We are the solution to our problem: A brief review of the history of racism and nursing

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There is strength in numbers. The large and trusted nursing profession has the collective power and influence to lead a systemic change in societal and healthcare equity, creating a bold future to modify values, core beliefs, and desires. This article explores and acknowledges structural racism in the nursing profession, past and present. It offers a concrete, feasible, and promising approach toward advancing health equity and addressing health disparities at their root cause.

KEY WORDS: **nursing history, APRN, structural racism, health equity**

Mary Mahoney, the first Black professional nurse in the United States

Nurses comprise the largest percentage of frontline healthcare workers, are widely reported to be among the most trusted, and are rated the highest of all professions for honesty and ethics.[1] As of 2019, there were 4,096,607 registered nurses and 920,655 licensed practical nurses in the United States.[2] The growing number of advanced practice registered nurses (APRNs) add to the strength of the nursing profession and wield power, privilege, and responsibility as leaders, clinicians, educators, and researchers. As of 2019, there are 325,000 nurse practitioners, of whom 2.9% are women's health nurse practitioners, and 12,872 certified nurse midwives.[3,4] There is strength in numbers. The large and trusted nursing profession has the collective power and influence to lead a systemic change in societal and healthcare equity, creating a bold future to modify values, core beliefs, and desires.[5]

Structural racism and health inequities

In the National Commission to Address Racism in Nursing, Dr. Rumay Alexander, Scholar-in-Residence, offers this definition: "Racism: assaults

on the human spirit in the form of biases, prejudices, and an ideology of superiority which persistently cause moral suffering and perpetuates racial injustices and inequities."[6] Although there is not one single definition of structural racism, it refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing structural policies in housing segregation, education, employment, earnings, benefits, credit, media, healthcare, and criminal justice.[7] These patterns and practices over generations in turn reinforce discriminatory beliefs, values, and how resources are distributed.

Almost 20 years ago, the Institute of Medicine 2002 report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" documented systematic and pervasive bias in the treatment of people of color, resulting in substandard care. More recently, the "2019 National Healthcare Quality and Disparities Report" continued to show that people of color receive poorer care than White patients by 40% of the quality measures utilized.[8,9]

In 2020, Covid exposed the deep divide in healthcare access, disease prevention, and policies for communities of color. In June 2020, a *Washington Post* poll found that nearly 1 in 3 Black Americans knows someone personally who has died of Covid-19.[10] The death rate among Black individuals is up to 10 times higher than among White individuals.[11]

In the maternal mortality reports for Black and African American women in the US, research has shown that they are three to four times more likely to die in childbirth than are White patients, despite controlling for education, socioeconomic status, and genetic factors.[12] The national infant mortality rate for African Americans is 2.3 times greater than the rate for non-Hispanic White infants.[13]

Call to nursing

The nursing profession is urged to understand and address the invisible internalization and manifestation of racism within our profession to advance the integrity of practice in the nursing profession and promote equity of healthcare.[14] The American Association of Colleges of Nursing (AACN), in its most recent nursing essentials on the core competencies for professional nursing education, states that the nursing profession must be able to address systemic racism and pervasive inequities in healthcare as the US population demographics shifts, health workforce shortages continue, and persistent health inequities increase.[5] To that end, the newly formed National Commission to Address Racism in Nursing has developed a mission statement for the nursing profession: "Set as the scope and standard of practice that nurses confront and mitigate systemic racism within the nursing profession and address the impact that racism has on nurses and nursing."[6]

A focus on exploring and acknowledging structural racism in the nursing profession offers a concrete, feasible, and promising approach toward advancing health equity and improving population health and to address health disparities and their root cause.

Looking backward to move forward

A review of racism in nursing history provides the perspective of change over time in the profession, which can inform the present and help plan the future of nursing. The limited scope of this review focuses primarily on the experiences of Black Americans, as most research on racism and health has focused on this racialized group. However, the authors acknowledge that Native Americans and other people of color, and those with less visible diversity, have also been the target of health-harming discrimination and injustice.

Racism in nursing is inextricably linked to structural racism in the US, and it starts with the experiences of Black people and the Indigenous people of North America. It was on these two groups that the initial White colonizers of North America first used genocide and the practice of enslavement, creating both legal and tacit systems of racial oppression. Born of a doctrine of White supremacy, it was built into policies and laws developed to justify mass oppression involving economic and political exploitation. It was continuously carried out through centuries of slavery as premised on the social construct of race.[15] Understanding that the nursing profession was shaped through the social, political, and historical contexts rooted in American colonialism is an important first step.

A society that consistently centers whiteness will also view nursing history through a White Eurocentric lens that traditionally has not recognized the many Black, Indigenous, and people of color (BIPOC) who have served as community healers and midwives.[16,17] Among the Africans abducted from their homes and brought to the US as enslaved people in the 1600s, there were trained and practicing midwives. As enslaved women, they continued to provide primary pregnancy and birthing care to other African enslaved women and, as required, to White women. Emerging from the necessity of survival, there was a hidden and unrecognized workforce within slave communities that continued well beyond emancipation in 1863. These healers were made up of primarily elderly women who provided physical and mental healthcare and spiritual healing with herbal remedies, charms, and ritual.[17]

Persistent and implicit racism

In the early development of medical education in the 1800s, Black enslaved women were given experimental medical treatments against their will and often exploited by healthcare providers that cast Black people as subhuman and innately diseased.[8,18] Dr. James Marion Sims, often credited with being the founder of modern gynecology but under great scrutiny in recent years, came to many of his discoveries in the 19th century by surgically experimenting on enslaved women while also forcing them to perform domestic duties and serve as nurses in his clinic. His repeated operations were performed without anesthesia on Black women without consent.[19]

In the early 20th century, the modern eugenics movement in the US included compulsory sterilization laws allowing the consistent targeting of poor, disabled, and institutionalized people that were disproportionately used against people of color. Of the nearly 8,000 people sterilized through the North Carolina Eugenics Board, nearly 5,000 of them were African American. The practice continued, and Native American women were subjected to involuntary sterilizations by the Indian Health Service in the 1960s and 1970s.[20]

Some of the most obvious examples of healthcare's history of racial injustice include the exclusion of African Americans from medical and nursing education.[8] American nursing history often excludes the Black nurse experience and its leaders. The professional nursing role emerged in the late 19th century amid the recent end of slavery and deeply entrenched racism. In 1878, Mary Mahoney, the first Black professional nurse in the US, was admitted to a nursing education program in a New England hospital under a policy that limited admissions to other than White European Americans to one African American and one Jewish student for each training class.[21] Mahoney became the first US Black professional nurse. Just 17 years earlier, Florence Nightingale was recognized for founding the first formalized training school for nurses at St. Thomas Hospital in London in 1860. Nightingale selected small contingents of White European women of the "right caliber" (eg, character) to train for 1 year.[14] Since that time, nursing practice as an "all-white female profession" has persisted in many forms and iterations despite numerous examples of Black Nightingales such as Mary Seacole, Susie King Taylor, James Derham, Bernice Redmon, Anna DeCosta Banks, and Estelle Osborne, to name a few.[21]

In US nursing schools, Black women continued to be restricted or denied admission.[22] Some of the Black physicians and nurses who were often barred from practice privileges at local hospitals, collaborated with the Black community and opened their own hospitals with schools of nursing to educate Black women.[23] In 1906, the National Association of Colored Graduate Nurses was created to address the specific needs of the Black nurse and timely issues such as racial segregation.[24] In 1916, the American Nurses Association (ANA) required members to join via state nurses' associations. At the time, most state nursing organizations denied membership to Black nurses, effectively excluding them from this national professional organization. Many states prevented Black nurses from taking the examination to become registered nurses and in agencies that employed Black and White nurses, Black nurses were often paid considerably less than White nurses.[22]

Over time, incremental and hard-won social justice changes were accomplished through mass social movements that challenged structural racism.[8] These changes resulted in laws that countered, but did not end, the long history of discrimination in academic admissions and work environments. In 1946, the Hill Burton Act provided funds for racially integrated hospitals. In 1954, the Brown vs Board of Education struck down "separate but equal," and the 1964 Civil Rights Act prohibited discrimination by race in public places, schools, and any public facility. In summary, the historical roots of racism in nursing and healthcare in the US have a long history of opposing desegregation and broader access to care, of barring or restricting Black nurses and physicians from receiving training and working, of championing racism in research, and of perpetuating race as a biologic variable.[8] The necessary work to dismantle structural racism continues to be at the forefront of an urgent call for the large and trusted nursing profession to confront and lead the work for healthcare transformation. As one author wrote: "Only when we consider racism and racial inequality to be persistent and implicit in our norms of practice and the ordering of society and not the exception, can we effectively begin to confront this issue."[20]

Levels of racism and women's healthcare

Three levels of racism, institutional, personal-mediated, and internalized, clearly connect to women's healthcare for African American women.[25,26] Each level of racism has an impact on healthcare outcomes. Institutional racism is characterized by organizations or governments that impose practices that negatively affect access to health services, which results in differences in the quality of healthcare for racial/ethnic

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minority groups. Personally mediated racism occurs when healthcare providers' preconceived notions about racial groups result in the provision of substandard healthcare to racial/ethnic minorities.[25] For example, there is an historical misconception that African American women have higher pain tolerance, and therefore providers may withhold proper medication for pain management.[27] Finally, internalized racism involves the embodiment and acceptance of stigmatizing messages from society by racially oppressed groups.[25] African American women may accept and normalize substandard treatment in clinical settings based on society's norms.

A growing body of literature supports that disparities in African American women's health and healthcare result from these three levels of racism. African American women experience higher rates of sexually transmitted infections, infant mortality, human immunodeficiency virus, and pregnancy-related morbidity and mortality.[26,28] Morbidities may include infections, mental health issues, obesity, diabetes, preeclampsia, and cardiovascular conditions.[29] African American women are more likely to experience discrimination, receive substandard care, and undergo unnecessary surgeries when compared to their White counterparts.[30–32]

Implications to clinical practice

Racism has critical implications to clinical practice. A diverse nursing workforce can provide increased access to quality healthcare and health resources for all populations.[33] A thoughtful and thorough assessment of patient outcomes using a lens of equity should be completed in clinical settings. Development of a strategic plan to address areas requiring improvement is a vital step in the process of dismantling structural racism in clinical settings. The following are recommendations to consider within the clinical setting:

- Increase recruitment and retention of diverse healthcare workers within one's respective organization.
- Provide continuous training related to topics of racism such as implicit bias, microaggression, and macroaggression. These trainings should be meaningful with measurable outcomes throughout each fiscal or calendar year.

Implications to academia

Currently, the healthcare workforce in the United States does not reflect diversity in all racial and ethnic groups.[34] It is essential that the makeup of healthcare providers mirror the US population. As the starting point for career pathways in healthcare and in particular nursing, there must be a concerted effort to diversify the academic setting. The following are recommendations to consider within academic settings:

- Recruit and retain a diverse faculty and student body.
- Establish leadership programs focused on the development of minority leaders in academia.
- Create pipeline programs to increase diversity within the nursing profession.
- Develop researchers from diverse backgrounds.
- Provide scholarships and other funding opportunities.

Selected resources

There are ample resources available to organizations and healthcare providers to address racism. Selected resources, some with a focus on women's healthcare, are described here:

Standard for holistic care of and for Black women

In 2018, Black Mamas Matter Alliance published a **Black Paper** entitled "Setting the standard for holistic care of and for Black women.[35] Healthcare providers can utilize this essential resource to improve care for Black women. Critical components of this paper include:

- Addressing gaps and ensuring continuity of care
- Affordable and accessible healthcare
- Confidentiality
- Safe and trauma-informed care
- Care that centers Black women and their families
- Care that is patient-centered and patient-led
- Culturally congruent and competent care

Position statement on eliminating preventable maternal deaths

The National Association of Nurse Practitioners in Women's Health (NPWH) published a position statement in 2019 on the elimination of preventable maternal deaths that provides evidence-based resources to assist healthcare providers in addressing the multiple contributing factors for pregnancy-related deaths for diverse populations of women.[36]

Diversity, equity, and inclusion committees

Several nursing organizations and academic programs have developed and implemented formalized committees to address diversity, equity, and inclusion. Becoming actively involved in this type of committee work at local, regional, and national levels supports dismantling structural racism that impacts healthcare. NPWH, AACN, the Association of Women's Health Obstetrics and Neonatal Nurses, ANA, National Black Nurses Associations, and the National Association of Hispanic Nurses are examples of organizations at the national level involved in this essential work.

Harvard Implicit Association Tests

The Harvard Implicit Association Tests are valuable to individuals seeking to understand, change, and address their respective implicit bias. There are a number of assessment areas including race, gender, sexuality, disability, weight, age, sexuality, skin-tone, Arab-Muslim, Native, religion, and others. The implicit association test for any chosen assessment area can be taken multiple times throughout one's career to assess how biases have improved with active engagement to change them.

Kirwan Institute for the Study of Race and Ethnicity

Kirwan Institute for the Study of Race and Ethnicity developed a complimentary series of four modules focused on addressing implicit bias. The series can be accessed online at the Kirwan Institute official website. This series is useful to healthcare providers as it provides in-depth information on biases and how to mitigate them. The modules focus on the following four areas:

- Understanding bias
- Real-world implications
- Understanding your own bias
- Mitigating unwanted bias

Conclusion

Racism in nursing has existed since the profession's historic beginnings, and it continues to permeate nursing education, practice, research, and policy. Access to high-quality and compassionate healthcare should not depend on the color of a person's skin or the neighborhood in which they live. Yet communities of color, accounting for nearly 40% of the US population, bear a disproportionate burden of preventable disease, disability, and death. Exploring and acknowledging structural racism in the nursing profession offers a concrete, feasible, and promising approach toward advancing health equity and addressing health disparities at their root cause.

The nursing profession, known for a holistic approach to healthcare and positive rapport with patients, can be instrumental in addressing the social factors that limit access to care. Health disparities are the result of a complex, interconnected system of social, racial, and economic injustice. Change will require setting bold goals individually and collectively in the nursing profession to hold ourselves accountable for tangible results to build an equitable healthcare future. ■

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