National Commission to Address Racism in Nursing

# Summary Report: Listening Sessions on Racism in Nursing

(*June 2021)*

*"Not everything that is faced can be changed, but nothing can be changed until it is faced."*

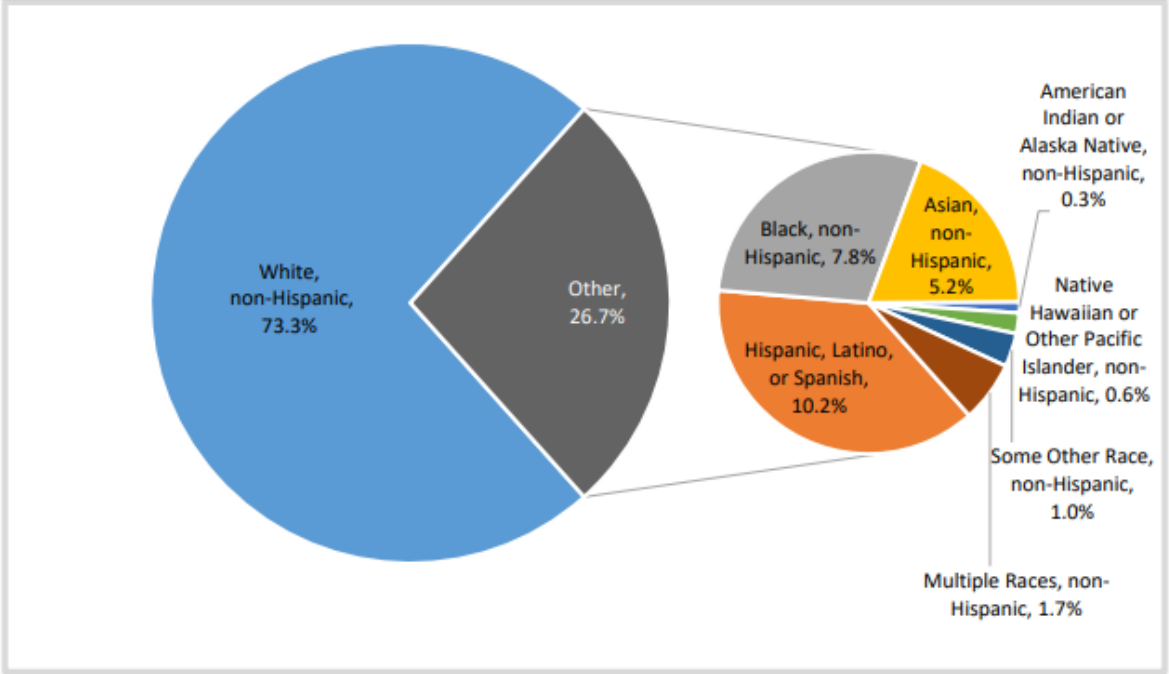
*— James Baldwin*

*The following document reflects the work of the American Nurses Association and the National Commission to Address Racism in Nursing. Convened in January 2021, the Commission's vision is that the nursing profession exemplifies inclusivity, diversity, and equity creating an antiracist praxis and environments. More information on the Commission is available here: https://www.nursingworld.org/practice-policy/workforce/clinical-practice-material/national-commission-to-address-racism-in-nursing/*

## Overview

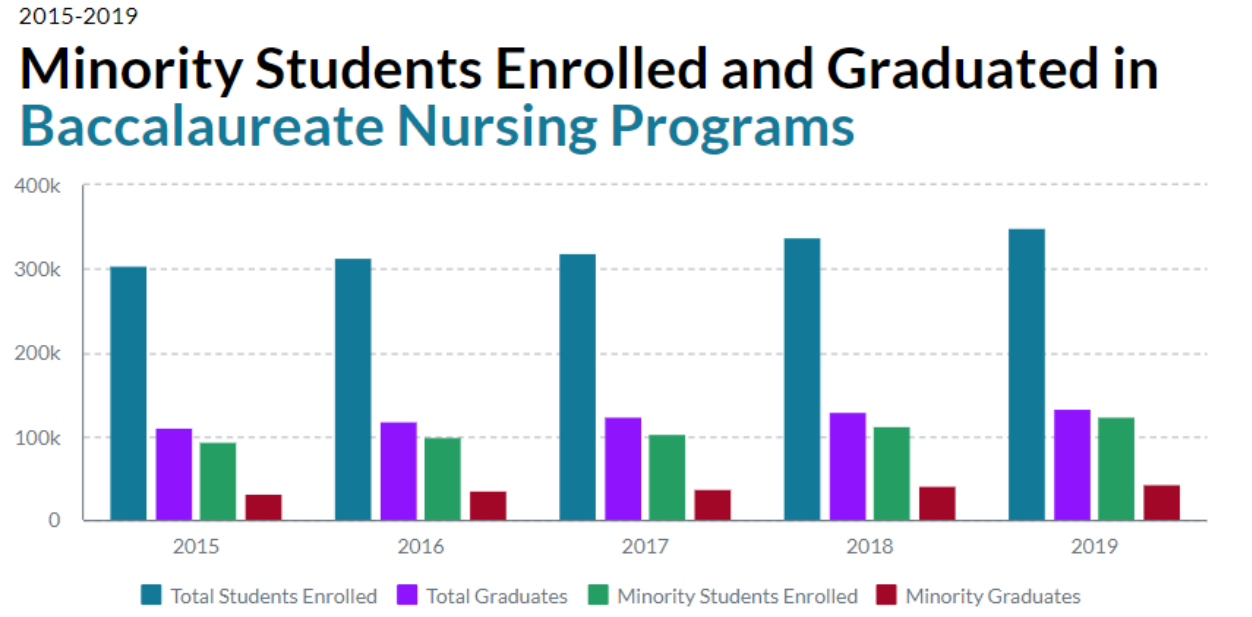
Black, Indigenous, and People of Color (BIPOC) nurses face a history of underrepresentation in all aspects of the nursing profession. In a 2019 Federal Workforce Analysis of 50,273 registered nurses, data show White, non-Hispanic nurses continue to dominate the nursing workforce, at 73.3%, leaving 10.2% of nurses identifying as Hispanic, Latino, or Spanish; 7.8% identifying as Black, non-Hispanic; 5.2% identifying as Asian; 1.7% as multiple races; 1.0% as other; 0.6% as Native Hawaiian or other Pacific Islander; and 0.3% as American Indian or Alaska Native (U.S. Department of Health and Human Services, 2019).

Figure 2: Distribution of RNs by Race and Ethnicity




U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis.

While diversity and inclusion data spanning 2015 to 2019 show an increase in the number of BIPOC students enrolled in and graduated from baccalaureate nursing programs, the numbers indicate slow progression, yielding approximately 8% growth over four years. Similarly, data on enrollment and graduation rates of associate degree nursing programs indicate 8.6% growth over six years from 2012 to 2018 (Mohammed et al., 2021).




American Association of Colleges of Nursing, *Latest Data on Diversity: Minority Students Enrolled and Graduated in Baccalaureate Nursing Programs*.

The same is true when we examine diversity among nursing faculty. According to a 2017 policy brief addressing nursing faculty and diversity from the American Association of College of Nursing, marginal growth of approximately 4% in diversity among all nursing faculty was seen between 2007 and 2016 (over a period of 10 years) (AACN, 2017).

When we consider the continuous underrepresentation of BIPOC nurses within the profession, we must ask, what is the impact of the lack of diversity and inclusion on the nurse and the work environment? Is there a correlation between lack of diversity and rates of attrition, retention, and burnout? When BIPOC nurses enter the workforce, are they included, and are their contributions valued? A 2019 study by AMN Healthcare measured the correlation between diversity and job satisfaction. Of nurses who indicated they often feel like resigning from their position, 45% indicated “not well” when asked, “How well does your current organization support diversity in the workplace?”, leading to the conclusion that “[o]rganizational support for diversity significantly correlates to nurses’ job satisfaction and their feelings about leaving their current jobs. Diversity efforts may be an important and overlooked factor in improving nurse retention” (AMN Healthcare, 2019).
The failure to address the lack of diversity within the nursing workforce is detrimental to the growth of a profession ranked as the most trusted profession for 18 years in a row by Gallup

polling. It is detrimental to the BIPOC nurses who have committed to the profession despite the adversity they face academically and professionally. Furthermore, the failure to address the lack of diversity is also detrimental to our patients and their health outcomes. The downstream effects of bias and structural racism contribute to further disparities in health care access, quality, and safety, resulting in mistrust of the medical system.

## Purpose and Format

The purpose of the listening sessions was to facilitate an in-depth exploration and to capture the experiences of racism shared by BIPOC nurses in academic and health care settings and the impact of racism on their professional practice and advancement within the profession. The intent of this work is to inform the National Commission to Address Racism in Nursing on policies and practices to address systemic racism and the impact on nurses and the profession along with patient outcomes. Information from the listening sessions was captured to also inform American Nurses Association's Membership Assembly and the American Nurses Association Enterprise's strategy to address diversity, equity, and inclusion.

The listening session questions were designed to explore overall challenges and barriers caused by racism within the profession; workplace culture, equity, and inclusion; sources for support; solutions; and recommendations for allyship.

Each session had a single moderator for dialogue, two chat moderators to field and respond to comments, and a notetaker for dialogue transcription. These sessions were not recorded.

## Sampling

Convenience sampling combined with a deliberate purposive sampling approach was implemented with the goal of targeting BIPOC nurses for participation. Participants were recruited through a broad announcement shared with organizations participating in the Commission. A key strategy was to target nursing organizations that represent ethnic and minority nursing groups to capture accounts of direct and indirect lived experiences of racism. There was a total of five listening session groups facilitated between February and April 2021. There were approximately 16 participants in each group.

An email to recruit participants was forwarded for distribution to each organization represented within the Commission, outlining the purpose and intent of the listening sessions. Instructions were given to respond with the desired date and time for participation. One hundred forty nurses responded. Each prospective participant was assigned to a listening session group based on their desired day and time. Each group averaged 16 participants.

## Methodology

All sessions were held via a private, invitation-only, virtual meeting room. Participants were visible via video or communicated by phone. All participants had the opportunity to provide a brief introduction by stating their name and geographic location. Use of video was encouraged but not required. While this was not a formal research study, the structure of the listening sessions and the analysis of the data captured comprised an approach similar to a qualitative research design, structured like a focus group. This approach was aimed at fostering a safe space for dialogue to gain a deeper understanding of the nature and impact of the participants' experiences.

Five 1.5-hour listening sessions were conducted over eight weeks from February to April 2021. Concerns of confidentiality were raised by some participants before each call. Therefore, it was decided that while notes were transcribed, we would refrain from video- and audio-recording each session. Some nurses who joined the call declared themselves upfront as "listeners" seeking to learn about the experiences of their BIPOC peers. However, during each session, all were encouraged to fully participate. A statement of confidentiality was made during each introduction and unique identifiers such as name, location, name of academic institution, and health system were not captured during note-taking. Eighty nurses participated, representing academic and clinical settings. The participants also represented nursing faculty and nursing students. Saturation was determined to be reached by the fifth session. The data shared present an inductive thematic analysis of the participants' experiences with racism in nursing.

## Observations, Limitations, and Reflections

Three key observations were made over the course of facilitating five listening sessions. First, there was misunderstanding of the phrase "listening session," resulting in participants signing up to engage with the intent of solely listening to accounts and experiences of racism to further their understanding of racism within the profession. All session participants were encouraged to engage at the start of each session. However, there were participants noted on the call roster who did not speak or engage in the dialogue. Evaluating this occurrence following sessions one and two resulted in follow-up communication that used the phrase "focus group," with the expectation that all participants are encouraged to engage. While improvement was noted in sessions three through five, non-BIPOC nurses remained relatively silent overall. It is important to note that there was improvement in engagement by non-BIPOC nurses when the topic of allyship was addressed. Non-BIPOC nurses expressed a desire to continue engagement through dialogue and to seek opportunities to learn more about allyship. Second, participants shared via a follow-up survey and through the chat at the conclusion of each session how meaningful it was to engage in a space to share experiences of racism openly and candidly without judgment. While this is not the first platform to engage in this dialogue, for some nurses this was the first opportunity to share experiences of racism they had suppressed for

decades. There was a spectrum of emotion shared, ranging from sorrow to anger to horror, as nurses recalled their experiences. Nurses expressed an appreciation to have the opportunity to share their experiences and gratitude to freely and unapologetically express their feelings of hurt and anger toward a broken system that has failed them. Multiple nurses expressed comfort in feeling validated and in feeling they are not alone by listening to their peers share similar accounts of racism. Nurses expressed a desire to continue the dialogue along with a desire to seek ongoing support through support groups. Finally, during each session, nurses acknowledged that the experiences of racism are not unique to them as individuals and sadly occur all too commonly toward BIPOC nurses throughout their careers regardless of geographic location or setting. Nurses shared frustration regarding the failure of health systems to address systemic and structural racism and the aspiration to finally dismantle racist policies, systems, and structures for future nurses who are rising behind them.

## Data Analysis and Coding

### Challenges and Barriers

| **Implicit bias, unconscious bias, prejudice, limitation by stereotypes and assumptions** | |
|---|---|
| Presumed incompetence and subsequent limitation and denial of opportunity for promotion. Lack of support; presumption; misunderstanding of tone of voice, facial expression, emotion, and persistent stereotyping as an angry Black woman. | 14 |
| **Discrimination** | |
| Outright **denial** of opportunity and advancement. Denial of advancement secondary to favoritism and nepotism. Use of **privilege** and **power** to modify roles and advance those who are favored and hinder those viewed through a biased lens. | 7 |
| **Exclusion** | |
| Feeling ignored/forgotten/overlooked. | 6 |
| **Microaggression** | |
| Verbal/nonverbal, intentional/unintentional slights, snubs, insults that belittle and demoralize persons of color. | 5 |
| **Oppression** | |
| Invisible boundaries and subsequent limitations and denial of opportunity set by power, privilege, and entitlement. Examples include denial of research opportunities, tenure, and professional advancement, and “stealing of credit” or ideas/thought plagiarism. | 4 |
| **Burden of representation: Tokenism** | |
| Unspoken expectation of BIPOC nurses to educate the majority on race/ethnicity, leading to tokenism and representation of one’s entire race/ethnic group. Subsequent “othering” occurs, resulting in persons of color being seen as different from all others within their race/ethnic group. This results in conditional acceptance of BIPOC nurses who are identified as exceptional and thus worthy of acceptance by the majority. This results in a broader sense of “us and them” and an expectation of BIPOC nurses to legitimize feelings and assumptions of the majority. | 4 |

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|---|---|
| **Inequity** | |
| Inequity in advancement despite qualifications or being overqualified for a role. Inequity in pay for same work. | 3 |
| **Insistence on conformity and assimilation** | |
| Hierarchy "pecking order" tied to perception of competence, favoritism, and conformity to standards set by the majority. Hindrance and lack of acceptance of one's authentic self or outward expression of culture, custom, or traditions. | 3 |

## Impact

| | |
|---|---|
| **Demoralization** | 7 |
| **Resilience, tenacity despite adversity** | 6 |
| **Exhaustion** | 6 |
| **Spirit murder ("murder of the soul")** | 5 |
| **Invisible workload:** Associated with tokenism; acceptance of the burden of risk—assignment/patient acuity, workload. | 5 |
| **Silenced** | 5 |
| **Frustration, guilt, inability to improve racism in nursing.** | 2 |
| **Invisible** | 1 |
| **Self-doubt:** Secondary to lack of validation and minimization of role and skill. | 1 |

## Sources of Support

| | |
|---|---|
| **Intrinsic motivation, self-reliance** | 6 |
| **Black student group** | 3 |
| **Family** | 2 |
| **Faith, spiritual group** | 1 |

## Recommendations

| | |
|---|---|
| **Accountability** | 11 |
| **Allyship** | 8 |
| **Calling out racism** | 4 |
| **Mentorship** | 3 |

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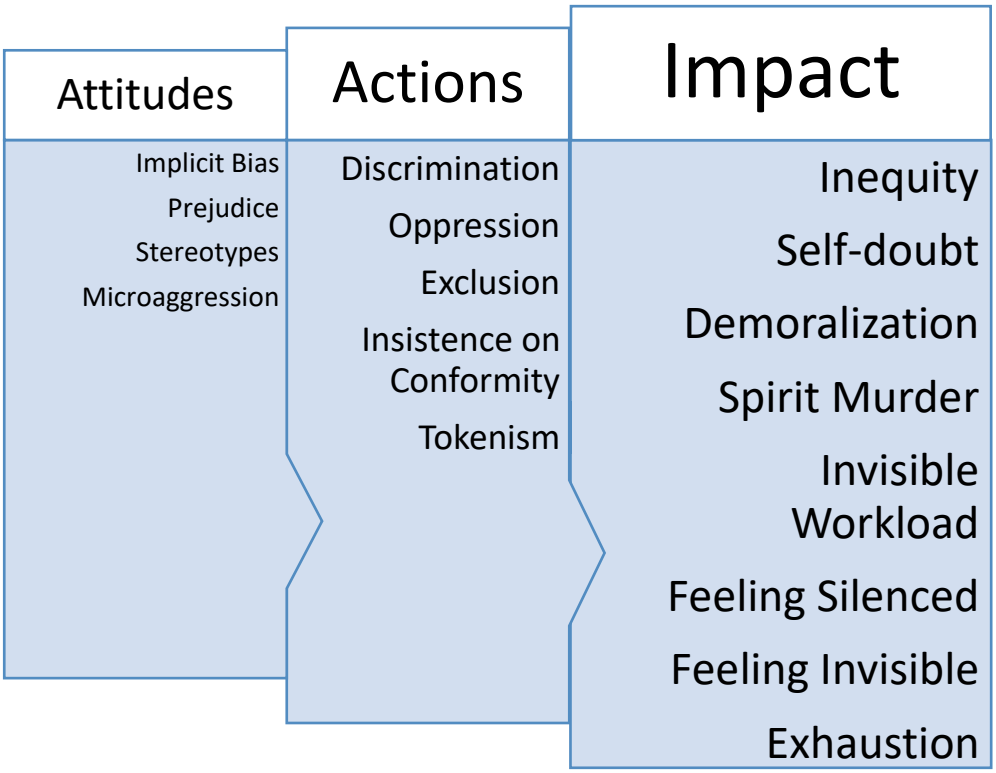
# The Core Story

## Bias, Presumptions, and Stereotypes

*"Many Black girls don't make it through this nursing education program."*




Whether in a practice setting or academia, nurses repeatedly echoed the same experience of a presumption of incompetence and subsequent limitation and denial of opportunity. BIPOC nurses often described the feelings of being challenged and having their knowledge minimized based on the belief that they are less than and therefore cannot provide qualified care. This experience transcended races—Black, Latinx, Asian American, Pacific Islander. Nurses shared experiences of the perpetuation of this stereotype woven through undergraduate and graduate education and even post-licensure, while they are practicing. Nurses shared accounts of being told to consider other roles within nursing, such as that of LPN; of being told to consider associate degree nursing programs over baccalaureate programs; and of facing outright denial of the opportunity to consider a nursing program. Furthermore, participants who identified as

nurse faculty described accounts of blatant disrespect from White students or refusal of students to engage with their professor or persistent challenging of their knowledge base. One nurse reported her faculty peers take anti-anxiety medication before entering the classroom to manage the anxiety associated with mistreatment from students.

There is a label of the "angry Black woman [who is] not promotable and [who] does not know enough and is not good enough." A narrative was shared when race was blinded during an interview. Once hired, the nurse arrived for orientation and approached the same manager who interviewed her. That manager assumed she was not there to start her first day; rather, she asked, "How can I help you?" Nurses agreed that once you do establish your role and your credentials, you are then subjected to questioning such as "Where did you go to school?" to determine whether the standard is met for acceptance. There was a resounding consensus that there is a failure of patients and their families, and some staff, to acknowledge BIPOC nurses by their role despite their designation by scrub color, name badge, or credentials. Rather, BIPOC nurses are prejudged to serve in every other role outside of nursing, such as dietary, administrative aid, or environmental services. A nurse from the Philippines recalled being seen as "the help," stating, "I was dismissed" and shared feelings of restricted potential and being seen as inferior and as less capable. Another nurse recalled looking for new employment every three to four years because of the treatment endured, asking, "Are we eating our young or are we just racist against someone who is Brown?" Nurses attested to being overqualified for their roles yet feeling as though they will never be good enough. "The assumption is that you cannot possibly be a nurse or, even more, my nurse," stated one nurse participant. Despite carrying the same credentials as their peers, BIPOC nurses recounted that they are not acknowledged by credential like everyone else in the room; rather, they are called by their first names.

Black and Latina nurse participants repeatedly reported the stereotype of "the angry Black nurse" and being labeled as "too assertive, too aggressive, and too Black." All too often, nurses retold accounts of being labeled as angry for simply asking questions or seeking clarification. Stories were shared of White nurses indicating they are afraid and uncertain of how Black nurses would react. One nurse recounted the uncertainty and perception of her assertiveness retelling an account when a White coworker stated, "When they see you coming, they see all of your blackness and the whites of your eyes and the whites of your teeth, and they are scared." She continued to share, "I was hurt by her comment." She proceeded to share that she addressed the nurse who made the comment only to receive the following rebuttal: "How can I be racist? As a little girl I wanted to be Black because of how you talk." She reported this incident, which resulted in retaliation.

Retaliation was another common theme, along with the call for accountability to address racist behavior, whether outright or through microaggressions. Nurses of color indicated that Human

Resources is not supportive and that when action is taken to report racist behavior, the aggressor is seen as the victim, and the actual victim is subjected to further incivility and bullying. When grievances are filed, "If at the end of the day the findings are in favor of a person of color, the administration often works to seal the findings and not have them disclosed." Accounts of bullying and belittling were shared across settings, further confirming racism and racist acts have no boundaries, even in the most trusted profession.

## Discrimination, Oppression, and Inequity

*"We don't get the opportunities, or we are not heard."*

The impacts of racist thoughts on the individual nurse transcend into acts of discrimination and oppression that result in disparities in advancement, lack of inclusion in decision-making processes, and inequities in compensation. Nurses shared experiences of outright denial of opportunities and roles for advancement. The implicit and unconscious biases transcend into the use of privilege and power to modify roles to advance those who are favored and hinder those viewed through a biased lens. "My professional work has been overlooked and given to a White nurse to move forward." It was agreed that "the denial of promotion has been a problem historically," as one nurse stated, while another agreed: "We don't get the opportunities, or we are not heard." Nurses reported experiencing peers' attempts to dissuade them from pursuing advanced education only to learn they later enrolled in a similar program or were encouraging other non-Black or non-Brown staff to do so. In addition, when seeking opportunities for advancement, nurses faced a denial of schedule adjustments to accommodate clinical and study requirements. Nurses shared accounts of knowing their professional work "has been overlooked and given to a White nurse to move forward" or finding out about open positions for advancement by accident only to learn the institution had someone less qualified in the role. Nurses shared accounts of placement in a wait-and-see category during a probationary period for determining whether "we can work well together."

> *"Regardless of education, as [for] a nurse of color, the opportunities do not seem to come; clinical skills are always being questioned; 'nurses eat their young' is doubled if you are a nurse of color."*

> *"[I] always had a hard time; never easy for me; first Black nurse in multiple departments in the hospital; they never made it easy; I have been told "people like me never get anywhere." I have staff—both Black and White—who disrespect you; they make fun of you; I looked forward to retirement."*

> *"Even our Black patients have bought into believing that Black nurses are less than and cannot provide qualified care."*

Nurses spoke of invisible boundaries and subsequent limitations and denial of opportunity set by power, privilege, and entitlement. Examples include denial of research opportunities, tenure, and professional advancement. There were multiple accounts of "stealing of credit" where the nurse of color would put forth a thought or idea only to have it taken and presented by a White nurse who subsequently received credit for doing so. Most of the nurses who participated in the sessions held advanced degrees, yet they spoke of lack of acknowledgment of their advancement and their leadership, of rarely being invited to the table, and of experiencing, when they were invited, "my inputs were invalidated." Nurses spoke of disparity in salary as often as they spoke of inequity in opportunity for advancement.

## Assessing the Impact of Racism on Nurses of Color

### Internalized oppression, silence, invisible workload, exhaustion

*"Why should any Black nurse go back for a PhD or DNP—[when they] will never get hired or promoted even with a DNP or a PhD?"*

*"If I were to replace my face with a White person's face, where would my career be?"*

Self-doubt or internalized oppression is a direct result of the lack of validation and support and of the ongoing minimization of roles and skills encountered by nurses of color. While this was directly referenced once, self-doubt was underpinned by feelings of demoralization and "murder of the soul." A common thread referenced was the need to repeat oneself to prove knowledge despite credentials and years of experience along with the lack of acknowledgment and respect for accomplishments. Nurses reported a lack of respect from colleagues and patients alike, even from patients of the same race. Nurses reported having their qualifications scrutinized more and an overall feeling of organizations "mov[ing] the goalpost if a Brown or Black person applies." Nurses shared accounts of attacks on their personal character and an overall sense of feeling ignored. One nurse reported feeling lonely and undervalued, while another shared that "nursing has not been safe or particularly uplifting." Nurses referenced the desire to provide culturally sensitive care yet feeling as though there is a minimization of the lived history of persons and communities of color and the perception that the historical underpinnings of our health care system for Black and Brown patients are irrelevant. When George Floyd was murdered, nurses spoke of the resounding silence and lack of acknowledgment of his death.

Nurses also shared how often they felt silenced by their colleagues in practice and academic settings. If you are invited to the table, you are not heard or are overlooked. If you speak out

against racism and racist acts, you become a problem. One nurse recalled an experience when a White student was screaming the N-word and there was a petition to have the student dismissed. The nurse petitioning for dismissal of the student was faculty. The petition was ignored, and the student was made to apologize and was allowed to remain in the nursing program. She shared that following the incident, Black students frequently shared how often the N-word was used, yet action was not taken. As faculty advocating for Black and Brown students, she described how she was seen as "a problem." This same nurse faculty spoke of students experiencing posttraumatic stress because of false accusations brought against their character and integrity, such as false accusations of cheating, and the harm the lack of action taken against racism is causing overall.

Black and Brown nurses shared their exhaustion from the impacts of racism. Nurses reported mental pain, returning home following a shift feeling sick, crying in the bathroom before leaving a shift, and crying into the mattress at night only to turn around and return to work the next day. A nurse shared, "I just disappear; they make decisions without including you; [you] have to remind people about sensitivity." Yet if you say something, you are angry, you are aggressive, you are perceived as difficult. Despite bearing the brunt of hatred and continued assaults against character, integrity, and knowledge, BIPOC nurses spoke of their tenacity, a reliance on faith, resilience, and a desire to improve the academic and practice settings for those entering the profession.

The invisible workload was a common theme identified throughout. There is the additional workload associated with proving the ability to do the work, and the additional workload due to acceptance of the burden of risk in the form of harder and riskier assignments passed off to Black and Brown nurses. Nurses spoke of being assigned the patients with the highest acuity and the patients who carried the greatest risk of harm to the nurse, such as tuberculosis patients or COVID-19 patients at the start of the pandemic. A nurse recalled, "I was the only Black nurse, and I caught it every shift—worst patient; [they] changed patient medications [without telling me]; bullying behavior—but they didn't treat other nurses that way. I was always viewed as a threat." Another recalled that on the night of Barack Obama's presidential win, nurses stopped responding—when a person of color coded, no one responded to the calls for help, leaving the nurse to run the code alone.

There is also the invisible workload that is bestowed upon one for being accepted by the masses in the form of tokenism. This results in multiple committee assignments as the single BIPOC nurse representative, the expectation to speak for and represent one's entire race or ethnic group, and the unspoken expectation to educate about and address racism as though it is a problem BIPOC nurses carry the responsibility of fixing. Subsequent "othering" occurs, resulting in persons of color being seen as different from all others within their race or ethnic

group, resulting in conditional acceptance of BIPOC nurses who are identified as exceptional or worthy of acceptance by the majority. Nurses spoke of an insistence on conformity and assimilation and an associated selection based on perception of competence, favoritism, and conformity to standards set by the majority. Ultimately, the insistence on assimilation hinders BIPOC nurses from outward expression of culture, custom, or traditions. As one nurse stated, "BIPOC leaders who are in the executive position often had to assimilate to whiteness to get there—so sometimes their advice to other [BIPOC] nurses will also be to assimilate, keep [your] head down and work harder, and win White people's respect."

## Recommendations

*"We also have to create avenues for others—recognizing the value and worth of what we bring. Experience is a formidable teacher."*

Mentorship

The need for formal and structured mentorship programs was a common theme referenced during each listening session. Nurses expressed the wish that they had learned how to navigate racism in nursing through mentorship programs. Nurses shared experiences of other BIPOC nurses who provided informal mentorship and support and even mentorship by White allies aware of the challenges of racism in the workplace who offered advice on how to navigate the challenges of racism imposed by their peers. Most important, nurses expressed the frustration of not seeing changes in the landscape throughout their careers and the desire to mentor future nurses to help them advance.

Accountability

Nurses called for accountability at the organizational level. With accountability, there was the call for transparency in the evaluation and resolution of grievances. The recommendation was put forth to build a partnership with key professional nursing organizations that can identify principles and measurable outcomes that address racism in the work environment. The recommendation was also given to consider partnerships at the federal level. Nurses recommended we look at accreditation and how violation of these principles affects accreditation standards. Nurses also described accountability for creating a safe environment, speaking of the trauma of racism and how "humanistic environments" are important.

Allyship

Nurses who identified as allies of BIPOC nurses spoke of the need to use their position of privilege to address racism, the need to "unlearn" thoughts and behaviors to become anti-racist, and the need to hold their peers accountable for their racist actions. Self-awareness of personal biases was described as part of the unlearning process, along with the need to call out

racist and diminishing behaviors. “Leadership is the ally.” Emphasis was placed on accountability of managers and leaders in the creation of environmental change to foster inclusivity and a climate where BIPOC nurses can thrive.

Calling out racism

Nurses agreed there is the need to be direct and call out racism. Participants called for the need for more research in the form of quantitative data to further “tell the narrative” of nurse’s experiences and a broad and profound campaign where recommendations for change are addressed. Nurses called for a change in the image of nursing to move away from “the stronghold of White women” and images of Florence Nightingale as the epitome of nursing.

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