Mapping the Landscape of Anti-Racism in Nursing[1]

Barbara Glickstein, MPH, RN, FAAN[2]
Diana J. Mason, PhD, RN, FAAN
Monica R. McLemore, PhD, MPH, RN
Kahlea Williams, MS

In 1906, prominent African-American scholar and civil rights leader W.E.B. Du Bois theorized the social determinants of health in "The Health and Physique of the Negro American," a publication from Atlanta University's annual conference on issues facing Black Americans. That year, the conference findings pointed to the impact of environmental and social conditions on Black morbidity and mortality. The report delineated disparities in the number of infant deaths and also identified diseases that were undeniably more prevalent in Black communities than their white counterparts: respiratory ailments such as tuberculosis (known then as consumption), heart disease, syphilis and others. Commenting on the higher Black death rates, Du Bois concluded that "the present differences in mortality seem to be sufficiently explained by conditions in life."

Though astute observation and analysis, Du Bois arrived at conclusions that the white health-care establishment of the day had not. Du Bois lived at the same time as the legendary Florence Nightingale, often considered the founder of modern nursing. Nightingale's work helped to establish the reputation of nurses as the most trusted professionals of any industry[3]; during the Crimean War of the 1870s, she pioneered ideas of infection control, patient involvement in their own care, nightly rounds and intimate nurse-patient communication as a core value for treatment. However, Nightingale's contributions are overshadowed by her promotion of British colonialism, including support of Native boarding schools to "civilize" indigenous youth, and her

[1] This report uses "their" as a neutral gender term, except in quotations from interviews with participants.
[2] The authors of this report are listed alphabetically to indicate shared effort and commitment to this project. All meet the International Committee of Medical Journal Editors criteria for authorship and have contributed to the design, development, and execution of this work.
[3] https://news.gallup.com/poll/467804/nurses-retain-top-ethics-rating-below-2020-high.aspx

embrace of ideas that framed racial “Others” as inherently less hygienic and, ultimately, inferior.

More than a century after Du Bois’ treatise and Nightingale’s death in 1910, the nursing profession struggles to adopt concrete strategies to uproot historical and ongoing racism within its ranks, which affects individual, community and societal well-being. Many social determinants of health can be perceived to be outside of health care per se: access to stable housing, transportation, and childcare; jobs that pay a living wage; and freedom from violence. The perception of these factors as separate from health— and the fact that the social determinants framework arguably has more advocates in the social sciences and humanities — perpetuates health-care hierarchy. While the study of health equity is maturing as a field, health professionals urgently need tools and language to remake their workplaces into anti-racist spaces.

Our society prioritizes goods, services, and resources, safety, and comfort based on perceived socially defined race (e.g., based on appearance, culture, geographic location). White supremacy is entrenched in every aspect of society including the provision of health services and care. It is in this context that the Robert Wood Johnson Foundation (**RWJF) funded efforts** to understand nurses’ roles in finding and pushing levers in addressing structural racism in health care by identifying potential barriers and best practices. Throughout this report, the term levers is used to describe the policies, practices, and procedures that contribute to curating a culture of health as defined by the Policies for Action program of RWJF.[4]

The Manning Price Spratlen Center of Anti-Racism & Equity (CARE) in Nursing at the University of Washington School of Nursing partnered with nurse leaders to conduct this study how nurses and associated colleagues within the health professions (e.g., administrators, researchers) acted to reduce structural racism in the profession and

[4] See: https://policiesforaction.org/

health care more generally. The team sought to elicit the challenges they confronted and “best” and “promising” practices in this realm.

The aim of this report is to inform future grantmaking and other work of the foundation. The specific objectives of this study are to:

1. Describe the views and experiences of nurses related to racism and equity in their workplaces at the interpersonal, institutional, internalized, and structural levels;
2. Identify best practices that nurses have developed and implemented to dismantle systemic racism in health-care organizations;
3. Identify actionable opportunities that could accelerate nurses’ and nursing involvement in dismantling racism in health care.

BACKGROUND

The year 2020 was particularly significant for health-care professions. The American Public Health Association continued to declare racism a public health crisis.[5] Similarly, the World Health Organization designated 2020 as the Year of the Nurse and Midwife.[6] Although these initiatives focused attention on the essential role of nurses across the globe and barriers to their optimal use, the COVID-19 pandemic disrupted potential gains in developing nurse leadership in promoting the health of individuals, families and communities. But it also spotlighted the longstanding health inequities in the United States (US) and other countries COVID-19 infections and deaths among Black and Latine populations,[7] to the perpetually higher rates of violence and police brutality Black, Indigenous, and people of color (BIPOC) and queer communities face, there are prevalent, inherent flaws in our nation’s structures that negatively affect determinants of health and outcomes.

The discipline of nursing, activated by protests and the recorded murder of George Floyd, developed national mandates to address or dismantle racism by establishing the

[5] https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations
[6] https://www.who.int/campaigns/annual-theme/year-of-the-nurse-and-the-midwife-2020
[7] We use the term Latine to collectively refer to Latina, Latino, and Latinx

National Commission to Address Racism in Nursing in January 2021.[8] Coincidentally, the second Future of Nursing report from the National Academies of Science, Engineering, and Medicine[9] was already underway when the pandemic and the public murder of George Floyd occurred. The committee responsible for the report delayed its release so it would "address deep-seated health and social challenges."[10] The study was co-led by Mary Wakefield, PhD, RN, is an American nurse and health care administrator, who served in the Obama administration as acting United States Deputy Secretary of Health and Human Services from 2015 to 2017, and as head of the Health Resources and Services Administration from 2009 to 2015 and David Williams, PhD, a public health pioneer in understanding social influences on health, including racism. Dr. Williams' participation is notable due to his deep understanding of racism on health and how critical race theory and public health praxis are powerful foundational tools of anti-racism principles (See Appendix 2 for a list of these principles). The final report included a call for nurses to understand and act on the pathways to achieving health equity.

The Campaign for Action (CFA) at the RWJF-funded AARP Center for Championing Nursing in America is designed to advance the recommendations laid out in *The Future of Nursing 2020-2030*. It has continued to work on recommendations from the initial *Future of Nursing: Leading Change, Advancing Health*,[11] and has framed its work on the second report as focused on developing "equity-minded" nurses who are addressing health disparities. The CFA has organized summits, webinars and meetings relevant to this focus; disseminated the work of "equity-minded" nurses; and launched a new Center for Health Equity Through Nursing. However, national nursing organizations such as Sigma Theta Tau, International and the American Nurses Association have been reluctant to accept CFA's leadership and coordinating roles to oversee the profession's work related to both reports. State Action Coalitions (SAC) are addressing

[8] https://www.nursingworld.org/practice-policy/workforce/racism-in-nursing/
[9] National Academies of Sciences, Engineering, and Medicine. 2021. The future of nursing 2020–2030: Charting a path to achieve health equity. Washington, DC: The National Academies Press. p. xv. https://doi.org/10.17226/25982.
[10] Ibid., p. xv
[11] Institute of Medicine. Future of Nursing: Leading Change, Advancing Health. Washington, DC: National Academies Press; 2011.

health equity and the CFA awarded 15 grants to SACs, most of which are focused on diversifying the nursing workforce.

For example, the Nursology Collective, a long-standing group of nurse theorists, scholars and activists had developed several public-facing tools including a virtual book club and webinar series geared to addressing racism within nursing education.[9] Simultaneously, the Nursing Mutual Aid Collaborative[12] came together to provide opportunities for early-career researchers and other nurses whose work was (or would be) disrupted by the travel restrictions and essential public health mitigation strategies to contain COVID-19. More broadly, this group took on several writing projects to explain how racism is embedded in nursing education including surveillance technology, dress codes and the new "essentials" under the American Association of Colleges of Nursing (AACN).[13]

During the so-called racial reckoning sparked by events of 2020, several professional organizations (e.g., Academy Health, Journal of the American Medical Association, New England Journal of Medicine, the American Nurses Association, and many others) attempted to retrofit past and current harms of scientific racism and adjudicate the harm of their roles in perpetuating structural racism. These organizations released policies and statements in support of Anti-Racism and Black lives while doing nothing to eliminate racism or white supremacy in their institutions.

The *New England Journal of Medicine* launched a Race and Medicine Series,[14] and the editorial board of *Cell* published several commentaries about racism (including one from Fund Black Scientists) that were well supported by data from the National Institutes of Health.[15] This prompted the birth of another collaborative initiative. *Health Affairs*, the journal associated with policy experts and health services researchers (HSR), and Academy Health (the professional organization affiliated with the journal) had been piloting programs to diversify the HSR workforce and also launched a series on racism

[9] https://nursology.net/category/nursology-theory-collective/
[12] https://nursingmutualaid.squarespace.com/
[13] https://www.aacnnursing.org/essentials
[14] https://www.nejm.org/race-and-medicine
[15] https://www.cell.com/cell/pdf/S0092-8674(20)30740-6.pdf

and health[16] and adjusted the types of manuscripts it would publish, including narratives and other perspectives and commentaries. The Journal of American Medicine (JAMA) infamous podcast[17] in which a physician-host questioned the existence of racism in medicine caused a shift in *JAMA* leadership and prompted the hire of equity editors empowered to review content.[18] That controversy contributed to increased creation of leadership roles to support Black leaders who were divesting from organizations that failed to seriously attempt to dismantle structural racism.[19]

Nursing publications have also created resources addressing racism and its impact and how nurses can authentically engage in this work. The International Academy of Nursing Editors has a dedicated web page for journal articles that address racism.[20] The *American Journal of Nursing* has a webpage of all articles, other than editorials, that address racism and has sponsored a webinar on racism, an archive of which will be posted on its website.[21] However, we know of no nursing journal that is examining how its own policies and practices around publishing may contribute to the perpetuation of racism.

***Exemplars of Nursing Professional Organizations*.** Specific to nursing and an overdue reckoning on racism, the American Nurses Association (ANA) launched a project documenting the journey to racial reconciliation by 1) crafting a statement for use by the profession; 2) establishing a National Commission to Address Racism in Nursing; and 3) launching a study to address racism in nursing and health care.[22, 23] Working in partnership with service organizations in nursing including the National Black Nurses Association (NBNA), the National Coalition of Ethnic Minority Nurse Associations (NCEMNA) and the National Association of Hispanic Nurses (NAHN), the ANA was finally prepared to collectively support the work these organizations had been

[16] https://www.healthaffairs.org/racism-and-health
[17] https://www.statnews.com/2021/04/06/podcast-puts-jama-under-fire-for-mishandling-of-race/
[18] https://jamanetwork.com/journals/jama/fullarticle/2780860
[19] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31408-2/fulltext
[20] https://nursingeditors.com/workgroups-initiatives/editorials-on-race-racism/
[21] https://journals.lww.com/ajnonline/pages/results.aspx?txtKeywords=Racism+in+nursing
[22] https://www.nursingworld.org/practice-policy/workforce/racism-in-nursing/national-commission-to-address-racism-in-nursing/
[23] https://www.nursingworld.org/news/news-releases/2021/leading-nursing-organizations-launch-the-national-commission-to-address-racism-in-nursing/

doing for years. The AACN joined the commission as partners and committed to listening sessions and development of tools to support the work of dismantling racism.[24] This work is ongoing and publications are expected in the Fall of 2023.

SIGNIFICANCE

Philanthropic responses[25] are crucial to the success of dismantling structural racism in health care and services provision. During this period, several major funders also doubled down on racial justice work and committed to providing essential resources to individuals and institutions prepared to do this difficult work. Funders have been key to catalyzing the change needed to resolve health inequities. Mackenzie Scott (Bezos) and her billions of dollars in unrestricted grants have made an impact on community-based organizations[26] and legacy foundations such as MacArthur, Ford, and Robert Wood Johnson have long seeded projects that address health inequities and are poised to do more.

The investment of major philanthropic players is a promising development, but more work needs to be done, particularly in developing a more diverse nursing workforce that is better equipped to deliver high-quality care to all. While nursing as a discipline has been examining its role in the perpetuation of racism,[27] the profession has been predominantly comprised of white women despite workforce diversification becoming a slow and steady drumbeat for decades.[28] According to data from 2015, only 65.6% of the U.S. population is White; however, 83.2% of licensed nurses and 90% of certified nurse-midwives are White.[29] Nursing remains a very gendered profession in a way that other sectors of health care are not: While 93% of licensed nurses or certified nurse

[24] https://www.aacnnursing.org/News-Information/News/View/ArticleId/24772/National-Commission-Address-Racism-in-Nursing
[25] https://cep.org/imagine-if-philanthropy-got-serious-about-ending-structural-racism/
[26] https://www.philanthropy.com/article/mackenzie-scotts-gifts-are-game-changers-for-racial-justice-groups-but-now-we-need-to-do-more
[27] Barbee EL. A Black Feminist Approach to Nursing Research. Western Journal of Nursing Research. 1994;16(5):495-506. doi:10.1177/019394599401600504
[28] Zangaro GA, Streeter R, Li T. Trends in racial and ethnic demographics of the nursing workforce: 2000 to 2015. Nurs Outlook. 2018 Jul - Aug;66(4):365-371.
[29] Ibid.

midwives are women, only 34% of physicians are women.[30] Nursing has been a field where women have been over-represented, but people of color remain under-represented.

Workforce development has long been understood and confirmed in nursing research to be directly related to improving patient experiences and to reflect fundamental values such as cultural and language concordance. Additionally, nursing organizations developed for Black, Indigenous, Latine, and other people of color arose because members of those communities felt marginalized by the white-dominated national nursing associations.[31] Often, nurses of color have attempted to bring issues specific to equity, diversity, inclusion, and justice to the attention and agendas of larger, White-led professional nursing organizations.

RWJF has had three streams of funding specific to nursing in recent years: the Clinical and Faculty Scholars Program, The Future of Nursing: Campaign for Action, and the Maker Nurse Programs.[32] These programs and their alumni can provide essential scaffolding for future work as the field prepares to seriously address health inequities and structural racism. Understanding the role that nursing—the largest and most trusted of all professions—can play in dismantling structural racism is integral to achieving the spread and scale for meaningful and lasting transformation. It is in this context that we launched the study entitled *Mapping the Landscape of Anti-Racism in Nursing*, to understand the role of nurses in finding and pushing levers in addressing structural racism in health care by identifying potential barriers and best practices.

METHODS

This qualitative study was reviewed by the Institutional Review Board (IRB) of the University of Washington (#STUDY00016744) and deemed to be exempt from human

[30] Ibid.
[31] Between 1916 and 1964, Black nurses were not permitted to join the some of the state nurses associations that were members of the American Nurses Association. The National Association of Colored Graduate Nurses dissolved once all Black nurses could become ANA members. In 1973, the National Black Nurses Association was formed in response to the persistent marginalization of Black nurses in the ANA. Carnegie, M.E. The path we tread: Blacks in nursing, 1854-1990. National League for Nursing Press; 1991.
[32] https://www.rwjf.org/en/building-a-culture-of-health/focus-areas/health-leadership-nurses-and-nursing.html

subjects protections procedures under category 2: Educational tests, surveys, interviews, observations of public behavior. We conducted 40 interviews with 42 nurses and others working in health care or nursing education via Zoom (two interviews included multiple participants). Potential participants were identified by the study team through their knowledge of health equity and anti-racism work in nursing and health care. In addition, we used a snowball sampling approach, in which participants were invited to recommend others they knew who were engaged in similar work.
Due of the sensitivity of the issues covered in the interviews and to be consistent with the exempt status of the study, we did not collect demographic data on participants; nevertheless, they included a wide range of socially defined races, gender identities, ethnicities, ages, work roles, positions, settings and geographic regions. All participants gave verbal permission to be interviewed and recorded; participants were informed that they would remain anonymous unless they gave specific permissions to be included with identifying information in the report; in which case, they would be sent draft portions of the report for their approval.

The semi-structured interviews used 10 high-level questions adapted from an interview guide developed by Lucinda Canty, PhD, RN, and used by the ANA National Commission to Address Racism in Nursing. These questions and interview script can be found in Appendix 4. Interviews usually lasted between 45 and 60 minutes. They were recorded via Zoom and the audio files were transcribed initially using Zoom technology and then by human transcriptionist for greater accuracy and formatting. Participants were sent the transcripts to determine if there were any corrections they wished to make or portions that needed further anonymization to protect from perceived retaliation.

The study team (e.g., Three nurses, and one masters level administrator)[33] reviewed the transcripts and identified potential themes, separately. We then discussed the themes and arrived at consensus on the themes; identified potential quotes supporting the themes; and selected potential "best" and "promising practices to be described here. "Best practices" are defined as interventions and initiatives for which there was some qualitative or quantitative evidence of effectiveness; "promising practices" are those for

[33] Short biographies for the research team are included in the Appendix 3.

which there are not yet any impact data, but we believe deserve consideration by the Foundation. It is important to note that many of the participants spoke about the impact of the public murder of George Floyd on May 5, 2020, as a sentinel moment that moved society, health-care organizations and the nursing profession to expand racism-reduction efforts. Given the recent and short timeframe of many interventions, few of the initiatives have outcome data that speak to their impact in ways that one might desire given the short timeframe for projects. All participants whose “best” or “promising” practices have reviewed the descriptions included in this report. In addition, any quotes or descriptions of participants’ views have been reviewed by those participants.

THEMES

Eight themes were evident from the interviews:

1. Nursing culture reflects a society that is so deeply rooted in white supremacy and racism, that the bias in the profession has not been obvious to many nurses.
2. A restorative justice approach of truth and reconciliation is crucial for understanding and addressing implicit bias and structural racism.
3. Having a shared value for the work is essential; however, it is also necessary to have shared definitions and language.
4. Some tools to address racism already exist or are being developed.
5. Data are necessary but insufficient for change; in fact, a preoccupation with data collection can inhibit the actual work needed to advance anti-racism efforts.
6. Diversity, Equity, and Inclusion (DEI) officers and other individuals responsible for the activation, policies and procedures for ensuring anti-racism approaches have mixed results.
7. Rapid and clear responses to racism are necessary to shift culture; but long-term accountability and sustainability need to be built into organizational mission, priorities, and processes.
8. Nurses can and should lead this work.

Theme 1. Nursing culture reflects a society that is so deeply rooted in white supremacy and racism, but it has not been obvious to the profession or many nurses.

Every participant we interviewed was able to share personal and/or professional experiences of racism, including as witnesses to racist interactions and organizational policies or practices, as two participants noted:

> *As a woman of color in the world, I've experienced not only racism within the health-care system but in the education system, as well as in my personal life, as a patient, as a woman in the community. It's just a part of normal life for a person that looks like me….You know that you don't send family members to a certain hospital in certain communities because you know that [they] won't be cared for adequately.*

> *[B]ecause I'm Black, because I'm a woman, because I wear a scarf? It could be all of it, but I definitely know when I say something, I need to say it three times. And I made it my business to say it three times because when I would say it once…people would say, "If you had told me. I would have done something about it."*

Another participant shared how the lack of real diversity in their organization's leadership supports the status quo:

> *[T]he last two managers were Black and the director over the Black manager is White, and I see that in a lot of places now…. They'll let them manage but the power's still going to be [with the White director]. [Those who] were saying [things that] are hurtful…what they're going to do is circumvent that manager and they're going to run to this director up here and this director is purposefully put in place and she's going to protect all of these people down here that are in the good old boy system.*

One nurse described being with a Black patient who was about to undergo a Cesarean section and was not fully anesthetized as the obstetrician began to cut; he continued to do so despite her telling him of her concern that the patient was still saying she was feeling the pain.

> *Then I tried to escalate it in a way that I could, telling the charge nurse—and to no avail. This patient went through her Cesarean saying that she was in pain, uncomfortable, despite my escalation of the situation. And the aftermath was that this doctor didn't get reprimanded. My head nurse did not support me in seeing it through.*

This incident reflects both institutional policies that protect physicians from being held accountable for racist treatment of patients of color, but it also calls out nursing's complicity in such racism and protection of those in power. Indeed, participants repeatedly viewed the culture of the nursing profession as being racist and problematic, as it reflects the broader society and has a long history of being led by White women who seldom see their own biases.

> *Florence Nightingale's legacy is really the colonization of nursing, and we really definitely see that and these Eurocentric Puritan ideals about what it is to be a nurse. I often say that nurses really don't need anybody to oppress us because we do a great job of doing that by ourselves and I think there's also this cognitive [dissonance] where we want to see ourselves as good people, and therefore we couldn't possibly be racist, we couldn't possibly be harming patients or our communities.*

> *Nursing was created with a white supremacy lens. So, with that, [racism is] just built into how textbooks are framed, how classes and knowledge is transferred, how instructors were taught, how we were taught as nurses ourselves, and how that carries forward intergenerationally.*

[Y]ou just don't have a lot of non-white nurse leaders in the higher levels that shape the culture of nursing. Nursing is still a very white place, from a leadership perspective.

Here are additional participant views of the racism that is embedded in nursing culture:

a nursing group, we talk a good talk. We say wonderful, aspirational things. But then if you look at the structure, and you look at who's in leadership, it does not reflect anything that we're saying.

As a white person growing up very privileged. I then started to recognize that...what I was seeing was racism. I grew up in a very homogenous [community]. There was only one Black family. So, it was also just our segregated society. And I think because it wasn't talked about and openly discussed in nursing school that we weren't helped to even see it.

The culture of nursing doesn't allow for a lot of diversity. Diversity in appearance, thinking, in trajectory, especially if it comes from people who are deemed to be "marginalized.

I had ambitions to go into leadership spaces in nursing. It felt very much like a closed network, a very closed society. I also experienced some of that in research...I didn't get the same networking. I wasn't included in publications that the team would have worked on….And it was a large research team that put out a huge mill of publications that would have really been helpful for me on that march.

I'm a White lady and most nurses are White ladies…Some of the racism I've seen in nursing academia in particular is related to nursing culture. It's the rigidity around what's right and that 'what is right' is very White supremacist….[There] is a lack of desire or resourcing to explore other areas of for example research,

exploration, or other areas or ways to bring students into a program and ways to evaluate students for their appropriateness as nurses, ways to evaluate students when they get into the program, or talking about who is a good fit can often be coded, and how to prepare students for the workforce. I think that our admissions criteria and some of the policies around matriculation and other ways that we prepared our students were…white supremacy at work.

The racism nurses reported experiencing not only came from patients but from nurse colleagues they worked on units with and their supervisors. This new registered nurse was met with alarming racism and highlighted the harm patients they serve can be harmed.

So, here I was 21 years old. I'm terrified…[and] sure enough I didn't last more than six months. I think the straw that broke the camel's back was I had a baby that was delivered one day and it had a mask over its mouth. So, I didn't know if I was to poke it or what to do. So I'm doing just like low vibe and three of the nurses just stood out in the hallway like this [arms crossed]. So, there is definitely a bullying, an isolation. They put their hands on me. They called me names. It was awful and nobody prepared me for that. It makes me tearful to this day. I was specifically told not to eat on the unit when everybody else was eating. So, that's the way it kind of works. You are isolated. You are given separate rules and if you don't follow them, there are going to be separate consequences that you're going to get. And so if you have to pay your bills, you need your job, you try to follow them….

I wonder if our nursing culture continues to perpetuate [racism] because everyone believes we're the most trusted profession. We love to rest our laurels on that. And so then it's easy to ignore. How could you be a trusted nurse and be racist?

> *I say to this day, all the work that we did in our department, had I been a different skin color, I'd have had accolades, promotions out of this world…. It took the pandemic finally for a superintendent to say, "Oh my God, I didn't know that your department was doing all of this, and you have shouldered all of this for so many years!"*

Both participants of color and those who are white experienced being shut down when they tried to discuss racism in nursing, whether with individuals, in their workplaces or in public forums:

> *Nursing's culture is just so grounded in whiteness, that to name whiteness is to become the problem. And, yeah, be immediately silenced and for many folks, pushed completely out, discredited, punished. Civility is a big word. Professionalism is a big word. And so then, anything that brings up feelings of discomfort, particularly in terms of even naming that reality and sort of the structures that got us here, is instantly viewed as problematic—or at least has been my lived experience.*

Even when the profession thought it was addressing diversity and cultural biases, it often was superficial or misguided. For example, a participant noted that, in recent decades, the profession addressed culturally diverse aspects of patients by adopting stereotypes that informed nurses' ability to provide culturally competent care. Several participants brought up the role of nursing textbooks in perpetuating racism and the importance of addressing this if the next generation of nurses is entering the profession with accurate information about people of color:

> *…we grew up with this cultural competency idea instead of cultural humility idea….[W]e were given [a] list of all of the attributes or interests of Asian people and Black people; and it got baked in, [including in] textbooks.*

> *[W]e [address] textbooks as well, not having the damaging information that still says things like Black people don't feel pain, they're stoic and other ridiculous and foolish type thoughts.*

This work may have already begun, as one participant noted that a publisher had invited her to revise a chapter in a textbook to remove inaccurate information and biases about people of color. But it's more than just textbooks:

> *It needs to be a part of every conversation, every training, any time you teach fetal monitoring….We had a nurse…recently who was trying to listen to the fetal heart rate. She says, "Oh, your little monkey's moving around." She realized after she said it that that was racist. But she didn't know what to do about it. So, all the nursing schools need to make it a priority to talk about [racism and implicit bias]. Two things that need to shift for people is that skin coloring is not tied up to genetics. Bottom line. People graduate today…were taught that race is a risk factor when race is a myth…. So that has to be completely redone in every educational program in the country. And that's part of where it starts. So, we are actually working on talking about all the textbooks have to be redone. NCLEX has to be changed because people will teach…to the NCLEX. They'll teach to the tests.*

Many participants recognized how the history of racism in nursing and the United States has affected their own responses and willingness to disrupt the status quo and engage colleagues in doing so:

> *In the United States…poor people are [viewed as] less deserving…, [and] if you're a person of color that you're more likely to be poor…. There's so much marginalization of people based on their skin color, and these assumptions that go into how care is given, based on the color of a person's skin. I've heard that and probably also participated in those kinds of ignorant approaches to*

care over many years or been silent and been uncomfortable, and just like didn't quite know how to what to say or what to do.

Several participants frequently noted that the racism they experienced affected their career opportunities and progression, as articulated by the following two nurses:

[A]fter going back for my master's, I could not get work in the place that I had worked at for 10 years. I could not get a place as a family nurse practitioner. I could not be hired despite excellent evaluations. I was always used as a preceptor for nurses on labor and delivery. There [were] all the indications that I was doing quite well in my career. However, my white colleagues got the positions.

People have tried to deny me opportunities for advancement – with the caveat that they were really doing something good for me – saving me from a job/or a position I didn't want – so I could focus and be successful in what I was doing. Really, this was only an excuse that made it easier for them to deny me opportunities.

It also has impacted patients:

Why is it that, if we're majority Black and this is a baby-friendly hospital, our Black moms [are] not successful in breastfeeding but our white moms are? The white moms that are asking to breastfeed, 80 something percent of them were able to go home breastfeeding and it was like 30 percent [for Black moms]…why is it still okay when we go into a room where the people are of color and the first question we want to know is whether or not they're married and oh, by the way, "Baby Daddy, how many other children do you have?"...When we're again speaking of a White father, it would be partner or it would be father of the baby. When we want to be negative and crass about Black people, it's Baby Daddy.

Every day people are being harmed in healthcare….And there's this lack of awareness to that, and it's a chosen lack of

awareness…. There are decades and decades of evidence—it's ridiculous the amount of evidence. But [the response it is], "No, [racism is] not happening" because at the end of the day, [acknowledging it] means they have to act.

When you know somebody has a high-risk patient that is not of color, oh, they're helping the entire day. The [charge nurses] are helping, they're jumping in, they're making sure that you're not left alone in a hemorrhage or in an eclamptic seizure. I've seen people of color where you can't find anybody [to help]. You're in that same emergency, and conveniently everybody's at lunch or conveniently everybody's in their rooms and they're busy. It happens time and time again..

Most recently we had a White patient on our unit for some time and he was on a PCA—that is a device that delivers medication—for about three weeks for an abscess in his leg. We had a Black patient who had open abdominal surgery and the PCA was gone within three days, and the patient was basically on Tylenol and Ibuprofen. It took a lot of extra energy to get that patient the pain medication that they needed, but it was worth it. The huge disparity was just beyond ridiculous.

Participant spoke of witnessing racism that was embedded into institutions' organization and delivery of patient services:

I worked in systems where disrespect exudes [through] the entire experience. Like…patients with public assistance or Medicaid [being] on different floors. They're not even painted nicely. They're not fixed up as nice.[34]

[34] Authors' note: On May 20, 1994, the *New York Times* reported that two academic medical centers in New York City were accused by the New York State Department of Health of segregating maternity patients by race (https://www.nytimes.com/1994/05/20/nyregion/2-hospitals-are-accused-of-segregating-by-race.html). In 2018, a nurse working on the maternity floors of one these same medical centers shared with of the authors that this practice still existed.

I've had institutional police officers tell patients they're gonna blow them away, that they're going to call ICE on them because they're undocumented workers. The use of child protective services [CPS] on birthing individuals—If you have a positive toxicology screening, it's likely they're going to call child protective services on you and you could potentially have your children removed. Just recently, we had a birthing individual who had to come back to the hospital because she was having some complications with her blood pressure. Her family members watched the twins for two days but said, "Hey, I have to go to work." So they brought the babies to her and the hospital typically provides services. They put the babies in the nursery. So because we were short-staffed, their solution was to call CPS and have them take the babies because if the mom were to decompensate and she had the children in the room, who would then be responsible? I have to put on my armor and go to battle over that as well because you are not going to take these babies on my watch because of staffing issues and it happened to be a Black mom. So, if this mom was white, or this birthing individual was white, would we have received the same response, which was call CPS and separate her from her infants?

Nonetheless, participants felt a sense of urgency to seize the moment created by sentinel events that have shifted how they and their organizations respond to racism. While a number of participants spoke about having a long history of trying to call out and rectify racism in interactions with colleagues and in their organizations, George Floyd's murder opened the door to the expectation that individuals and health care, academic and other organizations examine their own biases and address structural racism:

There was no urgency before the entire country stood up and woke up and decided that they no longer want to watch Black men being murdered and Black people being murdered. Or it was too shameful for them to continue to watch it. And now how bad do we

> *look if we don't say something? How bad do we look if we don't put a commission together to say something?*

Serena Williams's experience of having to continually convince physicians something (pulmonary blood clots) was wrong with her after childbirth similarly prompted people to reflect on their own biases and those within their organizations:

> *Serena Williams, probably one of the most privileged people in the country as far as like money and status…, almost died because people wouldn't listen to her. So she advocated for herself. We don't feel like the average person…even has the ability to get people to listen to her to them. So we need to change ourselves.*

Theme 2. A restorative justice approach of truth and reconciliation is crucial for understanding and addressing implicit bias and structural racism.

Truth and reconciliation is a process in which community members come forward, share and document harm, and ways forward. This kind of process, famously conducted in South African post-apartheid, convenes stakeholders — perpetrators of harm, survivors, beneficiaries, witnesses — to clearly describe traumatic events and, ideally, to initiate community-based recovery. By necessity, Truth and reconciliation processes include research, public acknowledgement of action or harm, and the engagement of community members in imagining remedy, often outside the threat of legal prosecution.[35]

Participants spoke about the importance of those who experience racism being believed and heard when they share or report it, particularly to white people who do not have the same life experiences as people of color.

> *[M]any people might say "Oh, well, that's not racism. That's not discrimination. That's just so-and-so being rude." So people try to minimize what that is and don't call it what is…. I just say "Hey, this*

[35] Institute of Justice and Reconciliation (2008), *Truth Justice Memory: South Africa's Truth and Reconciliation Process [Introduction]*, archived from the original on 21 December 2021, retrieved 6 June 2023

> *just happened to me. What do you think?" Because you question yourself. "Is this racist? Is it not?" And bottom line is' if that's what it feels like, that's what it feels like.*

Recalling the pain and harm of these experiences, even when they occurred many years ago, was still traumatic and emotional for many participants. Repeatedly, they noted that racism harms. It harms individuals and our society. Dismantling it requires owning the reality that racism is embedded in our professions, workplaces, and society.

"Truth and reconciliation"[36] is necessary for such ownership. Ownership by all cannot occur without understanding and establishing roles in dismantling racism and supporting anti-racism efforts. One participant who is a nurse educator noted:

> *[W]e had some significant harms that were occurring within our program due to racism and other discriminatory factors from faculty, and about two years ago we took on using transformative justice to work towards solutions and took on actually a truth and reconciliation process which I led….[U]p until that point I had not seen anything really be effective at helping reduce racism and the impacts from racism. What we did through our program was very intentional….[O]nce we got to that place where we could hold people's experiences and be able to move through it reflectively without having that defensive reaction that everyone seems to have, we were able to open it up and create space for people to share their experiences. We did that with students, alumni and then community stakeholders over the course of about a year. Through that, we had very clear ideas of what needed to change.*

Truth and reconciliation require ongoing conversations and careful listening for deep understanding of experiences of racism and a focus that moves from individuals to the organizations and society in which they live.

> *How do we repair the harms, and how do we move forward? [O]ur goal is to have a truth and reconciliation event after we've completed all of the analysis, we've verified our results with the community. And then, we want to have community action labs in the community to look at the ways that we can repair harms, or not replicate the harms as we move forward, and to really be a better community partner. The med center…sits in this poorer county, and we have not been a good community partner. There's a lot of distrust. And so how do we address that? So it's very community-driven. We've had community participants say one of the things they think all students just need to do is to listen to the stories. Because one of the biggest themes is no one listens.*

The conversations must also include the history of racism in society and its persistence today.

> *[A]s we were developing [our truth and reconciliation work], we knew that we had to lean on the past and to educate folks because the United States does not educate us about the truths. It's almost like "Why should Black women be believed because there's no evidence that…?" After hearing that slaves were happy and they participated in the atrocities of Dr. Sims[37] …why shouldn't Black women be happy and why should racism be a thing that is acknowledged as existing now? It's been, for lack of a better term, whitewashed.*

Participants noted the difficulties that arise when confronting racist behaviors or organizational policies if there is not a structured and sanctioned approach for these conversations to occur. Many participants noted that people of color often are left feeling silenced and shamed after confronting a colleague or manager with a racist

[37] The first successful operation to correct vesicovaginal fistula was developed by physician J. Marion Sims, an Alabama surgeon who carried out a series of unethical experiments on enslaved Black women and poor immigrant women between 1845 and 1849.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563360/

incident that is dismissed. Participants shared experiences of white people feeling angry and shamed when confronted by their own racist behaviors—white nurses crying instead of trying to understand what was being shared with them—in ways that reinforced their fragility and shut down conversations.

> *There's almost no greater danger than a nurse or member of this culture with unearned power, such as somebody deriving unearned power through the whiteness of the culture, who feels 'like they've been shamed or scorned or "called out.."…*

Conversations about racism can be complex and hard. Using a clear framework and principles for how these conversations will be approached can create a safe space for everyone. As one participant noted:

> *Deconstructing and reconstructing and healing…I really would like people to understand that it is going to be very uncomfortable for people who haven't unpacked their own biases and issues to hear a group of people who have felt so suppressed and so I guess stagnated in their movement….And in that uncomfortability people have to understand that us speaking out against racism and being anti-racist does not make us anti-white. It just makes us more empowered in order to feel like we can finally talk about this. It's like cathartic for us to be able to.*

Nonetheless, participants were clear that dismantling structural racism will not occur unless we have these conversations. The tension in addressing racism lies in two important factors highlighted by critical race theory[38]: 1) Racism is ubiquitous and embedded in our society and 2) Undoing racism requires individual and institutional interventions, given that racist behaviors will occur; but how the institution responds and hold individuals accountable is key. Health-care organizations and the nursing profession are inclined to believe that "educating" health-care workers (HCWs) on implicit bias and other aspects of racism will address racist behaviors. While it may be a

[38] Foundations of Critical Race Theory in Education: Second Edition. Edited by Edward Taylor, David Gillborn, and Gloria Ladson-Billings. Routledge Press; 2016.

component of truth and reconciliation initiatives, trainings are not sufficient. “[S]ending people to some education classes…[is] not really getting to the trauma and what we are doing in the moment.…[W]e have to have another way to approach this; otherwise, we'll never get there,” said one interviewee.

Several participants who have engaged in structured approaches to truth and reconciliation noted that there is a difference between the process and content when identifying and discussing racist behaviors. For example, nurses engage in shift report about patients on their unit and those reports can include nonessential information (e.g., number of partners a patient on a maternity unit has had as fathers of her children) and language about a patient that can convey and reinforce stereotypical biases; i.e., content. Standardizing shift reports to eliminate race and ethnicity if irrelevant is important, but staff may still talk about patients in biased ways. Disrupting the racism that is embedded in everyday conversations among health-care workers requires an organizational culture and leadership that has embraced truth and reconciliation as key to driving health equity. (See Theme 7.)

One participant shared their experience as a faculty member who is committed to ending the ‘otherness’ *(e.g., racial and homophobic bias)* that exists in their school and U.S. society. As she led work on raising awareness of long-embedded biases, including in schools of nursing and curricula, she realized the importance of the process beyond concrete deliverables:

> *I think at the first, I thought the process was about like, “Let's produce a new curriculum.” But now I realize the process was about the process because the conversations and the engagement and the relationship building [were] the key. The relationship building that's happened over [three years]—the process of getting to where we are now—has been probably…[been] the most valuable part of that in terms of effectiveness at shifting culture and the nature of some of our conversations. And I can't say whether or not it's been truly effective because again, I sort of sit in a space where I don't think I have direct access to knowing that [as a white*

person]. But I do think that I have noticed the words we use, the conversations we're having, and the subsequent policies and approaches we're applying to things—at least in the program that I have some control over as the director—have changed considerably over the last few years…. [We] pulled the whole faculty assembly into it. Because every time we had something new and we're giving monthly updates, they had to read it and talk about it and debate about it or not. And there was debate. There were folks who did not like what we produced, which I guess with any type of thing you're bringing to a space like that, it's not surprising. But the faculty had to consent to it, which I do think is a form of buy-in and which I hope will allow us to move forward

In addition, participants noted that historical harm from racism needs repair and this cannot occur without a culture of accountability. *"We spent a lot of time for the faculty…to first be able to acknowledge and hold the fact that we cause harm as faculty, and then be able to hold accountability for those harms and move towards action."*

Accountability is part of the process of truth and reconciliation and requires resources: *"[W]e really do need to invest in that conversation…. It's going to take years. And we have to be ready for that journey."*

One participant is using their position as the director of a clinical service to hold staff accountable as individuals: *"I say something like 'I hear you, we respect you, and we deserve to be treated with respect. Your comments are biased, your comments are racist, and we expect that you don't use them anymore.'"*

The organizations in which nurses and other HCWs work also need to be held accountable for expecting and supporting this truth and reconciliation work. This is reflected in Theme 7, but participants noted that truth and reconciliation occurring within academia, health-care organizations or professional associations needs buy-in and participation for all levels of management.

The expected outcomes of truth and reconciliation are that people are heard, their experiences of racism and the resulting harm acknowledged, and people are willing to commit to creating a different future. As one participant said:

> *Am I biased because I'm expecting [racist experiences] to happen? So I have to recognize that I'm expecting it to happen. So, part of the problem is myself. So, I want to be very objective when I'm doing these things…so we grow from it…. I'm learning that I also…have to listen in order for it to be a conversation…. And if someone thinks a certain way it's really not my job to make them think differently, but I expect them to treat me respectfully…. So that's the outcome that I want. Whatever you think I am, but when I'm working with you…, I expect to be treated as an equal.*

Participants were clear about the need for truth and reconciliation to be foundational to other efforts to dismantle structural racism. *"I think the work that remains is that we remain consistent in having conversations about the impact of racism and racism being the lens that we look through in making lots of our decisions."*

And it must involve communities and be interdisciplinary:

> *It's going to take all of us….[E]ach health profession has been kind of tackling this on their own….I would like to see some sort of collaborative effort, so that we're not operating in silos, so that we can maximize our potential impact.*
>
> *We have to think outside the box and really involve the community more, quite honestly; because we need them in order to get this stuff changed, because sometimes nurses talking to nurses or doctors talking to doctors doesn't always result in the change that we want. But I think that whatever it is, it needs to be interdisciplinary where we have patients, providers, legislators. It really needs to be an interdisciplinary forum because we need everyone onboard in order to make some of these changes because…if we don't have every onboard it won't really change.*

Theme 3. Having a shared value for the work is essential; however, it is also necessary to have shared definitions and language.

Participants said dismantling racism is difficult, if not impossible, without a shared value for the work. Raising awareness of racism is a key to creating this shared value and being able to garner commitments to address it.

Creating a shared language starts with understanding the history of racism:

> *I don't believe that you can go any further until history [is understood]—capital H history, History of the country, the History of the organization and institutional relation to the community, the History of that community and the History of your profession. It's not a quick 'let me pull out a book.' I'm not talking about revisionist history, either. I'm talking about the real connections between the founding of the country, the inequities and disparities and the racism that is structurally embedded. And understanding that and teaching that and getting grounded in that first.*

One of the major obstacles to creating a shared value for anti-racism work is understanding what racism is.

> *Do we even understand the fundamental concept of racism? Until you understand that, you can't lead the way in breaking down those barriers. So it is up to me as a co-chair along with my other co-chairs to educate nurses and whoever is a part of the committee because once we're fully educated, then we can go out there and make a difference.*

Participants were asked about their experiences of racism and whether these were attributable to nursing culture. The following response highlighted the importance of definitions.

> *But I really think [describing my experiences of racism] depends on how we define racism…. I'm going to use the National Commission to Address Racism and Nursing definition because they call it the*

> *assault on the human spirit in the form of actions, biases, prejudices, and an ideology of superiority that's, of course, based on race, and that it causes moral suffering and harm…. [I]t also drives injustices in what seems to be this never-ending cog wheel that churns out inequities with every generation….When the Commission to Address Racism and Nursing explored racism, they found that superiority continues to be, or continues to surface as a primary driver, and it starts at the top.*

These shared definitions and language lead to shared understandings that can help people to move from the personal to the organizational and structural levels of racism. Understanding the level at which racism is operating is crucial to grasping where best and potential practices may differ from levers of opportunity or accountability. One participant stated:

> *[W]e will begin to, one, define the language of what structural racism looks like because there are a lot of folks, you know, this is new terminology for them. And then…what does this mean for patient care…how it's then reinforced in practice, particularly, when you have a clinical guideline that will say do this if your patient is Black, do this if your patient is other [someone considered different from the racial or cultural norm]. Right? Or even the way, health systems are set up in terms of who gets access to quality of that care.*
>
> *And I think there are, particularly, some folks that are doing work that can measure the way structural racism shows up in health-care systems….I think that once we get to kind of like the root cause of what structural racism [is] and how that shows up and [leads to] these downstream outcomes of both interpersonal bias between not just clinicians and patients, but between clinicians, will almost sort of fix themselves. And then, that will lead to, then, the downstream outcomes of addressing health disparities….*

> *And so, I would say, "Okay. Let's talk about the language we're using, so we can make sure we both have a clear understanding of definition. And it's not that we're talking about individuals. We're talking about the systems in which people operate, so that you don't necessarily know you're operating in this type of system that is producing those types of outcomes." And so that language resonates a lot more with, particularly, clinicians than when we just say, oh, just racism as a general term. I find myself updating my language to be able to keep up and I work in this space full time. And so, I think that is probably one of the biggest challenges before we can even have the really deep heart conversations, there's just particularly words and terminology that some people will shut down immediately before you can get to the next step.*

Another reinforced this view, describing how they approach people when having conversations about racism:

> *"[L]et's talk about the language we're using, so we can make sure we both have a clear understanding and definitions; and it's not that we're talking about individuals. We're talking about the systems in which people operate [and] you don't necessarily know you're operating in this type of system that is producing those types of outcomes." [T]hat language resonates a lot more with particularly clinicians than when we just say, "Oh, you know, just racism is a general term."*

One participant spoke to the power of paying attention to language:

> *I was in a meeting at my current employer. We were having a conversation about how to address racism in curriculum amongst faculty, and one of the faculty members brought up that, when we frame doing anti-racism work in academia, we have to frame that from a trauma-informed lens because that's much more palpable for people to understand. People understand, "Okay, we have to*

assess the trauma and take that into account to their experience as to how we're going to make some change and really speak to these individuals where they are." And I was like, "That's genius!" Because when we say, we want to do structural racism and structural competency and anti-racism work, people just get all their biscuits burnt and panties in a bunch.

Participants also noted the importance of creating a "safe space" to talk with people about what racism is:

I spend time talking about the types of racism, how they manifest, examples from my experience, [etc.]. And trying to create a safe space…where we can talk about white privilege and not make you feel like you're a bad person because you have white privilege….The best I can come up with right now, is really lay a foundation of what racism is. Because then people get caught up in the interpersonal…. So it's still kind of working on that we have a problem, you contribute to it, we have a shared common goal, we all want our communities and our patients to do well. So now we have to take these steps together.

This modeling can be by white nurse-leaders who acknowledge when they or their organization has mis-stepped. One participant appreciated the message delivered by a dean of a school of nursing that was preparing to celebrate a Florence Nightingale memento the school had acquired, until nurses of color expressed their concern.

And then you get a message from the dean, "The event has been canceled. We received numerous feedback that, though we appreciate her contributions to nursing science, we don't appreciate how she contributed to hurt and harm indigenous people of color."

Participants of color often shared stories of white patients refusing to have their care provided by nurses of color or based on some other characteristic. Nurses at one major academic medical center realized that there needed to be a consistent, immediate response when such situations arose:

[I]f it's something due to their race or religion or background, we assure them that they [RNs] are educated, licensed individuals—they're professional—and validate where they're coming from, meet them where they're at; but also validate that our team members are very competent, they're well-educated, and they're trained in their profession. And our policy is if somebody refuses to take one of the nurses, then we say that we're…"sorry, but we can't provide care for you."

These nurses at this institution created a policy that addresses situations in which a patient refuses care from a particular nurse and also developed a pocket card for all staff and managers to use that provides the language to be used to respond to the patient (see Promising Practices). This was one of the first initiatives developed by a nursing council set up to address racism within the institution. It is part of an ongoing plan.

Changing what constitutes "best practices" can also help to undo implicit bias and structural racism. Something as routine as shift reports by nurses can help to shift engrained racist behaviors.

[F]or me best practice would be…emphasizing that shift report where we're doing it in front of the patient where there's less likely to be a lot of those undertones and biases; …we're here in front of the patient where the important stuff is being [reported]: How far dilated is she? How's her pain being managed? So we're focusing on those things and not her social situation…. A lot of times nurses would rather do it at the desk. They like that social stuff. People like to get into the lives of these patients and dig through their personal history and they feel like that is what you need to know, and it's not really. It's almost like "we can't save everybody," and so the biases kind of give you the "it's okay." If this one has an eclamptic seizure and dies, well, guess what? She is a teenager anyway. She probably shouldn't be pregnant. She missed three visits, so she

doesn't care about herself; so hey, if she has a hypersensitivity crises and croaks, then it's really kind of on her anyway.

Theme 4. Some tools to address racism already exist or are being developed.

Most of the participants were identified for interviews because they had been engaged in developing promising or best practices that demonstrate how nurses and others can address structural racism (see Appendices 4 and 5 for examples). They described both setting up the infrastructure for ongoing anti-racism work and ways they are intervening to dismantle structural racism. One participant spoke about their conviction that providing nurses with tools for addressing structural racism can empower them.

When I asked…all the nurses, "If tomorrow you were in charge of dealing with bias in your emergency room, you are empowered, you could do anything you wanted, they were going to give you full power, what would you do?" And every one of them said, "There's nothing we can do." Which was heartbreaking and disappointing and frustrating for me, and I had to keep a straight face with that. But I think the tangible things that say, "Here's the problem. Here's something you can do. And here is how you hold yourself accountable. So here are the metrics, or here's the process by which you need to evaluate that that actually works."

They described the expansion of infrastructure in their organizations as one means to engage as many people as possible. In several cases, DEI councils have been established within the organization to guide the work and get buy-in from frontline employees. For example:

I've been the lead for setting up diversity, equity, inclusion, councils across our 9 hospitals and I think that's extremely important to have a bunch of different backgrounds at the table, and a whole bunch of different perspectives at the table, to educate the Council, and have to like a train-the-trainer type of thing where it has a trickle-down effect.

Participants described a number of approaches to addressing structural racism that they either developed or adapted from others. Educating staff about DEI was a common priority that differed in specific approach. For example:

> *We also started doing education called Inclusivity Reset [included in Best Practices] —a lot of that content is evidence-based—and we've been doing that training throughout every possible department trying to make sure that we get a 100% of our employees within our organization trained on that. So within that education, we define what diversity is, equity, inclusion because I feel like [it is] just the basis…. [I]t's very interactive education where people share their different experiences. We try to especially make sure that people who may not have been like a direct victim of blatant racism understand what it means to be an ally.*

However, one participant had concerns about implicit bias training in medical and nursing practice and education.

> *The solution we've had to fix health disparities are through things like implicit bias training…. [T]here's tons of research that has just shown that it's not producing the outcomes that we have desired over the number of years it's been evaluated. And so, from my perspective, we have to get down deeper into…what is taught.… [I]n medicine, there's been a really strong movement to teach against race-based medicine, race correction factors. I have not yet necessarily seen that great of emphasis on nursing education to teach about things like the estimated glomerular filtration rate, the vaginal births after cesareans, or anything that uses a correction for race. I think there's an opportunity to start to interject that into the curriculum of nursing education, both at the undergraduate level, but then, also, at the continuing nursing education level.*

Several participants cautioned that bias can be embedded in how we think about and develop tools for dismantling structural racism. Even which data we collect to determine

where anti-racist opportunities lay may be steeped in bias, including how we interpret and use data.

> *There's a big push in tech now to start to collect patients' ethnicity, race, sexual orientation—not just for the sake of data collection, but to begin to stratify [clinical outcomes by these variables]. How do we start to reach these populations? Are we seeing a trend of more heart disease in a certain population? Until we can start to like really get down to certain granular levels, I don't think we can really just like toss an initiative out there. So, when we start having these conversations, it's about bringing clarity and bringing meaning to the initiative. So, someone's like, oh, yeah, they just want us to start collecting race. Then I can interject and say, "Did you know that such and such is more prevalent in this [population]," and bring it to life. [Nurses] have to take [their] experience and toss it back up to the other people who are maybe finance pros. I know people who can work data sheets like nobody's business. But until you make sense and correlation with how that tracks back to the patient, and how that affects the nursing community—I feel like you got a lot of gaps, and at this time you can't afford gaps.*

But one participant with expertise in data science noted that there is deep bias in that field that nurses and other should scrutinize:

> *And then also, algorithms [are] created by data scientists, a high number of whom [are] White males. And so when you think about things mathematically, if you don't have this other lens, …that's where algorithms go wrong because data science is built on what you input. And if you say, just look at carrots that we go and just look at carrots. But it's like, alright, you're not looking at vegetables. You're not even looking at fruit. You just look at carrots at this point.*

Identifying the systems and protocols in health-care organizations that perpetuate racism can be a challenge, as they are not always obvious. This includes ongoing developments with myriad ways that artificial intelligence (AI) is being used in health care. One participant whose work includes AI tools for clinical care said:

> *I've also talked about thinking about how we build things. And thinking about the bias that's baked into how we build things….[including] for the important stuff, which is clinical outcomes. If there's bias in there, you need to know what those biases are, and adjust for them; or else you're creating other biases that you don't even know about…. And it's like this tip of the iceberg thing—when you think of health care, where there's all of these systems, and we have all of these algorithms, and more and more machine learning and artificial intelligence—And if we don't understand the context, then we don't understand how…some of the biases [are] working. We just keep propagating those biases…. [W]here we are right now with artificial intelligence, it would only…increase the kind of racism and bias against certain types of patients that already exists. And I know that from the work that I do.*

It also includes clinical tools that have been accepted as valid and integrated into the electronic medical record.

> *It's actually kind of shocking, and kind of not, but there's so much bias built into this system. We've started at 231 different forms of biases, just around clinical decision support. And we've recognized that when you start thinking about the fact that…a lot of clinical decision support, it's…basically a sensor for clinician workflow. And if there's inherent bias in clinician workflow, then that bias is transformed into clinical decision support. And so, one of the things we did when we were trying to reduce the bias in our work, was we compared it to some of the other clinical decision support algorithms out there. There's a whole bunch to try to predict if a*

patient is going to deteriorate. And we realized after we had felt like we debiased ours, when we compared ours to theirs, that there's still a number of popular clinical decision support systems that perform much better for white patients than non-white patients. And so….I'm a big proponent of all of the problems that people are trying to fix in health care, like documentation burden…. If you don't think about it through a diversity inclusion perspective, then you're never really going to fix the problem. You're just kind of going to be ignoring a big part of it.

Similarly, simulation is being expanded as a learning tool in nursing education. One participant spoke about how it aids student and clinician learning about racism and responding to it:

Simulation is needed in nursing whether it's undergrad or graduate, nurse practitioner, nurse anesthesia, doesn't matter. The thing is that the simulation needs to change. Simulation meaning educators operationalizing a culturally responsive simulation. So, for example, simulating dialogue with those [for whom] English is the second language and how to deal with that….Incorporating scenarios on how to deal with patients with a racist ideology. We can learn that in simulation. We can all talk about that in simulation.

For academics, dismantling racism can and should include how research is done and taught. One participant spoke of a "design justice" approach to research that requires engaging the community in the research even as the focus of the research is being developed, and teaching students about this approach.

[I]it's actually about building community within the program on and off campus and with community partners…. We start the first couple of semesters with, "Let's understand who our accountability partners are in any given space. Let's figure out how we already have a relationship with them or would maybe need to build relationship with them. And then how do we move from that to then

> *what are some of the possible research questions? What are some of the possible approaches? So we're flipping it kind of on its head and using a design justice approach from the beginning. It took [some of] the faculty…a while to wrap their heads around this idea that we don't just start building research protocols from the first semester. We…need to back up and understand the critical history of any topic. What has already happened? What's been done? What are the histories too of trauma or generative work, whatever it is? How can we have some appreciative inquiry? How can we know who our accountability partners are? How can we center them in the generation of anything that comes next? And how will they be involved?*

This participant also spoke of the opportunity to build in funding for community engagement in research work.

> *We just got a new research theme funded…which some firm reps and I have created that includes in it seed funding specifically to pay accountability partners in community…for their labor and expertise at the earlier stages of these processes. So, oftentimes that stuff is built into grant proposals, but this is for before you even get to the research question. Are there folks that are going to…have their time and expertise taken without really any meaningful way to compensate them for that.*

Some participants articulated a difference between the intent of the approach and its impact. Some felt that it does not matter what your intention is; what matters it the impact of what you said or did. Many participants were able to describe experiences in which the intent to address reported racism only produced harm for those reporting the racism and those who may be involved in a racist interaction. Two examples are:

> *People always say when they're in conflict, "[T]hat wasn't my intent, but I'm sorry for the impact." And then, what then? …[M]aybe another way—when we're going to have a difficult*

conversation—even before we start talking about the issue, share with everyone…what your intent is.

Another participant addressed this obliquely.

[M]y biggest fear is—let's say we [have a] grant for simulation to really explore health equity and scenarios in there. If the faculty don't know how to teach that, if they can't debrief through it, if they aren't effective, then again, we're in the space of either not accomplishing anything or accomplishing harm.

Person-first language was identified as a small but significant way to ensure that the impact of an interaction is aligned with the intention of maintaining the humanity of the person. One participant who focuses on people who have contact with the criminal justice system described the importance of first-person language in their workplace, other settings and in publications:

I know there are some champions around the country who have done work in custody settings, and are excited to talk about nursing in custody, nursing and jails, nursing and prisons, and how that looks. I think historically, it's been done…in a limited way…but from a pretty stigmatized perspective…for example, using "inmate", "prisoner", "convicted felon" in things like that, words that I refuse to use and have been taught by my directly impacted colleagues are harmful and shameful, and continue the stigma. I agree with trauma-informed perspectives, but also ensuring that racism doesn't fall off and "trauma-informed" doesn't become the euphemism because we tend to do that with, "You know, the microaggressions that I'm experiencing." No, the racism that you're experiencing.

Another participant stated,

[A]nytime I've had the opportunity to talk about it with other nurses I've really tried to get the word out about humanization, person-first

> *language, talking openly about racism in these systems, and also talking about the community-level effects of it…. How we can be so quick to put people in these different categories of deserving care and not deserving care. And people that are safe to provide care to and people who are unsafe to provide care to.*

Participants talked about external funding support for developing and sustaining anti-racism tools. For example,

> *[E]xternal pressure is important for accelerating because people have to be motivated to do the work…. I also think funding opportunities really help, right? If you can get a grant and bring that into your program to do this work, that can be a major motivator. [W]hen I encounter nurses who are…trying to understand [and] starting to do the work, they just don't know even where to start. So I do think some funding around toolkits, maybe academia type toolkits. Even if you had, for example, for academia, a structured outline of content that should be threaded throughout the curriculum, and what the competencies of the people who are teaching that should look like.*
>
> *And maybe there's grant funding, or toolkits, or education to help nurse leaders have a change in their frame of thinking.*

Finally, one participant articulated the need for nurses to include policy levers in their toolkit for addressing systemic racism*: "We really need to begin to leverage policy so that we can have an impactful change on healthcare and healthcare delivery and begin to dismantle some of these racist policies that have just been embedded in the way that we practice."*

Theme 5. Data are necessary but insufficient for change; in fact, a preoccupation with data collection can inhibit the actual work needed to advance anti-racism efforts.

Participants spoke about the importance of data for driving change. Data can provide a insight into the problem and undo misconceptions that may be steeped in bias. One participant spoke about this in regard to maternal mortality:

> *[T]he clinicians wanted to blame the patients.…I read every death that happened. We formed a maternal mortality review committee for the state. And we had to set it up. We had to be very sensitive how we set it up because there were so many challenges in the past. Anyway, as we read every death, there were some deaths that really haunted me, of people of color who had hours and hours of not being taken care of. Just ignored. And the aggregated data showed this huge disparity.*

Some participants were focused on looking at disparities in nurse-sensitive indicators,[39] but acknowledged the importance of having someone on the team with expertise in data sources and management:

> *We are looking at data for 2023. We're going to start looking at our nurse-sensitive outcomes, particularly hospital-acquired pressure injuries, Stage 2 and beyond, to see if we see a disparity or discrepancy in care—and understand I do not have that skill set—…through a data analyst to help us with not making gross guesses but using the data to tell our story and to lift the lid to see if we see anything.*

Other participants confirmed that accessing and interpreting the right data can be a challenge:

> *We haven't even really done a deep dive into the data because our data is very difficult to ascertain. When you can't get it, when it's not readily available, you're unable to present it in a way for them to*

[39] https://ojin.nursingworld.org/table-of-contents/volume-12-2007/number-3-september-2007/nursing-quality-indicators/

> *understand practically. [The hospital's leaders] know there's an issue….*

But other participants argued that more data, in itself, won't move the needle on structural racism in nursing and health care. The existence of data doesn't always beget/lead to action.

Another participant shared this perspective:

> *I feel like as an industry, similar to the social determinants of health, we spend so much time trying to convince people there is a problem. And then we spend so long researching the problem. Like, "Oh, look, here's evidence, here's evidence." Okay, like after a while, we should just jump into action instead of this continuous waiting for full buy-in. You're maybe not going to get full buy-in….*

Participants were clear that the data must be used to drive change. Making data visible to frontline staff was crucial in one hospital unit's effort to reduce racial disparities in breastfeeding practices; but using data to hold staff accountable for improving outcomes is key, as noted by a participant who was in a leadership position:

> *[We] engaged nurses in pushing the levers that need to be pushed to have [reduced disparities in mothers breastfeeding on discharge] happen…. [O]ne of the key factors that's needed is the visibility of the data. You know we shouldn't depend on people to have to go somewhere to find what's our current breastfeeding rate…. [W]e make [patient satisfaction] very visible on our Huddle boards, which is centrally located in the nurses station…. It's part of the Huddle boards. So…visibility is super important and connecting it to the "why"—Why is this important? It's important, because, you know, we're committed to providing the best experience…for our clients, and we know that breastfeeding is one of the best things that we can do to improve a nutrition, a bonding relationship, you name it.*

One participant described the role of data in driving change in nursing practice:

> *[W]e were looking at acute care emergency departments and how frequently patients were put into restraints. And when we looked at race as a variable, we found that being Black made you much more likely to get put in restraint than if you were White. Now, we did not see that correlation with Asian, or Hispanic, or Latinx individuals. In fact, it was inversely related…. [I]t's very clear that if you're Black and come into a [our] emergency department, you're three times more likely to be put in restraint than if you're White. And so here, we can't ignore that. And so that was the evidence that we had. Really, I think it was a best practice to one, collect the data because nobody was proud of this. And then to try and address what the data shows and to try and fix that…. [W]e put a task force together. We brought in our DEI folks, we created an educational package that was actually pretty robust. It had e-learning components, it had in-person courses, and it was specific to emergency departments. And we followed that up with also practice changes. So we debriefed every restraint episode and we collected better data than we had before…. And we definitely had a drop in restraint usage of persons of color*

Another participant agreed that data is important for holding people accountable for changing behaviors and practices:

> *If you had measurable outcomes for clinicians that held them accountable for the care that they provided, I think that makes things change…. [A]nytime you can measure something and give it an outcome and hold people accountable, I think change comes.*

One participant argued that quality improvement science provides a framework for collecting and using data. "*I really feel strongly that the quality improvement methods and tools are really the approach.*"

While clinicians often focused on patient data, several interviewees questioned use of specific types of admissions data. Several participants said schools that rely on the data

obtained from GREs or other such “standardized” exams for admission to their programs are perpetuating discriminatory admission practices.

> *The evidence has been out there from the testing agency themselves that they're [standardized tests] predictive of success their first year, and women, people of color, and others – score lower. This is well-documented. So, if people rely on GRE scores only and not take a look at what we call holistic admissions, you're not going come to the same conclusions and [will] end up with a homogeneous group. …People love to hang onto those numbers. I think we’re finally on a trajectory where people speak with their wallets. They don't apply to schools that require GREs…because [cost] that’s one less barrier that I need to overcome.*

> *[W]hat I find is those that have the GRE as a requirement that is the bottleneck right there because if nurses of color are not meeting that requirement, then they don’t even get an opportunity to interview, even though they met or exceeded everything else that was on the list.*

Theme 6. Equity, Diversity, Equity, and Inclusion (DEI) officers and other individuals responsible for leading the activation, policies, and procedures for ensuring anti-racism approaches in an organization have mixed results.

We asked participants if their organizations had a DEI officer or someone in an administrative role to oversee activities for the organization. In some cases, the participant was the organization’s DEI officer or equivalent. Consistently, participants were clear that addressing racism is everyone’s responsibility:

> *DEI is everybody's issue. It's not just nursing. It's not just the frontline. It is everybody's issue…. We cannot do this alone.*

> *It’s not shaming anybody. It’s really trying to make a difference. So I think that's the biggest area of opportunity—still making people realize that this is an issue, bringing awareness to it, and that it’s all*

> *of our jobs to do together; it doesn't fall on one race or ethnicity. I think it falls on all of our shoulders to take part and to change it.*

One participant noted that their DEI officer had left and their workplace were in the process of finding a replacement. But they used the opportunity to hold everyone accountable for DEI:

> *But in their absence, it's recognizing and holding people—ALL people accountable. So, what I said is "DEI does not live in one person." And so it's made me recharge folks. It's "So what are you going to do? How are you going to address this? What are the accountability measures in your area? Whether it's finance, facilities, alumni relations, marketing—what are you doing to ensure DEI?" And if they don't know, I ask, "Well, here's some ideas I have for you…. [I]t's being…deliberate in saying "How are we creating this environment? Are we being inclusive?"…*

Other participants viewed the position as key to guiding and supporting the work that they and others were doing within their organizations.

> *It definitely [helps] having [a university EDI] office…. There's a lot of workshops, and, like networking events to kind of to support us…. [W]ithin our school, we decided that we're not going to have a faculty for DEI or a committee for DEI. We decided that it's a everyone's job to do this. I'm part of our Faculty Council, so…it's always on the agenda. I share what helps [the EDI officer], what potentially could hinder that we do not want to have. We do not want to have someone who is responsible for [leading the work] and that everyone would just be tagging along.*
>
> For the *multicultural* nursing association that I'm part of, I feel like [having a DEI officer] is actually part of the capacity building, because, you know, being an ethnic minority, doesn't mean that I am well merged into this, and that I am committed, and I want to

> fight and racism. No, actually a lot of us…maybe don't want to, or maybe they're traumatized.

Another participant spoke of how essential the DEI officer at the system level had been to supporting the work that busy nurse administrators were leading, Including providing user-friendly materials, helping with writing and vetting institutional policies, and more.

> *[System DEI officer] is like this rock…. [A]s slow as we've been moving, we wouldn't have been able to move this slower/fast without having our lead in the Office for Diversity and Inclusion. Because I just think about all of the work that we take from them that's already been established over years…I could not imagine doing … it would be my full-time job. You can't do this and manage a hospital.*

Some participants viewed the DEI officer role as being marginalized in a no-win situation. One participant experienced racism from White colleagues in a new job in academia and was then assigned to being the DEI officer:

> *It's like, okay, I'm going to stay in the lane that they will let me stay in because I like academia. I like the freedom; I like to do my research…and I know I can make a difference in this area. But even…being here for a couple of years…I know that several of my White female colleagues see me as a threat. And now I'm the DEI guy. So you know I'm the guy that, you know, gets to tell them you know how racist they're being.*

Those working with DEI officers or supervising their work viewed the human resources (HR) and the legal departments as necessary to advancing anti-racism work.

> *…we need the [DEI officer] to work on guiding our curriculum, which is probably key; creating that inclusive environment; and making sure that [the DEI officer is] working with HR. So now we have a DEI-JAB Committee—Justice, Acceptance and Belonging.*

But other participants reported that HR and legal can be huge barriers to supporting anti-racism work. In one organization, we interviewed both the DEI officer at the system level and other individual employees who were engaged in leading anti-racism work across the system. The individual employees viewed the DEI officer as powerful and essential to supporting their work. But the DEI officer expressed that they felt frustrated and powerless to move things at a deep structural level. They viewed HR and the legal departments of their healthcare organization as needing to reinvent their approaches to dealing with complaints about racism, as did others we interviewed. One of the participants who is an DEI officer said:

> *[T]he ability for you to lead, the way that we know you would and could, is structurally impossible [because] the role has no authority with HR and legal….Once you admit that you have a problem, if you haven't fixed it, then you're liable when somebody comes forward. That becomes a big complication in all of this. So, it's all built into all this structural mess…within the legal system, labor system, labor relations. So, interestingly, part of our work to being an anti-racist organization is under one of the areas that I'm overseeing—I say, supposed to help address—is how do we allow people to come forward…and express if they've been treated in a racist manner, and how are we really going to be dealing with that? …I'm actually having a discussion soon with our HR person and our head of legal to talk about these things because something's got to give. If we stay in the exact same place where we are, and everyone defends everything and keeps saying, "Oh, well, we interview people and now we're doing an investigation; and we go in and we talk to everyone." No, it's really robotic and it happens so much. And I don't even want to talk to the labor people anymore. [They just say,] "We didn't find anything racist there…." Historically, practices and things are in place on purpose to marginalize people.*

Participants noted that their DEI officers were effective when they had the financial resources (i.e., budgets for anti-racism work) and authority to

hold individuals and the organization accountable for addressing structural racism. The authority that comes with the position can be particularly complicated based on setting. Specific to academia one participant said:

> *The office…seems to exist as much to sort of provide a space to send complaints as it does to meaningfully intervene on anything directly….I don't know that I ever actually expected it to be effective. Because I feel like DEI machinery is so contingent on various factors including not just who's in the job, but whether they have any authority whatsoever to actually do anything….faculty retain, academic freedom, and control over their syllabi…Committees and policies of individual colleges are under faculty governance, which means they sort of have almost, like in Congress, states' rights.*

One participant suggested that it would be better to hire top executives who already bring a DEI perspective to the roles in the C-suite.

> *[There has been] a lot of conversation about the number of folks that have been brought into executive DEI roles in the last two or three years….[T]hey're expected to make these big changes and prove outcomes in organizations, but they're a single FTE. They don't have a budget. They might not report to the CEO, so they're not set up for success and the turnover rate is high—talk about the glass cliff where…you're not supported and all the failure is on you. …[I]n my opinion, organizations need to move away from just hiring chief diversity officers. Instead, hire people who can bring an equity lens into key C-suite roles, whether it's the CEO, the chief strategist, the chief whatever that have an equity background that can seamlessly integrate that into the operations, the policies, and the infrastructure of an organization, so that it's not just one person. And then, it's also better resourced with the appropriate funding*

and the ability to pull the levers where they need to be pulled within an organization.

Nonetheless, participants believed that DEI officers were valuable as sounding boards for complaints or barriers to dismantling anti-racism efforts.

What is great is from our Office of Diversity, Equity and Inclusion—they're leading the way. They're the trailblazers. So when it's coming from them and it's also supported from our top senior leadership, that's great….[I]t gives us more room and more power to say, "Hey guys, this is what we need to do," right? It's not a question, right?

Participants noted that DEI roles can be isolating and challenging. But creating opportunities for shared learning can support individuals in these positions and advance the role.

There is a certain resiliency that needs to be built up in folks that are doing this work, because this work is hard. It is mentally, emotionally, spiritually taxing to always have to talk about your vulnerabilities when it comes to race, gender, sexual orientation, and identity. And that we need to build these people up to then go out and continue to do the work. … What well-being resources do they need? What social support resources do they need? How do they reinforce one another in a group wellness model or even peer-to-peer support through mentorship? I think [this] is…something that is missing from this landscape.

Theme 7. Rapid and clear responses to racism are necessary to shift culture; but long-term accountability and sustainability need to be built into organizational mission, priorities, and processes.

Participants consistently spoke of the need for nursing, healthcare, and academic organizations to act swiftly to identify opportunities for dismantling structural racism and addressing it. As one participant said, *"[W]e have to move very quickly, because people are suffering."*

Anti-racism work requires building trust among members of an organization through clear, timely responses to reports of racism. A major part of this trust building is holding people accountable and establishing a commitment and recommitment to the work and how it is approached. Trust cannot be assumed or taken for granted.

> *Probably the most uncomfortable part…is accountability. We established a rapid response team which…allows any member of the community—that can be our nursing staff; it could be any of our workforce members, patients, anyone who comes into contact with our health centers, or even if they work in any of our affiliates—[to] submit a report and that report is confidential. It gives a lot of liberty to the reporter, and how much they want to divulge….[I]t allows the JEDI [Justice, Equity, Diversity, Inclusion] office along with oftentimes their senior clinical leader to get involved [to respond to the report]. But that accountability is important because we can say we're going to do all these wonderful things, but if we don't…then it's for naught.*

Modeling timely, sensitive, and targeted behavior is an essential part of any anti-racism process.

> *…it's important that we not just talk to talk, but that we walk the walk…. Oftentimes folks will hear me say that we're calling people up to a higher-level understanding, as opposed to calling people out or condemning people when they make mistakes because we all make them. So it's about modeling good behavior. And what does that look like?*
>
> *I'm more of an observer, and when I see things happening, I tend to call them out. Sometimes it's not a matter of racism, sometimes it's just a matter of bias. People aren't aware that they're bringing their implicit biases to this workplace. And now they're using it to basically further scrutinize and marginalize a group of people. And I think confronting it head-on and not calling people out, sometimes*

it's good to call them in and say, "Hey, you may not have realized this, but this is how this sounded to me."

The importance of having a plan and implementing it relatively quickly was underscored by participants.

I don't want to say people aren't genuine about it because that's not it. But when you make a plan and actually have action steps toward it, I think you can move the bar a little faster versus when people keep talking and it's like you going in a circle.

But dismantling structural racism is not a quick fix. It will require a long-term commitment to the work. Participants repeatedly spoke of their concern that the current expectation that individuals and organizations address racism in a focused, "all-hands-on-deck" way will wane, when some other issue emerges in the news cycle.

…it's popular; now everybody wants people to do equity work. Everybody wants to be inclusive in the end because it feels faddish right now…don't know if it's a manufactured urgency, but this has been urgent—for people who look like me—forever. So, now that it's urgent to you, now it can take the front stage….So, I question what is the incentive now for this to be an urgency? And how do we stop it from being that? How do we embed it in a way where a U-turn is not possible? It can't be a window. Like you hear right now, people are like, "Oh, the window of opportunity is open to do equity work and not resilience [Editor's note: Meaning teaching how people to navigate racism and not dismantle it]. Let's hurry up and do it." Why should we be hurrying up and doing it? This should be in status quo.

Frontline staff and middle management play important roles in keeping health equity as a long-term organizational priority; however, dismantling structural racism requires a long-term commitment to action and sufficient resources at the executive level, including an organization's board of trustees.

> *I think when we can make sure that we have those key people across all industries that are understanding and inline and support of the work that gives a bit of a…trickledown effect. Then it will integrate throughout the entire system. So identifying who those key stakeholders are and making sure we onboard them appropriately.*
>
> *Every year we need to look at the makeup of our board in our organizations and say, these voices are not part of creating care. And change it.*
>
> *[T]he hospital has to also send a message that this is what we want to do…by bringing it to the forefront of the staff and letting the staff know it's not just talk; it's not just – you know in nursing we want to do this, and then two months later we come with something else and then we haven't followed up with it.*

And the commitment needs to be systemwide. One participant held a leadership role in a hospital that was part of a large health system and was the only person of color in the C-suite:

> *One of my biggest challenges within my organization is really getting the buy-in not from my [chief nursing officer], but I think more [getting it from] the conservative administrators higher up—conservative White administrators. I'll give you an example. The health system has roadmaps to address racism, and they talk about everything from LGBT to racism against Black people to African-American maternity mortality and…anti-Semitism. [But] I have to go through my chief operating officer to get approval to send these roadmaps out when it's really available to anyone from the health system.*

Another participant discussed what happened when leaders would not hold people accountable for addressing concerns of racism:

> *We're stuck in this place now where we cannot hold people accountable for actions…. What I'm actually hoping to do…is get at [experiences of racism] it before we get to the grievance level and hopefully support people to be able to hold accountability and solve problems together collaboratively. You know, find ways to reconcile harm without getting to the grievance place. But unless we have a pathway for people to be held accountable if they choose to be, no one is going to put the work in.*

Organizations must clearly articulate their positions on racist behaviors. One participant reflected:

> *I just wonder, until an organization takes a stance and has policies in place, will we continue to see the microaggressions and discrimination? That if we just say, "We have no tolerance for racist behavior," and if you engage in that, here are the consequences.*

One participant believes that the way to accelerate how nursing responds to racism is by adding a higher, robust level of accountability:

> *[M]any of us have been retaliated against. [We need] accountability because accountability is going to make a lot of people cut the crap and stop coming after nurses…. There has to be a regulating system, a national system that we adhere to as a body. We have state boards…. That's fine, but there should be a federal, national board that if you do this, this is the outcome.*

Organizations have competing priorities, as was evident during the pandemic. One participant who talked with us during a strike at their health-care organization said, *"You couldn't even talk about this right now because everybody is on negotiations."*

Nonetheless, organizations need to demonstrate a long-term commitment to this work by embedding it in their mission statements, strategic plans, and budgets.

> *I have to say, in having led many quality-improvement initiatives, it's all of the competing priorities that the clinicians have [which*

constitute obstacles to fostering equity]. Make sure they have prioritized this above anything. This is actually causing death. The racism is causing people to die and suffer and is further perpetuating disparities. …[A]nother challenge is people want to check the box. They want it quick and done. "I checked the box. I'm not racist." Nobody wants to hear that [they are]. This is not a check-the-box, I'll be done tomorrow….that's I think a huge shift in mindset.

If you were to look at an organization and determine what they're doing with equity, it's just follow the budget….We are a capitalist nation….We tend to put money to anything that we think is important or a priority or is of value. if antiracist work or diversity work, equity work, justice work is important, then I expect to see an enormous amount of the budget allocated for that and the capacity to do the work.

…if we're going to engage in quality improvement, equity has to be a part of the fiber—fabric. It has to be. You cannot have quality without equity.

There are enduring power dynamics within organizations that must shift for everyone to be part of the anti-racism work. Organizational leaders must also be accountable to their staff and the communities they serve. As such, they must make their efforts visible to both audiences.

The institutionalized frameworks are also very good at maintaining status quo and these power dynamics.

[W]hat they're doing right now is, which I think is wonderful, they're making the president of the hospital responsible to hold him accountable to drive the change. And I think that was really—that was such a wonderful way [to support our work]….they have a hotline where if you experience racism, if you think you've experienced bias, you can report it…. I think that's one of the great

things that they've done. And the other thing is we need to be patient, but we need to be consistent…

Participants viewed accrediting bodies as key to holding health-care and academic organizations and their leaders accountable for sustained efforts to address racism and improve health disparities. When The Joint Commission includes criteria for health-care organizations to meet for accreditation, these organizations pay attention, and likewise for organizations that accredit nursing education programs (e.g., the Commission on Collegiate Nursing Education (CCNE) and Accreditation Commission for Education in Nursing (ACEN). A few participants spoke to the potential role of the Magnet Recognition Program (for excellence in nursing and health care) by the American Nurses Credentialling Center as a way of escalating healthcare organizations' commitment to long-term anti-racism work.[40]

[T]here's the need to kind of put pressure [on organizations]; and, unfortunately, people respond to pressure more than they do the need to do what is right. Certainly, health-care organizations, though I think we need to have pressure on accrediting bodies.

…that work of anti-racism and dealing with bias really [has] got to be driven from leaders, and it has to be embraced, right? Can't just be like, "The new accreditation standard says we have to do implicit bias training. So, everybody's getting implicit bias training for an hour." And then we go back to doing exactly what we've always done….[T]here's an opportunity with The Joint Commission standard [on health equity]. I'd like to see more, but with this one, to kind of use that as a lever: Hey, you guys need to do this.

Theme 8. Nurses can and should lead this work.

While nursing has been rooted in and reflects a racist society, nurses can potentially transform health care and nursing education. Nurses are everywhere.

[40] https://www.nursingworld.org/organizational-programs/magnet/

> *One of the things that we did early on was…[to appreciate that nurses] have a huge impact on making anything happen. We know this. We're a powerful force…. [T]hings happen when nurses are leading the helm, and you have your champions and you have your champion physicians and other interprofessionals. We've always understood that impact and used it to improve care….*

Nurses of color are initiating anti-racist initiatives within the profession, nursing education, and health-care systems. But their leadership is not always recognized:

> *It's all about trying to change perceptions or what people think of a nurse as, and what people perceive as a nurse in leadership … Historically, honestly, older White women is what people perceive who's walking through the door, who's leading the way. So we have to change that narrative as we continue to address racism in nursing. So that person can be any race, any ethnicity, any gender identity. So how do we change people's mindsets for having this image of what they expect to walk in a room as a nurse or as a nurse that's a leader?*

Other participants want to see nursing do better: *"I think nursing has to get much more intentional and step their game up. Really get into the game. This is not a spectator's sport. You can't dabble in it. If you're going to be in, then be in."*

One participant raised the issue of whether a coordinated effort to dismantle structural racism in nursing and health care needs to exist:

> *We need to have consensus, I think, within the discipline. There are so many specialties and so many subspecialties and so many different nursing associations and organizations. And everybody's doing something. And not everybody's coming together to do something collectively. I don't think nursing has a North Star in this space. There should be.*

White nurses are contributing to this effort, though many more create barriers to the work. One participant underscored the importance of getting White nurses, particularly those in leadership positions, on board with anti-racism efforts:

> *[W]hen you think about making change in racism, and in nursing, diversity in nursing…you have to convince the white leaders in the field to care about it, and do it. Because, when you think about it just from a tactical perspective, non-Whites make up the minority of people in the leadership. So if you really want change, you have to find a way to make it important to people who haven't had a lived experience of why it's important.*

If white nurses are in positions of power, they need to be allies and mentors/colleagues, engaging in the work with nurses of color and not merely expecting them to do the work. One Black participant acknowledged their white supervisor's support of anti-racist efforts that the participant and others were leading:

> *…She is standing side-by-side with us just like if you were looking at the civil rights movement and that march with Martin Luther King. She is right there with us…. She is really in the details and the weeds of everything along with us, and she really is a mentor for me in my struggle here…being a part of the system because I do struggle.*

A white participant who held an administrative position in a hospital concurred:

> *This is must-be-done work…. [W]hite people are just like, "Oh, I don't know where to start." And it doesn't affect the white person in the same way. We can live our lives very nicely without seeing it, if we want to. And I have for many years. So helping everybody see what they can each do is really important.… We have to get leaders onboard in a very big way…. [N]urses need to be part of leading this effort. Nurses in particular set the culture on a unit more than anyone else…. I think for us bringing [an anti-racism initiative] to the nurse leaders of the organization was really powerful because*

they were like, "Oh my goodness. This is something that we have needed for a long time."

And there is evidence that nurses of color and White nurses are joining together to address racism in their workplaces and associations. At one large academic health system, diverse nurses created an initiative called Nurses Against Racism (NAR) after the murder of George Floyd and are leading anti-racism work across hospitals.

We're trying to be like an octopus and be like tentacles where we're trying to just go into every crevice there is to say, "Hey, wait a minute. We have this group, Nurses Against Racism." It's not about Black and White. It's about really deep diving into how do we understand what [racism] is? What can we do to break down these barriers? What is the difference between equity and equality?

Participants identified the opportunities they and other nurses have to address racism within the profession and stakeholder organizations. For example, participants in nursing education spoke to the importance of leading changes in licensure and certification exams, which continues to perpetuate structural racism.

[T]he focus of education is very tied to the licensure examination…. Is this on the NCLEX? Do we need this for the NCLEX?....I have been very fortunate to be able to build certain competencies into curriculum just because I felt it was necessary from the experiences that I have.

One participant shared their experience with leading changes to standards of care in carceral settings and the participant's persistence in changing stigmatizing language that affects how patients are treated:

I was blessed four years ago now when the most recent AMA work came out on the standards of care in custody facilities or for what they call "correctional nursing".... I hate that term because custody facilities aren't correcting at all…. But I was able to be a part of that group, and one of the things I was most proud to do is to talk about

racism in custody and in the criminal legal system and get that integrated into the document in a way that it hadn't been before and also to change the language and to use person-first language…. Because people in prisons and jails, they're hidden away, and so few nurses see them because there's very few nurses who work in custody settings. However, we all see patients who are impacted by the criminal legal system even personally or from a brother, a husband, a boyfriend. Maybe they're on parole, probation all the time and it really is impacting their health. And so just talking about that and about how that impacts people…. When I was privileged to be able to teach, I talked about it in my classes. I would just sneak it in…. And I talked pediatrics and so I would talk about family health from an anti-racist perspective and how systems and structures affected families….

One academic nurse has been persistent in leading efforts over 40 years to raise awareness of the racism embedded in research, beginning in 1982 when the National Institutes of Health added a mandate for including minorities in NIH-funded studies. Recently, the National Institute for Nursing research (NINR) declared a focus on examining structural racism in research.

I've been…trying to elevate the research that we do to address how our methods and science perpetuates racial stereotypes…. I was writing about this 1982…. [Y]ou can't be in this for the short term. This is not a one-and-done. You have to be in it for the long term and wait for the ebbs and flows. And…we said, "Getting more people in these studies was not enough because if you don't look at recruitment, if you don't look at the methods, if you don't look at the instruments, if you don't look at the theories, if you don't take at that and understand the applicability of those components to what we're doing, then it's not going to happen." And now, here we are. Whether you consider us "woke" or the changes that have happened within NIH to again say "We're looking at structural

> *racism in our methods and research priorities in NINR…" The blowback has been phenomenal. There's been overt and covert work by some nurse-scientists to try and overturn those priorities….*

Another participant from academia shared challenges and opportunities for changing how schools of nursing prepare the next generation of nurses, including by diversifying the kinds of clinical experiences students have:

> *We want to talk about ways to raise money or write policies, go up on the Hill and change policies and practices. How can we impart change within our communities? Raising money, grassroot efforts. We want to know deeper how to use some of this social justice, social change work into nursing because we recognize that nursing is the tool we use to advance health equity…. "I'm a nurse. What can I do as a nurse? What tools do I have in my back pocket that can advance that, whether it's making sure that the doctor understands that my patient doesn't have a car, so they use public transit….*

The same nurse continued to discuss health equity and stated:

> *[W]e had to really dig deep…and really discover that people need education in: What does health equity mean? What potentiates health inequities? What does racism mean? What do the terms mean? And how can we teach curriculums that are meeting the hunger that we're seeing from our students that they're calling us out on? And it was very difficult conversations. But I was excited about it because our dean was all over it. She was like, "Our students are our customers. If they're saying we aren't giving them what they need to be able to perform, to dismantle structures of racism and inequities, then we really need to revamp a lot of stuff." Because we need transformative change.*

The same nurse channeled tools from critical race theory to combat racism, namely storytelling:

We don't just need change. We need stuff that is going to flip and dip, flip tables, and bust up this stuff, is giving voice to the stories. Because that's much more impactful. People want to hear stories. "What's your story, like what do you think?" more so than just the next journal about structural racism.

Another participant is leading work on structural bias in the technology space in ways in which everyone can benefit:

I moved into technology. I figured maybe I can utilize my clinical knowledge to help business systems make fair and just, equitable decisions in terms of creating technology processes that actually meet the vulnerable people. And that's still my passion, to this day. But I think you need somebody there to advocate, to say, "Okay, that initiative is cool, but did we look at our seniors? Did we look at our LGBTQ seniors? Did we look at the people who are caught in the intersectionality?" It's not just about Black, and Hispanics, or like immigrants. It's like, what about the people who are faced with multiple different challenges on top of more challenges?

This participant went on to talk about strategies for leading anti-racism efforts:

You have to be relentless.... You read the room. You seize opportunities that are available. You create coalitions. You let people lead who have no business leading, support related efforts. All of those things. But it's constant…. It's not one strategy; it's a variety of strategies, depending on time and context and what you're willing or able to do.

Engaging frontline staff in anti-racism work and recognizing their expertise in this area can be affirming, according to one participant in a management role:

… We ask them what they're seeing and what they're experiencing. And then, the fact that the follow-ups are all nurse- led. We need to support that. We need to give nurses that opportunity to use their

skillset, to connect with our families, because we know that they're so good at it.

Still, nurses of color in leadership positions in organizations face often catch-22 dilemmas:

…I had to remind people…that when you have people of color who are in those higher positions. who are in positions of management, sometimes we do not realize that their position is just as precarious as ours…. [S]ometimes they absolutely have to go by the book. There is no leeway for being lenient this way or lenient that way because then they'll come under scrutiny because they'll say, "Well, you're treating them differently. You're showing favoritism."

Creating safe spaces for nurses of color to discuss their own experiences and explore ways to address racism may be an important aspect of this work:

I call it, for lack of a better word, affinity spaces for people of color or marginalized, or racialized people. [It] is so important for us to decompress and process because no one understands the words, the language, the perspectives that we see because our backs are constantly against the wall. That's just the way society has structured it. And so it's always interesting trying to share and validate the importance of having community for folks of color, marginalized people. It's just something that people just have to accept that has to be part of the structure so that we can at least be seen, heard, and re-energized to come back the next day.

Finally, one participant summed up nursing's potential to lead this work:

I see this as sort of an opportunity for nursing as a profession to change the frame. Nursing in general, as a profession, leads with empathy and compassion and care, and I think that is what is needed in this space to change culture. I feel like we're ahead of the game in terms of comparing to schools of medicine or other

health profession schools, so I really do feel like nurses can take this on and do amazing things.

DISCUSSION

> **"***It is certainly the case that responsibility for diversity and equity is unevenly distributed. It is also the case that the distribution of this work is political: If diversity and equality work is less valued by organizations, ten to become responsible for this work can mean to inhabit institutional spaces that are also less valued." Sara Ahmed, On Being Included: Racism and Diversity in Institutional Life. Duke University Press. Durham, NC: 2012.*

It will be impossible to improve population-level health outcomes without addressing the racism embedded in our society. The themes that emerged from this qualitative analysis of 42 diverse participants suggest that nursing, as a profession and the individuals that identify as nurses, are steeped in a culture of racism, as are most societal institutions in the United States. Racism is longstanding and may be experienced in ways that Whites and even some people of color may not recognize. Dismantling structural racism requires that everyone engage in some version of a truth and reconciliation approach to ongoing conversations about implicit bias and experiences of racism that are embedded in our psyches and organizations. These conversations aim to create a mutual understanding of diverse experiences of racism and require a shared understanding and language about the meaning of racism in order be able to collectively move nurses to anti-racist action. Some action must be rapid to be able to shift the culture of organizations and to build trust that organizations are committed to action.

Tools for short-term and long-term action exist, but thoughtful innovation in anti-racist work is needed and best practices need to be made visible and shared. Carefully designed data on identifying health inequities are necessary and can be used to measure progress, to evaluate the effectiveness of interventions for health equity, and hold individuals and institutions accountable. But data are insufficient for changing existing racist cultures and structures. That requires an ongoing, enduring commitment from organizations for clear and rapid responses to uncovered racism. DEI officers can be invaluable drivers and supporters of change—if given the power, authority, and resources to create meaningful change. Whether they have a powerful, well-resourced

DEI officer, organizations must send a clear message to all employees that everyone is responsible for creating equitable, anti-racist spaces.

From the board of trustees to the executive leadership of the organization, a long-term commitment to social justice and health equity must be clear in the mission statement, strategic plan, and other communications and actions of the organization. Additionally, accrediting bodies such as The Joint Commission and likewise for organizations that accredit nursing education programs (e.g., the Commission on Collegiate Nursing Education (CCNE) and Accreditation Commission for Education in Nursing (ACEN) need to include competencies and metrics that are essential for nurses to understand how interpersonal, internalized, and institutional racism impacts quality care, health-care access, and patient-provider and community-provider relationships over time.

The eight themes identified in this study are discussed below in context of existing literature and each represents a distinct paragraph. The themes are presented in order of appearance above, which does not reflect a hierarchy of importance.

Theme 1: Nursing culture reflects a society that is deeply rooted in White Supremacy and racism, to the point that it has not been obvious to the profession or many nurses. Understanding that racism is not exclusive to nursing because it is a profession that is predominantly White women is important. Work from minority-serving professional organizations has pointed out for years the racism embedded in standardized testing for admissions including the graduate record examination (GRE) and for entry into the profession, the National Council Licensure Examination (NCLEX-RN® exam). Others have pointed to how dress codes, principles of professionalism and classroom surveillance are components of how racism is embedded in nursing culture. Fortunately, several nurse educators have spent time developing skills of ungrading,[41] dismantling structural racism in education,[42] and assisting faculty to understand how to create case studies and other learning materials that are grounded in anti-racism principles. Reimagining how to fully integrate a thorough accounting of nursing history and ethics in

[41] Posey A & Novick K. Ungrading: Changing Your Beliefs and Your Classroom with UDL. Cast Professional Publishing, Inc. 2020. Wakefield, MA.
[42] Porter, C. P., & Barbee, E. (2004). Race and racism in nursing research: past, present, and future. Annual review of nursing research, 22, 9–37.

foundational pre-licensure nursing education at all levels could provide essential scaffolding to help nurses to understand how White Supremacy and structural racism are embedded in our society and the profession they seek to enter, while simultaneous teaching skills to dismantle both. Ongoing education about nursing's historical racism and its societal context is equally important for those already in the profession.

Theme 2: A restorative justice approach of truth and reconciliation is crucial for understanding and addressing implicit bias and structural racism. As social scientists have pointed out,[43] undoing racism is a process and will be lifelong work.[44] Developing tools, skills, and strategies to authentically engage with individuals and institutions about this topic will be crucial. Restorative justice[45] posits that redemptive narratives are possible, that no one is expendable, and that change is always possible.[46] Originally developed for incarcerated persons and people who committed crimes, this framework is powerful and teaches nonviolent communication, reflexivity and positionality, as well as skills to navigate conflict and change.

Theme 3: Having a shared value for the work is essential; but it is also necessary to have shared definitions and language. The thematic findings of this report are grounded in the understanding that there are multiple definitions and levels of racism;[47] and that racism is a feature of, not a bug in, our society. Additionally, different definitions can lead to different actions and accountability. Understanding how structures contribute to poor outcomes for both individuals and communities (or populations) is an essential skill that integrates the social, political, and moral determinants of health. Particular to the health professions, it is necessary that clinical racism (e.g., obstetric racism, harm from race-based algorithms); scientific racism (e.g., the inappropriate use of race in research studies or use of inappropriate control or comparative groups); and other forms of limited resource allocation (e.g., underfunded/segregated hospitals and/or health

[43] https://www.hks.harvard.edu/faculty-research/library-knowledge-services/collections/diversity-inclusion-belonging/anti-racist
[44] https://www.hks.harvard.edu/faculty-research/library-knowledge-services/collections/diversity-inclusion-belonging/anti-racist
[45] https://transformharm.org/tj_resource/transformative-justice-a-brief-description/
[46] https://restorativejustice.org/
[47] See Appendices 1 and 2.

systems, lack of workforce development of minoritized communities) be examined and challenged.

Theme 4: Some tools to address racism already exist or are being developed. *Public Health Critical Race Praxis* is a book that was developed to assist practitioners to identify and address structural racism.[48] One aspect of this book is exclusively dedicated to research methods and methodology specifically when it comes to the generation and analysis of data that include variables of race without accounting for experiences of racism. Additionally, large data sets and complicated statistical analyses need to consider the extraction of data and the narratives associated with how the data are contextualized.[49] Additionally, racist algorithms that underpin the collection of health data in electronic medical records allow for the potential for racially profiling of patients in the chart as well as during report and hand-off. Standardizing how patients are discussed among teams in clinical environments can reduce the potential for harm and mistreatment.

Other tools specifically developed with, for, and by nurses can be found in Appendix 5, from the Mt. Sinai Pocket Guide Responding to Racist and Discriminatory Behavior,and Appendix 6, the SPEAKUP Against Racism toolkit developed by the Institute for Perinatal Quality Improvement.

Theme 5: Data are necessary but insufficient for change; in fact, a preoccupation with data collection can inhibit the actual work that needs to advance anti-racism efforts. Similar to the continued descriptions of health disparities without any corresponding action or intervention, data collection specific to documenting racism can be harmful and unethical. Research that is conducted to understand how racism manifests in clinical encounters or structures, namely the inability to attend to the social needs of

[48] Racism: Science and Tools for the Public Health Professional; Ford, C.L., Griffith, D.M., Bruce, M., Gilbert, K., Eds.; American Public Health Association: Washington, DC, USA, 2019.
[49] McLemore, M.R. (2021), Reimagining methodological considerations for research studies using 'big' administrative data sets. Paediatr Perinat Epidemiol, 35: 491-492. https://doi.org/10.1111/ppe.12796

citizens, needs to also map assets and potential opportunities for intervention.[50,51] And yet, data can be helpful in identifying health disparities and holding people accountable for ending racist practices that contribute to these disparities.

Theme 6: Diversity, Equity, and Inclusion (DEI) Officers and other individuals responsible for the activation, policies, and procedures for ensuring anti-racism approaches have mixed results. Embedding efforts to address DEI and anti-racism within positions in institutions has had mixed results for several reasons including: dismantling racism should be the work of everyone; siloing the work in an office that is under-resourced results in inaction and frustration; and expecting the "policing" function of DEI work to sit in a single office is unrealistic. However, institutions that have C-suite support, leadership from the top engaged in DEI officer activities, and have clearly articulated the culture that is being curated have had a good amount of success in shifting organizations to be more anti-racist. Human resources, legal, faculty councils and senates, and other bodies responsible for the conduct of employees need to partner with DEI officers to be effective. Finally, adequate human, money, time, and space resources need to be allocated for DEI and anti-racism activities with an appreciation that these concepts are interrelated, yet distinct including the strategies and approaches necessary to effectively operationalize the work.

Theme 7: Rapid and clear responses to racism are necessary to shift culture; but long-term accountability and sustainability need to be built into organizational mission, priorities and processes. Many participants, regardless of setting, called for clear messaging and rapid action on dismantling structural racism, while simultaneously expressing concern about organizational accountability and sustainability. There was significant concern from almost all participants that anti-racism had become the "flavor of the month" and that when a new topic emerges, it will fall out of fashion. They noted that a key step is ensuring that anti-racism work is seamlessly integrated into the

[50] Adkins-Jackson PB, Incollingo Rodriguez AC. Methodological approaches for studying structural racism and its biopsychosocial impact on health. Nurs Outlook. 2022;70(5):725-732. doi:10.1016/j.outlook.2022.07.008

[51] Lewis LM, Perry MA, Joseph P, Villarruel AM. Dismantling structural racism in nursing research. Nurs Outlook. 2022;70(6 Suppl 1):S32-S37. doi:10.1016/j.outlook.2022.03.010

organization—from its mission statement to its strategic plan and budget, as well as part of a new organizational culture. There is a real need to align anti-racism principles with mission, vision, and values of organizations with associated metrics and rewards. Incentivizing anti-racism approaches was mentioned in several interviews and suggestions about how to do this are included in the recommendations section. This requires a clear and visible commitment from executive leadership in the organization and its governing body.

Theme 9: Nurses can and should lead this work. Despite the fact that this thematic list began with understanding that White Supremacy and structural racism are embedded in society, we are convinced that nurses can and should lead anti-racism work. Nursing has a strong foundation within its code of ethics and interpretive statements; we are the largest and most trusted of the health professions; and we need skills and investment to translate what we know to partner with individuals and institutions who are and have been doing anti-racism work.

The ANA Code of Ethics and Interpretive Statements[52] is a crucial document that can be interpreted as being consistent with anti-racism principles (Appendix 2). All eight of the provisions could align with anti-racism principles, but three in particular underscore why nurses and nursing with the right investments, skills, and tools, could and should lead this work. Provision 1 includes respect for human dignity, examines our relationship with patients, defines the nature of health, and affirms the right to self-determination and our own relationships with colleagues and other members of the health professions. Provision 8 supports health as a universal right and emphasizes that collaboration is necessary for health, human rights, and health diplomacy. Nurses have an obligation to advance health and human rights and reduce disparities, and to collaborate for human rights in complex, extreme, or extraordinary practice settings. Provision 9 clearly states the values and integrity of our profession and the imperative to integrate social justice in nursing and health policy.

[52] https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

Leveraging the existing infrastructure that has been built by RWJF, ambassadors and coaches can be developed from the Clinical and Faculty Scholars programs as well as the Campaign for Action. We are at a watershed moment where the momentum and commitments made in 2020 should be used to further advance investments in the nursing profession as the de facto leaders of health equity and anti-racism work. Nursing and midwifery have long helped communities develop innovative programming and interventions to improve health. There is no reason that, as we diversify our workforce, that we cannot simultaneously transform health care and health services by insisting on a fundamental shift in health care. Despite the racism that is embedded in nursing culture, nurses can, are, and should lead this work and partner with others to dismantle structural racism in the profession, health professions education, and health care organizations. With the appropriate human, money, space, and time resources, we can nurse the nation into the next iteration of itself where anti-racism is the norm and the harm from racism is mitigated.

CONCLUSIONS AND RECOMMENDATIONS

The Robert Wood Johnson Foundation and other philanthropies have an important and unique role to play in driving health equity by supporting initiatives that dismantle structural racism in nursing, nursing education, and health care. RWJF has a history of addressing health disparities through its work on building a culture of health in all communities. As the foundation knows, investing in work can also legitimize that work.

Dr. Antonia Villarruel emphasized the difference that philanthropy can make in supporting work to diversify the nursing workforce and promote health equity in communities. In 2022, the University of Pennsylvania School of Nursing received a $125 million gift from Leonard A. Lauder to:

> *…support the creation of nurse practitioners who are committed to and prepared to work in underserved communities. And so that involves working with communities in a different way, not just for precepting but for us to engage communities in the clinical education in the broadest sense. It means we need to be supportive of other areas that are important to the communities….*

It's getting connected with communities and making them feel welcome and valued. …[W]e can't do that if we don't support the communities that we work in. So the Leonard A. Lauder community Care Nurse Practitioner Program is not just about scholarships because scholarships would not have been able to create the impact or even supported the communities to provide the clinical education that we envisioned. Resources help, but what we're trying to do with this program is say, "Okay, maybe [you] didn't get $125 million bucks, but here are things that you <u>can</u> do that can make a difference." You just don't need money. You need the human capital that you have within your schools, and you need the commitment to genuine partnerships to prepare clinicians to work with communities to achieve health equity.

This report's interviews, themes, and related work in the field provide the basis for the following recommendations.

1. RFPs for work related to health equity require applicants to describe work they are already doing to address racism and reduce health disparities, and what they are planning to do with a structured approach that includes:
    a. Ongoing conversations about racism that use a truth and reconciliation framework. Depending upon the nature of the grant proposal, the applicant should speak to the recommendations and actions that have already occurred as a result.
    b. Clarity on who is responsible for leading and tracking progress on anti-racism efforts in the organization. If a DEI officer is in place, the role and authority of any DEI officer should be illustrated in a specific example that demonstrates the DEI officer's role in driving and supporting institutional change.
    c. Sustainability in meaningful ways, including embedding health equity in organizational mission statements and strategic plan, as well as demonstration of support of boards of trustees and executive leadership

for the work. The latter component was evident in the Foundation's requirement that CEOs, CFOs, and CNOs in organizations that were funded for Transforming Care At the Bedside (TCAB)—a RWJF and IHI initiative two decades ago—attend part of an annual meeting of grantees and speak to how they were supporting these projects, the challenges, and opportunities.

   d. The funds and staff the organization has already committed to anti-racism work and whether these are short-term or long-term commitments.
   e. Demonstrate how nurses are being empowered to lead or co-lead the work, while ensuring that the work is or has the potential to be interdisciplinary.
   f. Demonstrate diversity among the organization's leadership, including the board of trustees.

2. All RFPs for funding by RWJF, even if not directly related to health equity and anti-racism work, require applicants to describe how their project relates to health equity and how their organization has embedded health equity into their organization.
   a. Leveraging the existing infrastructure that has been built by RWJF, ambassadors and coaches can be developed from the Clinical and Faculty Scholars programs as well as the Campaign for Action.
   b. Reviewer infrastructure will need to be built to ensure that racism is not reproduced during the review process and that the experts in anti-racism science are engaged and financially compensated for their time assisting the foundation to both develop a review rubric and time reviewing.
3. Targeted funding can be used to accelerate work in the following areas:
   a. An analysis of the racism embedded in nursing textbooks, similar to the analysis that RWJF funded on the end-of-life content in nursing textbooks two decades ago.
   b. An analysis of bias in the Next Generation NCLEX-RN and other credentialing/certification examinations.

c. An analysis of bias in clinical support tools and the electronic medical record.
d. Creating a learning community for DEI officers to share experiences, challenges, and successes.
e. Create opportunities for boards of trustees of health care organizations to learn more about structural racism in health care and what trustees can do to foster a culture of health and equity in their organizations.
f. Funding for institutional activities, particularly for those without institutional power (i.e., pre-tenure assistant professors most impacted by harms of structural racism)
g. Provide funding for simulation opportunities to provide skills in disrupting interpersonal racism, designing projects and programs from an anti-racism perspective, and to develop curricula and new tools to address structural racism.

4. The Foundation, perhaps in partnership with other relevant organizations, convene key stakeholders for specific purposes:
    a. Partner with the Institute for Healthcare Improvement to engage leaders of health-care organizations in addressing systemic racism in their organizations, its impact, and the keys to successfully ameliorating it at an executive level. Such a meeting may result in the creation of a periodic learning community to support ongoing work, but this should not be the same learning community as the one for DEI officers. But an initial meeting could include the C-Suite (including CMO and CNO), DEI officer, HR executive, and legal counsel from an organization.
    b. Partner with the American Society for Healthcare Human Resource Administration to engage these key professionals and the society in examining how longstanding HR practices reinforce institutional racism and develop a strategic plan for shifting the culture and practices in HR departments.

c. Partner with labor unions and HCOs partner on bringing restorative justice to HCOs in ways that address HR and legal barriers to Anti-Racism approaches.
d. Reviewing human resources and risk management approaches with ombuds support – prior to conflict. Alignment of DEI offices with these existing structures.
e. Partner and engage the American Health Law Association and the American Health Lawyers Association in similar change work around legal frameworks for approaches to responding to racist events reported in health-care organizations. Alignment of DEI offices with these existing structures requires conversations about how institutions respond to identifying barriers to dismantling racism and support for HR and legal departments to rethink their responses.
f. Convene national nursing associations to discuss how the profession is or could be coordinating accelerating anti-racism work in accountable ways that mark gaps, opportunities, and progress. This should include gatherings with the National State Boards for Nursing, the American Nurses Credentialing Center (including the Magnet program), and other bodies concerned with licensure, certification, and accreditation. Funding work in this area could be groundbreaking, with other professions following suit. Although one could argue that the nursing associations should convene such a meeting, having RWJF do so, at least initially, would legitimize the need for and importance of the work. The Campaign For Action would be important to include and play an important role in such a meeting.
g. Engage book and journal publishers and INANE (International Academy of Nursing Editors) to explore current efforts to ensure that nursing textbooks and journals present accurate information in unbiased, non-racist ways; as well as a commitment to solicit papers on the topic of health equity and racism in nursing and health care. In prior years, INANE has organized

initiatives to cover specific themes across as many nursing journals as possible, including writing editorials and soliciting and publishing papers on a theme. They would likely respond well to a request to do so and to focus on this topic at their annual meeting, with sponsorship by the Foundation.

   h. Encourage/fund/begin dialogue with companies that produce electronic medical records and other technology and nurse experts in this area to examine bias that is embedded in these important clinical tools.

5. In partnership with other foundations and evaluation entities, create a funding pool for rigorous external evaluation of anti-racist tools and interventions that can be requested by individuals and organizations with limited capacity for evaluation research.
6. Once evidence is available on interventions and tools that are effective in addressing racism, provide funding for augmenting the best practices with training tools, simulation scripts, role playing, etc., that can be widely shared and are open source/free for use without licenses. This could include:
   a. Anti-racism toolkits that can be used by schools of nursing, nursing associations, and health-care organizations.
   b. "Maintenance" toolkits to develop empathy and to support anti-racism principles long-term, similar to a car tune-up where maintenance of skills is the goal.
   c. Encouraging national nursing associations, such as the NLN, AACN, ANA, AAN, and others to showcase successes through dedicated awards with media outreach to extend visibility, highlighting at their annual meetings, and creating spaces for describing the work in their publications.
7. Develop a robust media plan to continue to raise awareness of how racism persists in nursing and health care, why it matters, and what nurses and others are doing that is effective in ameliorating racism.
   a. Invite news-related organizations such as the National Association of Black Journalists, National Association of Hispanic Journalists,

Association of Health Care Journalists,[53] Kaiser Health News,[54] NPR Radio, PBS, Telemundo, Univision, and others to design ongoing series that highlight racism in health care and the health professions and showcase solutions that work to dismantle racism.

   b. Support initiatives for preparing nurses to share their experiences and stories with various media outlets.[55]

8. The Foundation convenes a meeting of other philanthropies concerned with racism, health disparities, nursing, health professions education, and other focal areas to discuss an agenda for collaborative funding opportunities to accelerate this work.

   a. Collaboratively fund a virtual journal club for discussion and simulation with anti-racism scholars and experts in the field to review the special issues of JAMA, NEJM, Health Affairs and others to make the content freely and widely available.

The political context of our times may make work in dismantling structural racism in health care challenging for risk-averse organizations. Nonetheless, this *is* the time for organizations such as the Robert Wood Johnson Foundation to use their substantial resources and standing in society to be bold in its actions to support those who are, against all odds, refusing to be silent about racism in nursing, health care, and educational organizations, while raising awareness of the work that remains to be done in this space if the United States is to have health people and communities that thrive.

[53] Barbara Glickstein and Diana Mason are members of AHCJ.
[54] Diana Mason is a member of the National Advisory Committee of KHN.
[55] Nurses are underrepresented in health news media, partially because of bias about women, nurses, and sources of authority in health care. See: Mason, D.J., Nixon, L., Glickstein, B. Han, S., Westphaln, K. & Carter, L. (2018). The Woodhull study revisited: nurses' representation in health news media twenty years later. *Journal of Nursing Scholarship,50*(6), 695-704; and Mason, D.J., Glickstein, B., & Westphaln, K. (2018). Journalists' experiences with using nurses as sources in health news stories. *American Journal of Nursing, 118*(10), 42-50.

Appendix 1: Operational Definitions

Anti-racism: Encompasses a range of ideas and political actions which are meant to counter racial prejudice, systemic racism, and the oppression of specific racial groups. Anti-racism is the active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably. Commitment to anti-racism requires a commitment to dismantling racism, which has dimensions that are institutional and social as well as attitudinal and behavioral.[56,57,58]

Health equity: For the purposes of this report, we found several definitions for health equity that we find useful. We present them all:

Health equity will be experienced when we set ambitious but attainable goals for the health of all humans and work together to realize those goals."

"Health equity is not something that is "achieved," wrote social epidemiologist Ryan J. Petteway and indeed requires the absence of conflict. Properly understood, health equity in a beloved community — as the embodiment of our resistance and resilience — does not aspire to reach mountaintops and take selfies, but to move mountains and take names. It's not a data point or objective to "achieve;" it's a call to be (permanently and thoroughly) about that business."[59]

- Dr Camara Jones' definition of health equity, which "is the assurance of the condition of optimal health for all people." [60]
- Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental

[56] Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017;389(10077):1453-1463. doi:10.1016/S0140-6736(17)30569-X

[57] Bassett MT. Tackling Structural Racism. *J Public Health Manag Pract*. 2022;28(Suppl 1):S1-S2. doi:10.1097/PHH.0000000000001457

[58] Racism: Science and Tools for the Public Health Professional; Ford, C.L., Griffith, D.M., Bruce, M., Gilbert, K., Eds.; American Public Health Association: Washington, DC, USA, 2019.

[59] https://www.healthaffairs.org/do/10.1377/forefront.20210204.432267/full/

[60] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Division of Behavioral and Social Sciences and Education; Board on Children, Youth, and Families; Roundtable on the Promotion of Health Equity; Forum for Children's Well-Being: Promoting Cognitive, Affective, and Behavioral Health for Children and Youth; Keenan W, Sanchez CE, Kellogg E, et al., editors. Achieving Behavioral Health Equity for Children, Families, and Communities: Proceedings of a Workshop. Washington (DC): National Academies Press (US); 2019 Feb 13. 2, Introduction to Health Equity and Social Determinants of Health. Available from: https://www.ncbi.nlm.nih.gov/books/NBK540766/

human right. **Health equity is achieved when everyone can attain their full potential for health and well-being.**[61]

Implicit Bias: According to the National Institutes of Health, bias is defined as Bias consists of attitudes, behaviors, and actions that are prejudiced in favor of or against one person or group compared to another. Therefore, implicit bias refers to a form of bias that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behaviors.[62]

Institutional racism: Refers specifically to racially adverse "discriminatory policies and practices carried out…[within and between individual] state or non-state institutions" on the basis or racialized group membership.[63]

Levels of racism: Three levels: institutionalized, personally mediated, and internalized.[64]

- Institutionalized racism is defined as differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need. Institutionalized racism manifests itself both in material conditions and access to power. With regard to material conditions, examples include differential access to quality education, sound housing, gainful employment, appropriate medical facilities, and a clean environment. With regard to access to power, examples include differential access to information (including one's own history), resources (including wealth and organizational infrastructure), and voice (including voting rights, representation in government, and control of the media).
- Personally-mediated racism is defined as prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race. This is what most people think of when they hear the word "racism." Personally mediated racism can be intentional as well as unintentional, and it includes acts of commission as well as acts of omission.
- Internalized racism is defined as acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth. It is

[61] https://www.who.int/health-topics/health-equity#tab=tab_1
[62] https://diversity.nih.gov/sociocultural-factors/implicit-bias
[63] Jones C. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. American journal of public health, 90(8), 1212–1215. https://doi.org/10.2105/ajph.90.8.1212
[64] Ibid

characterized by their not believing in others who look like them, and not believing in themselves. It involves accepting limitations to one's own full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable self-expression.

Race: a specious classification of human beings with Europeans being a standard model of intellect, morals, culture, etc, with the sole purpose of upholding White privilege. In the context of health services provision, race is a shortcut. A crude but convenient proxy for health-related factors, like muscle mass, enzyme level, genetic traits and in many cases, race adds no relevant information. Race also tends to **overwhelm** the clinical measures. It blinds clinicians to patients' symptoms, family illnesses, their history, their own illnesses they might have — all more evidence-based than the patient's race. Race can't substitute for these important clinical measures without sacrificing patient well-being.[65]

Structural racism: Refers to "the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems…(e.g., in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.) that in turn reinforce discriminatory beliefs, values, and distribution of resources," reflected in history, culture, and interconnected institutions.[66]

[65] Roberts, D. How Science, Politics, and Big Business Re-create Race in the Twenty-first Century. The New Press. New York, NY: 2012.

[66] See Bailey, Jones and The Aspen Institute: 11 Terms You Should Know to Better Understand Structural Racism. Retrieved from https://www.aspeninstitute.org/blog-posts/structural-racism-definition/

Appendix 2: Basic Anti-Racism Principles informed by Critical Race Theory[67]

Since many principles that can be interpreted as anti-racist, this list is not exhaustive nor inclusive of **all** anti-racism principles. These are foundational to our work.

1. Racism as normal: neither aberrant nor rare. The primacy of racialization and the ordinariness of racism are upheld by the normative endorsement of whiteness.
2. Interest convergence: The interests of Black people gaining racial equality have been accommodated only when they have convergence with the interests of powerful White people.
3. Historical context matters, including multiple perspectives and origin stories.
4. Narratives are essential; thus, positionality is a core principle/central tenet of critical race theory.
5. Challenging Eurocentrism in knowledge exchange and production is foundational (epistemology, meritocracy, objectivity). Counter-storytelling is essential.
6. Collective wisdom is more valuable than that of individuals.
7. Artistic approaches should be encouraged as part of the educational process; this is particularly true in the caring and health professions.
8. Understanding intersectionality and anti-essentialism: Standpoint theory (Patricia Hill-Collins) is an important skill as is mapping the margins (Kimberle Crenshaw) and Centering the Margins (bell hooks)

[67] The principles used in this report are adapted from many put forward in Foundations of Critical Race Theory in Education: Second Edition. Edited by Edward Taylor, David Gillborn, and Gloria Ladson-Billings. Routledge Press; 2016.

9. Transparency in identity development beyond from clinical novice to expert (i.e., racial, sexual orientation, religion). Transparency of the clinical, didactic faculty as well as the institutions responsible for education and training of students.
10. Recognition of race consciousness (Ford & Airhihenbuwa)[68]: Differentiating between biology and our sociopolitical race classification system is foundational to an anti-racist clinical praxis.
11. Evidence-based practice should be informed by an iterative methodological approach or critical praxis that combines theory, experiential knowledge, science and action (Ford & Airhihenbuwa).

[68] Ford CL, Airhihenbuwa CO. The public health critical race methodology: praxis for antiracism research. *Soc Sci Med*. 2010;71(8):1390-1398. doi:10.1016/j.socscimed.2010.07.030

Appendix 3: Research Team Biographies

Barbara Glickstein (she/her) is a public health nurse, health reporter and media strategist. She is the founder of Barbara Glickstein Strategies, a training company in media, leadership and advocacy skills and produces HealthCetera, a podcast that provides evidence-based health news, analysis and commentary. Ms. Glickstein trains national leaders in healthcare on how to be a media maker in both traditional and digital media to advance the health of the public and public policy and serves on the Board of Project Kesher, a global Jewish feminist women's advocacy organization.

Diana J. Mason, PhD, RN, FAAN, (she/her) is Senior Policy Service Professor at the Center for Health Policy and Media Engagement, George Washington University School of Nursing; and Professor Emerita at Hunter College. She is the Programme Director for the International Council of Nurses' Global Nursing Leadership Institute, a past President of the American Academy of Nursing, and former editor-in-chief of the American Journal of Nursing. She is Principal Investigator on a 2017 replication of the 1997 Woodhull Study on Nurses and the Media published in 2018 in the Journal of Nursing Scholarship and an additional analysis of journalists' experiences with using nurses as sources in health news stories, published in the American Journal of Nursing. The only nurse serving on the National Academy of Science, Engineering and Medicine's committee on Integrating Social Care into the Delivery of Health Care, she chairs the National Advisory Board for the Rush Center Health and Social Care Integration and serves on the boards of directors for the Primary Care Development Corporation, Public Health Solutions, and Margaretville Hospital (Westchester Medical Health Network).

Dr. Monica R. McLemore (she/her) is a Professor in the Department of Child, Family, and Population Health Nursing at UW School of Nursing, Adjunct Professor in the School of Public Health, Immediate Past Chair of the Sexual and Reproductive Health Section of the American Public Health Association (2020-2026), a Board Member of the Black Mamas Matter Alliance and Editor in Chief of Health Equity Journal. She is a preeminent scholar of antiracist birth equity research, community-informed methods, and policy translation. She earned a bachelor's degree in Nursing from The College of New Jersey in 1993 after declaring at eight years old I would become a nurse. She earned a master's in public health from San Francisco State University and a PhD in oncology genomics at the University of California, San Francisco. She has worked my entire career in reproductive health, rights, and justice.

Ms. Kahlea Williams (she/her) is the Project Operations Manager for the Office of Diversity, Equity and Inclusion in the School of Nursing. She leads and facilitates many DEI projects within the School of Nursing, including facilitating the listening sessions for the Center for Antiracism in Nursing.

Appendix 4: Script for Interviews

[Introduce yourself and relationship to the work]

This project is led by the Center for Anti-Racism in Nursing at the University of Washington in partnership with nurse scientists with expertise in strategic communications.

Thank you for agreeing to participate in this exciting project we are conducting for the Robert Wood Johnson Foundation to delineate nurse-led (or nurse-adjacent) programs that are designed using an anti-racism lens. We selected you because we believe you have skills and knowledge to identify potential levers that nurses can use to reduce structural racism in institutions and organizations and ways to incentivize their replication to accelerate anti-racism.

This interview can go up to 45 minutes, and we have 10 questions to ask you. After it is completed, you will receive a brief survey asking if you would like to be remunerated for your time and, if so, a $50 gift card will be provided to the email address you provide.

We are recording these interviews for transcription purposes and notes for our thematic analysis. They will be anonymized to protect your identity. Before we turn on the recording, do you have any logistical questions I can answer?

[**If questions, answer, if none, turn on record**]

1. Have you had either interpersonal or individual experiences of racism that you attribute to nursing culture? If so, briefly describe them.
2. Describe the best practice(s) and the issue(s) of racism it addresses and why YOU wanted to address it, the evidence you have for how it has or has begun to reduce structural racism.
3. Describe the process of designing the approach and implementing it and how nurses were leaders or catalysts in the change.
4. What have been the challenges to doing this work?
5. What helped to overcome these challenges?
6. What work remains?
7. What recommendations do you have for spreading the best practice with nurses leading the work or being catalysts for the work?
8. What would accelerate the pace of change in this space?
9. Does your organization have a DEI officer and, if so, has this helped or hindered?
10. Is there anyone else we should talk with about best practices in addressing structural racism, particularly in clinical settings?

Appendix 5: Pocket Guide

Pocket Guide

Responding to Racist and Discriminatory Behavior

Conversations with a Staff Member

Everyone at Mount Sinai is entitled to safety, courtesy and respect. Use the prompts below to have a conversation with a staff member who has been targeted by a patient, family member, or visitor who is displaying racist, biased, or discriminatory behavior.

Patient makes a discriminatory comment or uses profanity or abusive language toward one or more staff members. Remember to always check in with the targeted staff or learner.	**Patient or patient's family member asks to change a staff assignment based on the perceived race, ethnicity, religion, or sexual orientation of the care provider. Such requests will not be honored, except in rare cases determined by the care team or Nurse Administration.**	**Patient or patient's family member asks to change room assignment based on the perceived identity of the roommate or their visitors. Such requests will not be honored, except in rare cases determined by the care team or Nurse Administration.**
A. "I am so sorry this happened to you. Would you like to tell me more about it? What do you need to feel safe here?" **B.** "It upsets me that this happened to you. I want you to know that you have the right to refuse to care for this patient. We want to make sure that you feel supported and have the agency to make this decision for yourself." **C.** "You are completely entitled to express your feelings. I support your decision to continue to work with this patient, or to have them reassigned." **Scan the QR code to view the Health System's entire policy**	**A.** "I am so sorry this happened to you. At the Mount Sinai Health System, our policy is not to honor any requests that are of a discriminatory, racist, or biased nature, and it is my responsibility to support you." **B.** "You are entitled to request an assignment change. Your fellow staff members and I are here to support you. However, you may also choose to remain on this assignment. The choice is yours." **C.** "I understand you want to continue working with this patient. Would it be helpful if I joined you in addressing this patient in an educational manner to defuse the situation?"	**A.** "Would it be helpful if I joined you in working to address this issue with this patient in an educational way?" **B.** "You have the authority to tell the patient that their request is denied. If you require additional support, please let me know." **C.** "The patient's request has been denied. We do not make room assignments based on race, ethnicity, religion, or sexual orientation." **D.** "The patient is being inappropriate, and we do not indulge this behavior. They may not change rooms assignments. If the targeted patient is uncomfortable, I can help you find a new room for them."

MOUNT SINAI HEALTH SYSTEM POLICY & PROCEDURE

POLICY TITLE:	**Responding to Racist and Discriminatory Patient Behavior**		
POLICY NUMBER:	MSHS 130	**POLICY OWNER:**	Office of Patient Experience
EFFECTIVE DATE:	February 2021	**LAST REVIEWED DATE:**	February 2021

TABLE OF CONTENTS:

I. POLICY

At the Mount Sinai Health System (MSHS), we strive to provide care that is safe, compassionate and equitable. All individuals within our organization are entitled to safety, courtesy and respect. We are committed to creating a safe environment free from all forms of racism, bias and discrimination for all who enter our doors both virtually as well as physically. Any behaviors that undermine this commitment will not be tolerated. This policy will be enforced based on the impact of the discriminatory behavior or speech, not the intention.

Consistent with federal, state and city law, it is the policy of the Mount Sinai Health System that the hospitals, ancillary areas, medical practices, and the Icahn School of Medicine will not tolerate hateful, discriminatory, racist, bigoted or abusive speech or behavior of any kind on the basis of age, color, disability, gender, gender identity, immigration status, marital or partnership status, military

service, national origin, pregnancy, race, religion/creed, sexual orientation or any other status protected by law.

This statement of policy not only applies to the MSHS workforce which includes our faculty, staff (including all clinical as well as non-clinical staff), residents, fellows, postdoctoral appointees, nurses, student employees, students, volunteers and vendors but is also extended to our patients as well as their family members and visitors. It is the expectation of The Mount Sinai Health System that our staff, managers, educators, mentors and leadership support any individual who encounters racist, discriminatory and/or bigoted behavior or speech while continuing to honor its commitment to providing compassionate, equitable, safe and high-quality care.

This policy was created by the Work Group Responding to Racist and Discriminatory Patient Behavior.

II. SCOPE

Any patient, family member or visitor who displays racist, biased or discriminatory behavior in any way towards any member of the MSHS workforce, learning community or another patient/ family member or visitor.

III. DEFINITIONS

"Racist" behavior includes but is not limited to any verbal denigration or physical harassment or intimidation, violence, or threat of violence because of a person's race or ethnicity.

"Antiracism" is the policy or practice of opposing racism and promoting racial tolerance.

"Antiracist behavior" is behavior that moves beyond being "not racist" and instead takes action when faced with racism. It describes someone who supports antiracist policy through their actions or the expression of antiracist ideas.

"Discriminatory" behavior includes but is not limited to language, requests or behaviors targeting workforce members based on their personal characteristics which include and are not limited to age, color, disability, gender, gender identity, immigration status, marital or partnership status, military service, national origin, pregnancy, race, religion/creed, sexual orientation.

IV. ESCALATION AND REPORTING OF RACIST AND DISCRIMINATORY BEHAVIOR:

The following sections contain concrete steps to take when racist or discriminatory behavior is encountered. The urgent medical needs of the patient will be the most important guide in decision making, which also includes determination of capacity. When racist or discriminatory behavior is exhibited in any way, we must prioritize antiracist and anti-discriminatory behavior as a reaction. Accordingly, the person exhibiting the offending behavior must be informed that we will not tolerate any such behaviors and that the targeted individual(s) and their welfare are a priority,

If a patient, family member or visitor exhibits discriminatory, racist, bigoted and/or abusive speech or behavior, the staff member, learner/trainee should report the incident to the care

team and/or Nurse Administrator, and when possible, the Patient Relations. If the patient's family member(s) or visitor(s) are exhibiting the inappropriate behavior related to this policy, the family member(s) visitation may be limited, and in extreme cases, visitation may be prohibited.

The policy does not advocate that a staff member should refuse treatment of patients in critical or unstable condition.

A. Process

The following general process should be followed in all instances:

1. Patient's medical condition must be evaluated.
    a. If the patient's condition is emergent, then the patient must be treated in as effective way as possible.
    b. If the patient is stable, capacity must be assessed.

Capacity[1] should be determined by a physician and when appropriate, Psychiatry. The team will determine whether the offender's problematic behavior is the direct result of a clinical impairment, such as psychiatric, neurologic disease or medication side effects/substance abuse. The care team may choose to take this into account in addressing the behavior.

    c. If the patient lacks capacity, the resolution should be decided on a case- by-case basis.

2. If the patient has capacity, the reason(s) for the behavior, or request to change providers based on the provider's perceived identity, must be understood. In the rare instances when the reasons are clinically and ethically appropriate, an accommodation may be considered. After a determination of capacity has been made, efforts should be made, led by the care team and Nursing Administration, to address any behavioral issues *(see section V for guidance).* If the speech or behavior persists, additional efforts to resolve the inappropriate behavior prior to discharge include:
    a. A behavior plan,
    b. Change in the provider or other adjustment to the care team depending on the comfort level of the provider involved
    c. Restrictions on patient privileges[2]
    d. Hospital security involvement

If the patient does not abide by the guidelines as per the behavior plan and the patient is in an out-patient location (ambulatory, medical practices, etc.), the patient may be asked to leave the premises. In extreme cases, the patient's access to the medical practice may be restricted for a given amount of time, or permanently.
If the patient does not abide by the guidelines as per the behavior plan and the patient is in inpatient care, the patient may be discharged from the hospital. Please note: patients cannot be restricted from access to Emergency Rooms.

[1] Capacity is defined as the patient's ability to make decisions and to understand the benefits and risks to their behavior.

[2] Patient privileges can relate to visitation,

B. Discharge Protocol: Inpatient

Once appropriate steps have been taken up to and including a meeting with the patient (and representative, if applicable) and a behavioral agreement that has been properly explained to the patient (and representative, if applicable) and documented in the patient's medical record, a patient may be discharged.

Patient will receive the discharge notice (IDP), and discharge instructions will be reviewed with the patient. The care team will provide all necessary prescriptions needed for discharge. If needed, equipment and home care needs should be in place and follow-up appointments/referrals will be made on the patient's behalf. If necessary, security may escort the patient off the unit. At no time should Mount Sinai personnel remove a patient unless that patient is posing an immediate danger to others on the unit.

If police involvement becomes necessary, the following steps should be taken prior to police removing the patient from the unit:

a. Security and/or Engineering should be called to control the elevator (an elevator must be designated for the sole use of this activity).
b. All of the patient's belongings must be gathered and discharged with the patient.
c. It should be determined whether the Nurse Manager and/or designee should escort the patient with Security/police during removal.

C. Discharge Protocol: Outpatient

1. A discharge letter must be mailed (certified) to the patient and include:
    a. Thirty-day notification from the date of the letter that patient will be discharged from the ambulatory practice.
    b. At least three appropriate referrals to outside facilities/physicians.
    c. Letter must inform patient of their right to utilize the Emergency Room at any time.
2. If a patient's behavior is felt to be so egregious or their actions of such a threatening or harmful nature that immediate discharge from the practice is warranted prior to a meeting or behavioral agreement, a discharge letter may be issued as follows:
    a. Immediate notification from the date of the letter that patient will be discharged from the ambulatory practice.
    b. At least three appropriate referrals to outside facilities/physicians. Letter must inform patient of their right to utilize the Emergency Room at any time.

D. Requests to Change Providers Based on Perceived Identity of the Clinician:

Any requests for change in provider, other staff person or learner/trainee based upon any of the protected classes delineated above will not be honored, except in rare cases related to the distinctive clinical needs of the patient as determined by the care team. Additionally, patient requests for room changes based on their roommate's personal characteristics related to protected classes will be treated similarly. Exceptions will be considered on a case-by-case basis and may include, cognitive dysfunction, past trauma that may be linked in a patient's mind to personal characteristics or gender preferences relating to modesty issues. These exceptions will be considered by the care team and/or Nurse Administration on the unit in

conjunction with Patient Services (during normal business hours). PFEC is always available for consultation. In complex cases where special concerns arise, Legal and the Ethics Committee may be consulted.

If the incident occurs outside of regular business hours, the care team, Nurse Administration and/or resident on call can convene to decide whether there is any basis to honor the request. Patient Services should be notified of the incident during normal business hours. All incidents should be appropriately logged in the patient's medical record.

E. Referral to the Patient Family Engagement Committee (PFEC)

The Mount Sinai Health System Patient and Family Engagement Policy (PFEC 2017) supports the staff and learners in the event a patient and/or family member(s) engages in inappropriate, harmful and/or disruptive behavior. The Patient Family Engagement Committee is available to review and make recommendations regarding the management of racist and discriminatory behavior.

F. Report and Review

Racist and/or discriminatory behavior by a patient or family member towards another patient or family member, or towards any member of the MSHS workforce, learning community or another patient/family member or visitor should be reported by a entering it into the *Safety Net* database, which can be accessed via the desktop or the application launcher. Any events involving racial or discriminatory bias not perpetrated by a patient, family member or visitor, but rather by staff should be reported to the compliance hotline. Requests to change providers should be documented appropriately in the patient's chart.

The Workgroup on Racist and Discriminatory Patient Behavior will review this data on a regular basis.

V. SUGGESTED MESSAGING TO PATIENTS

If the staff or learner/trainee is comfortable speaking to the patient and/or family member(s) about their inappropriate speech and/or behavior, the scenarios below may provide guidance.

1. Patient makes a discriminatory comment to a group of staff members/staff member, learner/trainee. Response should be similar to any patient, family member or visitor who is using profanity or abusive language:
    a. "Please do not use that type of language as it is offensive to others and not acceptable at Mount Sinai."
    b. "Here at The Mount Sinai Health System, we do not tolerate such inappropriate comments. Please refrain from speaking them."
    c. "MSHS supports and upholds values of antiracism. We believe in supporting those targeted by racist or discriminatory behavior. Our policies are enforced not on the basis of intention but on the impact of one's inappropriate behavior."
    d. "Those comments have no place in this hospital. Our staff is well-trained and very capable of providing high quality care, all are professionals and will be respected as such."

e. "You will be cared for by another clinician. The former clinician is not comfortable treating you based on your behavior."

2. Patient or patient's family member makes a request to change a staff assignment or learner/trainee based on the perceived identity of the care provider, and the request is denied.
   a. "It is not our policy to make staff changes based on race, ethnicity, religion or sexual orientation of the care provider. Our staff/learners/trainees are well-trained and extremely competent."
   b. "We will not make changes based on the comments you have provided. We treat all of our patients, staff, and learners/trainees with respect, and we expect the same from our patients."
   c. "Your request has been denied. You will continue to be cared for by [provider's name]. Our staff is well-trained in giving the highest quality of care. If you are not comfortable, you are welcome to leave the facility."
   d. "Your request has been denied. You will have a new clinician assigned to you because the former clinician is not comfortable treating you based on your behavior."

3. Patient or patient's family member make a request to change room assignment based on the perceived identity of the roommate or the roommate's visitors, and the request is denied.
   a. "It is not our policy to make room changes based on race, ethnicity, religion or sexual orientation of your roommate."
   b. "We assign room assignments at random and do not plan roommates based on race, ethnicity, religion or sexual orientation."
   c. "Your request has been denied. We do not make room assignments based on race, ethnicity, religion or sexual orientation."
   d. "Your request has been denied. The patient you are currently rooming with will be changing rooms because they are not comfortable with your behavior."

VI. SUGGESTED MESSAGING TO TARGETED STAFF MEMBER/LEARNER

1. Patient makes a discriminatory comment to a group of staff members/staff member. Response should be similar to any patient or family member who is using profanity or abusive language. Remember to always check-in with the targeted staff or learner.
   a. "I am so sorry this happened to you. Would you like to tell me more about it? What do you need to feel safe, here?"
   b. "It upsets me that this happened to you. I want you to know that you have the right to refuse to care for this patient. We want to make sure that you feel supported and have the agency to make this decision for yourself."
   c. "You are completely entitled to express your feelings. I support your decision to continue to work with this patient, or to have them reassigned."

2. Patient or patient's family member makes a request to change a staff assignment based on race, or sexual orientation, etc. of the care provider, and the request is denied.
   a. "I am so sorry this happened to you. At the Mount Sinai Health System, our policy is not to honor any requests that are of a discriminatory, racist or bias nature, and it is my responsibility to you to support you."

b. "You are entitled to request an assignment change. Your fellow staff members and I are here to support you. However, you may also choose to remain on this assignment. The choice is yours."
c. "I understand you want to continue working with this patient. Would it be helpful if I joined you in addressing this patient in an educational manner to defuse the situation?"

3. Patient or patient's family member makes a request to change room assignment based on the race, religion, or sexual orientation of roommate or visitors, and the request is denied.
   a. "Would it be helpful if I joined you in working to address this issue with this patient in an educational way?"
   b. "You have the authority to tell the patient that their request is denied. If you require additional support, please let me know."
   c. "The patient is being inappropriate and we do not indulge this behavior. They may not change room assignments. If the targeted patient is uncomfortable, I can help you find a new room for him/her."

VII. PATIENTS' RIGHTS AND RESPONSIBILITIES

Your Responsibilities as a Patient at the Mount Sinai Health System

This statement of Patient Responsibilities was designed to demonstrate the mutual respect and cooperation that are basic to the delivery of safe, compassionate and equitable health care delivery.

Demonstrate Respect and Courtesy:

Patients along with their family members and visitors, are expected to recognize and respect the rights of other patients, visitors, staff and learners/trainees.

Consistent with federal, state and city law, it is the policy of the Mount Sinai Health System that the hospitals, ancillary areas, medical practices, and the Icahn School of Medicine will not tolerate hateful, discriminatory, racist, bigoted or abusive speech or behavior of any kind on the basis of age, color, disability, gender, gender identity, immigration status, marital or partnership status, military service, national origin, pregnancy, race, religion/creed, sexual orientation or any other status protected by law.

Any threats of violence, disrespectful communication or harassment of any kind will not be tolerated.

Furthermore, any requests for change in provider or other staff person or learner/trainee based upon their race, ethnicity, religion, sexual orientation or gender identity will not be honored, except in rare cases related to the distinctive clinical needs of the patient determined by the care team. Additionally, patient requests for room changes based on their roommate's race, ethnicity, religion, sexual orientation or gender identity will similarly not be honored except in the event that the request is ethically and clinically appropriate.

VIII. EDUCATION

Advance knowledge and training about this policy will better prepare staff to assess the appropriate course of action in these challenging situations. Accordingly, this policy should be included regularly in workforce and learner/trainee education.

REFERENCES:

1. Kendi, I. (2019). *How to Be an Antiracist.* Random House.
2. K. Paul-Emile, J.M. Critchfield; Margaret Wheeler; Shalila deBourmont; Alicia Fernandez. Annals of Internal Medicine, Addressing Patient Bias Toward Healthcare Workers: Recommendations for Medical Centers, Annals.org. July 14, 2020
3. Oluo, I. (2018). *So You Want to Talk About Race.* Seal Press.
4. Reynolds, Kimberly L., Cowden, John D., Brosco, Jeffrey P., Lantos, John D. (2015). When a Family Requests a White Doctor. *Pediatrics 2015;* 136;381. DOI: 10.1542/peds.2014-2092. https://pediatrics.aappublications.org/content/136/2/381

Appendix 6: Speak Up Against Racism

Focus: Raising awareness of and addressing implicit and explicit bias

Organization/Individual Developer: Institute for Perinatal Quality Improvement, founded by Debra Bingham in 2016 to eliminate preventable deaths and injuries and eliminate perinatal disparities. Co-creator Rene Byfield, SPEAK UP Program Director.

Description: Begun in 2018, this in-person and online program creates a safe space for conversations among health care workers, including administrators, about recognizing one's implicit and explicit biases. "Conversation is where change begins." It is organized around the pneumonic, SPEAK:

Set limits - allow only racially respectful speech and action in your work space. #NotOnMyWatch
Practice and prepare - Plan how to act and to disrupt conversations and behaviors that are disrespectful, racist, or dehumanizing.
Express your concerns - Be bold, clear, and straightforward. Discuss why you are concerned.
Apologize - Say you are sorry, change your behavior, and ensure reconciliation if you said or did something that perpetuates racism.
Keep Improving - Be courageous. Become aware of your implicit and explicit biases. Seek feedback and collect data so you can keep learning and improving.
Uncover and learn - Be curious, mindful, and open to new perspectives as you deepen your understanding of racism and its harmful impact.
Persuade others - Spread the word and encourage others to #SpeakUpAgainstRacism**!**

Once participants complete the program, they can pledge to be champions for speaking up against racism; or they can attend become ambassadors an online course on strategies to help individuals and groups dismantle racism, provide quality equitable care, and reduce health disparities. The Institute is also developing a train-the-trainer approach to prepare additional faculty who can spread the program.

The model uses five key strategies:

1. Apply a systems approach based upon the socio-ecological model.
2. Identify root causes of disparities.
3. Identify and eliminate strong but wrong routines.
4. Use improvement and implementation science methods and tools.
5. Use data to guide the plan and track progress.

Outcomes: As of 2023, over 1300 people had completed the 8-hour in-person program. Online modules that augment the in-person program were developed during the pandemic. The Institute is consulting with healthcare organizations in Illinois, Oklahoma, Washington, and Georgia, as well as partnering with the Massachusetts (MA) Department of Public Health and Perinatal Neonatal Quality Improvement Network of MA (PNQIN) to "support MA perinatal facilities to accomplish birth equity focused goals aimed at providing high quality, respectful and equitable care to all birthing people"

through four workshops. Bingham and Byfield are tracking outcome data but would welcome funding for a rigorous evaluation of the program.

Challenges to Spreading: A financial model for the program that is sustainable; funding for a rigorous evaluation.