Nursing Research (NINR), almost 50% of NINR grant recipients were not minoritized nurses with white women recipients being and remaining the dominant race and gender (Kippenbrock & Emory, 2021). In this study sample of 135 grant recipients, only 6.8% of grants were awarded to Latinx nurses, with Black and Asian nurses as the lowest racial recipient group (4.1%) (Kippenbrock & Emory, 2021). These concerns underpin the need to prioritize research on racism, equity, and health disparities, which would be improved by diversifying funded recipients. Race must be recognized and understood as a sociological construct impacting the growth and development of minoritized nurse researchers and removed as a barrier to allow for health inequities in socially disadvantaged communities to be effectively addressed. Unfortunately, nursing research typically focuses on downstream and midstream factors, validating the importance of this Commission’s focus on upstream factors.

Dismantling structural racism in nursing research starts with addressing its roots. Structural racism has far-reaching effects and impact, ranging from its manifestations in nursing curricula to admission practices (e.g., SAT, GRE scores) that disadvantage students from minoritized and historically disadvantaged groups seeking to enter research training programs (Roberts et al., 2021). Additionally, there is an underlying perception by minority nurse researchers of having to take on additional uncompensated tasks to advance or improve diversity and inclusion at their institutions (referred to as the minority tax) or submergence which is “flying under the radar,” particularly if they do not hold institutional power and privilege.

Traditional research inculcation required methodologies that were discrete, answerable questions, with attainable samples of these restrictions providing set answers but consequently failing to illustrate the broader issues inherent in design and implementation of human research that shifts from inquiry to impact (Lyon, 2021). The themes below emerged from a nine-question survey to collect qualitative data from 19 nurse participants – 10 in practice and nine in academia – on how racism manifests in nursing research and how these issues can be addressed.

Top Themes Identified

There is a lack of funding and access for minoritized nurse researchers to conduct research.

Funding is crucial to shift the nursing research paradigm. Minoritized researchers are not awarded funding at the same rate as white researchers, which is evidenced in funding disparities (Hoppe et al., 2019). Studies that seem to benefit white populations are prevalent, with race being listed as a risk factor, at the expense of further marginalizing minoritized groups. Federal and private research funding must be intentionally directed and focused on how racism has impacted nursing research. Funding would also provide support for examining and exploring registered nurses' (RNs) experiences of racism in the nursing workforce. Such efforts could also prioritize equitable advancement policies and practices to ensure RNs from minoritized racial and ethnic groups equitably ascend into the higher nursing ranks. Dedicated financial support also creates an avenue for effective and unconventional partnerships, such as engaging community leaders including but not limited to those from faith-based organizations, nonprofit organizations, and community activism groups. Efforts must be made to support studies investigating the impact of racism on nursing education, research, practice, leadership, and care delivery. To address access to funding and support for research by minoritized groups, funding bodies and boards must have representation of people from minoritized populations.

Systemic and institutional roadblocks exist with decision-makers, institutions, academia, publishing, and governmental agencies.

Racism shows up in career development, funding, education, and conduct of research. Representation from racial and ethnic minority groups is critical at governmental agencies like NINR and other funding sources that decide on and disseminate funding. Additionally, students from racial and ethnic minority groups experience hostility in predominantly white nursing schools from white faculty, staff, and

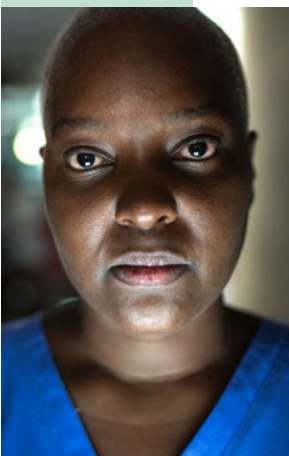
students (Whitfield et al., 2017). Already vulnerable minoritized nursing students also experience microaggressions and racial battle fatigue. Academic institutions must engage faculty from racial and ethnic minoritized groups who tend to be knowledgeable of racially and ethnically diverse university communities to develop plans to create equitable and nondiscriminatory spaces with agency, true intent, and initiative (Arnold et al, 2016). All faculty regardless of background should be encouraged to work together to find sustainable solutions. It is also important that all research funding entities, both federal and private, address policies and practices that support the repeated allocations of research funds to predominantly white schools of nursing (PWSOs), allowing them to build research departments larger than those of many Historically Black Colleges and Universities (HBCUs).

Health equity research is more extensive, fully culturally interpreted, and understood when people from racial and ethnic minority groups conduct research in communities that reflect their racial and ethnic identities. It also moves the dial from curiosity or a short-term “flash in the pan” exploitation to an actual long-term investment and commitment to improve access to resources and to employment-related and health outcomes in underserved communities. Upstream impact on nursing research starts with diversifying individuals at various decision-making tables of institutions and agencies that educate, cultivate, support, and disseminate nursing research conducted by nurses from racial and ethnic minority groups. It is critical that we acknowledge the interconnectedness of these issues that are part of the pervasive and systematic racism in nursing.

Lack of diversity among nurse scientists and researchers at PWSOs impacts the pipeline. In nursing education, most associate and full professors are non-Hispanic white women, while Black and African faculty occupy mainly instructor and assistant professor roles (Aycocock et al., 2021). Systemic barriers prevent faculty from racial and ethnic minority groups from ascending to higher levels of rank and/or leadership in nursing academia. Based on 2016 data from the American Association of Colleges of Nursing (AACN), only 15.9% of full-time nursing faculty come from racial and ethnic minority groups, with only 186 professors from minoritized backgrounds compared to 1,827 white professors (AACN, 2017). In a field of predominantly white leaders who are key decision-makers, hypervisibility (bearing representation responsibility) and invisibility (lack of acknowledgment by white peers) present occupational

hazards including racial battle fatigue (Cooke et al., 2021). These issues compound a cultural obligation among racially and ethnically minoritized nurse scientists to conduct research that highlights and exposes issues in their own communities, while feeling conflicted with further contributing to race based clinical care versus individual based care and data discrimination within systems that are hazardous to those researchers' own health and well-being (Cooke et al., 2021). It is important for racially and ethnically minoritized nurse researchers to conduct research to address health inequities; otherwise, methodologies and analyses can become decontextualized, whitewashed, inequitable, and mis-framed. The majority of data collection instruments need to be decolonized, as they were developed to study Western and white populations, which can be more self-serving for researchers serving the “publish or perish” culture – i.e., as research publications grow, underserved populations and communities continue to perish (Cooke et al., 2021).

A lack of racially and ethnically minoritized nurse researchers in turn shrinks the pool of diverse mentors to whet the appetites of future or aspiring nurse researchers from racial and ethnic minority groups. Furthermore, the current environment reduces interest in nursing research as a career among such future or aspiring nurses. Mentorship is critical for effective pairing for research competency to be achieved with aspiring minoritized nurse researchers and for a consistently diverse research participant pool that will eliminate harmful race-based healthcare based on inaccurate assumptions and algorithmic colonialism.



Minoritized nurse researchers feel devalued, experiencing hostility, microaggressions and feeling unsafe. The devaluation, covert and overt hostilities, and microaggressions toward minoritized nurse researchers must be understood to be addressed. Nurse researchers' “fly under the radar” survival approach has been normalized for far too long as nurses from racial and ethnic minority groups must be psychologically safe to conduct research that is not based on what is tolerable or desirable by decision-makers. The opportunity cost of the current system has directly impacted the professional and personal lives of nurses and the communities that nurses should equitably serve.

Strategies and Next Steps

Deficit funding for racially and ethnically minoritized nurse researchers, systemic and institutional roadblocks, lack of diversity of nurse scientists and researchers, and marginalization of diverse researchers and research projects were identified as root causes for the lack of meaningful health equity knowledge development and subsequent impacts. We should no longer sustain a fraught system designed with health inequalities; a revision of that system is urgently required (Cooke et al., 2022). We must dismantle systems of exploitation of participants and communities of color in nursing research that favor individual career advancement, funding inequalities, lack of growth in health equity research, and biased institutional policies and practices by advancing the following strategies:

- 1) Create awareness of racism in nursing research and the impact on health inequities.
- 2) Assess for faculty from racial and ethnic minority groups' disengagement and burnout from the minority tax evidenced by overcommitment of responsibilities without recognition for the work, and fear of saying no out of fear of being excluded and/or of retaliation.
- 3) Address upstream structural racism by changing policies and diversifying based on race and ethnicity the decision-makers, review panels, committees, and research investigators.
- 4) Direct and provide access to funding.
- 5) Design anti-racist research methodologies and prioritize research on social determinants of health, health equity, health inequities, and health disparities.
- 6) Educate, mentor, sponsor, and fund more nurse researchers from minoritized groups.

In response to the question “Where Does Racism Show Up in Nursing Research?” we present key findings and recommendations related to increasing the number of nurse researchers from racial and ethnic minority groups and advancing an anti-racist nursing research agenda. The recommendations include the following:

- 1) Prioritize funding to support the research career development of current and aspiring nurse researchers from racial and ethnic minority groups.
- 2) Mitigate (or eliminate) systemic and institutional practices and policies that adversely influence the research career development and trajectories of nurse researchers from racial and ethnic minority groups.
- 3) Increase the number of racial and ethnic minority nurse researchers.
- 4) Eradicate hostility and microaggressions toward racial and ethnic minority nurse researchers.

When addressing these recommendations, it is imperative that a wide array of diverse stakeholders (i.e., no matter the race or role) work in tandem to mitigate racism across the entire nursing research continuum and to alleviate the impact of racism on the research interests, efforts, and career trajectories of nurse researchers from racial and ethnic minority groups. To identify where racism shows up in nursing research, one must simultaneously acknowledge the existence of racism in nursing education, administration, and practice. The implicit acceptance, and thus complicit support, of racism in our society is engrained in the institutional fabric of nursing and evident in nursing research. Increasing the number of nurse researchers from racial and ethnic minority groups is critical for addressing racism across the research continuum and advancing nursing science while reflecting the composition of the U.S. population and improving the health outcomes of populations from racial and ethnic minority groups. Thus, one recommendation is for federal and private grant funding agencies to prioritize funding to support the research career development of current and aspiring nurse researchers from racial and ethnic minority groups. This is particularly important for early to mid-career nurse researchers from racial and ethnic minority groups. As funding organizations (federal and private), nursing research societies, and others express an interest in increasing diversity and inclusion programs, calls for proposals should reflect a commitment to enhancing racial and ethnic diversity in the research pipeline to inform, implement, evaluate, and disseminate research using an anti-racist lens. We need more initiatives that focus on supporting the research career development of investigators from racial and ethnic minority groups; for example, the NINR previously funded the Mentored Research Scientist Development Award for Minority Investigators. This will encourage the development of qualified racial and ethnic minority nurse investigators in research settings who in turn can serve as role models and mentors for nursing students belonging to racial and ethnic minority groups. The NINR Strategic Plan Working Group Draft Framework is another example where dismantling structural racism will be critical for advancing nursing science and supporting the research career development of racial and ethnic minority nurse researchers at each career stage (NINR, 2021).

Funding agencies, academic leaders, journal editors, grant reviewers, and other key decision-makers should commit to mitigating systemic and institutional practices and policies that adversely influence the research career development and trajectories of racial and ethnic minority nurse researchers. Our survey's qualitative findings revealed that racial and ethnic minority nurse researchers encounter barriers when proposing

research projects that include a focus on structural racism or other topics of systemic oppression or inequities. Even though some improvements have been made in addressing lack of diversity in publication authorities, bias remains pervasive in the publication process from authors to peer reviewers to editorial board members and editors, indicating lack of representation of underrepresented racially and ethnic groups (Rouan et al., 2021). During the grant review process, there are concerns that some reviewers issue unfavorable reviews because they focus on the topic (e.g., racial injustice) instead of the science of the actual proposal. Funding agencies and organizations should immediately institute mission and vision statements and a strategic plan that incorporate principles and practices that support anti-racist research principles and policies. These barriers coupled with the lack of appropriate mentorship diminish a racial and ethnic minority nurse researcher's ability to establish a program of research compatible with their commitment to reduce health disparities and achieve health equity.

Removing systematic and institutional policies and practices that perpetuate racism across the entire research continuum is critical for ensuring that nurse researchers from racial and ethnic minority groups secure promotions and tenure in academia, sustain a program of nursing research and scholarship, and receive recognition for their unique contributions to advancing nursing science. Some barriers to pursuing a research career may manifest during the admission process when the GRE is required to enter a doctoral nursing program. Increasingly, some graduate programs have reconsidered this requirement, citing concerns about diversity and the exam's poor ability to predict success, both of which are of concern for underrepresented minorities (URMs). Some nursing programs have adopted a holistic approach to nursing school admissions, emphasizing equity and diversity with less focus on traditional test scores as a requirement for entry into a program (AACN, 2020; Glazer & Bankston, 2015). The adoption of a holistic admissions framework at the doctoral level has the potential to increase the numbers of URMs seeking admission into a Ph.D. nursing program, the research career degree in nursing. Further, the adoption of holistic admissions frameworks for entry-level nursing degrees can increase the pipeline of racial and ethnic minority nurses prepared to enter Ph.D. nursing programs (Wilson et al., 2019). DNP-prepared nurses are engaged with teams of researchers in the application of this research and are uniquely qualified as a bridge between research and the bedside, given their foci

and understanding of key concepts in organizational systems, translation of evidence into practice, implementation science, and research (Trautman et al., 2018). When we prioritize the conceptualization of racism and anti-racism in nursing, we are better positioned to advance nursing science and improve clinical care.

Noting the importance of disseminating scholarly publications, peer-reviewed journal publishers have instituted new guidelines for writing, reviewing, and publishing scholarly work in recent years. For example, in 2021, the journal *Advances in Nursing Science* issued new author guidelines to include an anti-racist framework for scholarly publications and resources. These guidelines benefit all researchers who conduct research with racial and ethnic minoritized populations. We anticipate that other publishers will institute similar guidelines for writing and publishing scholarly work.

The recommendation **to increase the limited numbers of racial and ethnic minority nurse researchers** is dependent on the success in implementing and evaluating the recommendations mentioned above. For some nurses from racial and ethnic minority groups, racism shows up when they receive counseling to pursue a diploma or an associate degree in nursing versus a baccalaureate degree in nursing. This negatively affects an applicant's potential exposure to nursing research presented during BSN or graduate education. This lack of exposure to research early in the educational process can limit exposure to nurse researchers who are advancing nursing science and can serve as role models and mentors for aspiring nurse researchers. Research mentoring and sponsorship are key to enhancing research competency and necessary for the development of nursing science as the foundation and the growth of nursing as a discipline and profession (Byrne & Keefe, 2002). Numerous authors have provided exemplars of programs and models focused on exposing students to nursing research as one strategy to increase the pipeline of nurse researchers from racial and ethnic minority groups (Goepfinger et al., 2009; Kim et al., 2009; Leeman et al., 2003; Stanfill et al., 2019; Wallen et al., 2005). Increasing the awareness of nursing research and facilitating exposure to nurse researchers, especially for aspiring nursing students from racial and ethnic minority groups, will stimulate interest in pursuing a nursing research career. Such efforts have the potential to translate into better health outcomes for some of our most economically disadvantaged and marginalized and minoritized

populations. Notably, the executive summary of the NINR Pathways Work Group Report supports early exposure to nursing research and its impact on patient outcomes. This is particularly important for undergraduate nursing students from racial and ethnic minority groups.

Devaluing hostility/and microaggressions toward racial and ethnic minority nurse researchers, our final recommendation, is critical for addressing racism across the nursing research continuum. Oftentimes nurses from racial and ethnic minority groups avoid nursing research because of institutional and interpersonal barriers, which depict nursing research as daunting and unattainable. In many settings, most experienced senior nurse researchers are white women. This can leave prospective nurses from racial and ethnic minority groups, in need of mentorship and research opportunities, alone to work with senior researchers who may lack competencies in cultural humility and best practices that facilitate successful cross-cultural mentorship. Nurses from racial and ethnic minority nurse groups may find themselves on the receiving end of micro-aggressive or macro-aggressive behaviors and toxic or hostile work environments. Racial isolation, racial battle fatigue, hypervisibility, and invisibility tend to result from these types of unhealthy work environments. Such environments deter racial and ethnic minority nurses from pursuing a nursing research career. Increasingly, as more schools and colleges of nursing employ associate deans of diversity, equity, and inclusion, there is movement to implement and monitor anti-racist policies, practices, and faculty training as well as create environments where all students, faculty, and staff feel included, valued, and respected. For example, schools and colleges of nursing should institute mandatory education on implicit bias, individual and institutional racism, anti-racism, and other forms of inequities as a key component to address these efforts. Ro and Villarreal (2021) recommended creating a functional department-level diversity committee, incorporating implicit bias into faculty training, and developing an anonymous reporting system as important strategies to combat microaggressions in academia. In summary, a well-prepared and supported anti-racist workforce, including a larger proportion of nurse researchers from racial and ethnic minority groups, is critical to begin to dismantle, reimagine, and redesign the nursing research agenda to truly reflect the diversity of our society.

High-level Conclusions

- Racism will show up wherever it is given space, time, and energy.
- The nursing profession has both actively and passively contributed to racism in healthcare.
- Anti-racist nursing research and funding is critical to support the career development of nurse researchers from racial, ethnic and minoritized groups.
- Findings from research that addresses racism in nursing should be disseminated widely, translated, urgently addressed, and incorporated into nursing practice.
- Nurse educators and faculty must keep the phenomenon of racism and its legacy of harm on the radar across all academic disciplines and programs, not solely schools of nursing.
- Racist and discriminatory practices and policies in nursing research harm people from racial, ethnic and minoritized communities.
- Nurses from racial and ethnic minority groups are underrepresented in leadership roles, especially at the executive level. As such, organizations must take measurable and monitored steps to increase multilevel representation of leaders from these groups, and, just as important, ensure inclusion and equity practices.
- Scholarly work (dissertations, research projects, etc.) must be continuously evaluated to determine whether there are embedded structures of racism within the writing, theories, methodologies, etc.

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