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ScienceDirect

Nurs Outlook 68 (2020) 539–541

Nursing Outlook

www.nursingoutlook.org

"I can't breathe": A call for antiracist nursing practice

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ARTICLE INFO

Article history:
Received 9 June 2020
Received in revised form
23 June 2020
Accepted 8 July 2020
Available online 15 August 2020

Keywords:
Racism
Nursing practice
Health equity
Health disparities

In 2020, nurses are confronting emerging and persisting health crises that are propelled by systemic racism. Coronavirus disease 2019 (COVID-19), originally called the "great equalizer," has ravaged the nation, but is disproportionately impacting Black Americans (Centers for Disease Control [CDC], 2020a). Meanwhile, civil rights protests are underway after the killing of George Floyd, the latest extrajudicial killing of a Black American by the police. Police violence is a significant health issue. Negative experiences with police are associated with increased medical mistrust (Alang, McAlpine, & Hardeman, 2020). Police killings are a leading cause of death for young Black men and Black women are 1.4 times more likely to be killed by police than White women (Edwards, Lee, & Esposito, 2019). George Floyd's final words were, "I can't breathe." In a clinical context, when nurses hear a patient say, "I can't breathe," it is an immediate call to action. Protocols are followed, resources are gathered, and steps are taken to maintain the patient's airway. "I can't breathe" has become the rallying cry of a movement. Whether from the disproportionate mortality from COVID-19, or police violence, when Black Americans call out, "I can't breathe," nurses must respond. In the International Year of the Nurse and Midwife it is critical that we advocate for justice for Black Americans with a unified and powerful voice.

Racism exists in internalized, interpersonal, institutional, and structural forms, all of which nurses must recognize and name. Structural racism in particular impacts our patient's health, which is dependent on their living conditions and environment. For example, residential segregation, a product of structural racism from the 1930s to 1960s in the U.S. housing system (e.g., redlining), produced racially segregated hospitals and differences in hospital quality that persist today (Sarrazin, Campbell, Richardson, & Rosenthal, 2009). These policies also perpetuated differences in opportunities for employment, socioeconomic status, and physical and social environments (Williams, Lawrence, & Davis 2019). Structural racism is also contributing to the disproportionate racial impact of COVID-19. Economic disenfranchisement may make exposure more common for Black Americans working in essential jobs who are unable to self-isolate and racial residential segregation impacts differential access to high quality care (CDC, 2020b). Racism, not race, is the critical distinction that we must address. As the writer, Ta Nehisi Coates writes, "Race is the child, not the father, of racism" (Coates, 2015, p. 7).

We credit professional nursing to Florence Nightingale, who highlighted the importance of studying health disparities and their determinants. Nursing falls short as a profession if we are not actively and explicitly naming racism as a root cause of racial health

Financial Disclosure: The authors have no financial relationships relevant to this article to disclose.

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https://doi.org/10.1016/j.outlook.2020.07.004

disparities. Nurses value empathy and bearing witness to what is happening not only in our healthcare settings but also in our communities. The ANA Code of Ethics urges nurses to confront moral wrongs, promote, protect, and advocate for all patients and communities, and urges nurses to confront biases, protect human rights, and reduce disparities (American Nurses Association, 2015). Nursing, public health, and medical organizations and professionals have previously released position statements addressing the impact of racism on health and healthcare (American College of Nurse Midwives, 2018; American Public Health Association, 2001; ANA Center for Ethics and Human Rights, 2019; García & Sharif, 2015; Hardeman, Medina, & Kozhimannil, 2016; Trent, Dooley, & Dougé, 2019). However, nursing must also develop antiracist practice, research, and education to begin to address racism. The status quo of race-neutral, race-blind, or culturally competent care will only strengthen existing disparities. We propose the following calls to action as a means to recommit our profession to naming and breaking racist structures and shifting towards an antiracist nursing practice.

We call on nurses to commit to antiracism in their clinical practice. Nurses, nurse practitioners, and midwives have historically been committed to addressing health disparities and promoting justice, but we can lose sight of that when things become politicized. Being antiracist is not political rhetoric but is rather a moral imperative. It requires each nurse to engage in a daily practice of actively combating racist structures, institutions, and practices. We must combat racism within ourselves - no one is born racist or antiracist. We can do this by identifying our implicit and explicit biases. Tools such as the Implicit Association Test by Harvard's Project Implicit (2011) can highlight our biases and spur internal reflection on how these biases impact the care we give. Nurses, particularly those in positions of privilege, must also use moral courage to speak up when witnessing discriminatory words or actions in practice. We must push healthcare and political institutions to transform structures that potentiate poor health outcomes through inaccessible and expensive care, and ensure they are accountable to the communities they serve.

We call on nurse scientists to prioritize work that exposes inequities in care quality and health outcomes for Black Americans. The National Institute of Nursing Research strategic plan emphasizes the importance of using community partnerships with underrepresented and minority communities to study wellness strategies aimed at reducing health disparities (2016). While research with these populations is challenged by issues of trust related to historical grievances, newer methodologies that elevate the participant as the informant and that rely on partnerships, yield meaningful and helpful results while reestablishing trust in the ability for research to help their communities. The science examining racism and its effects on health is nascent. Rather than merely identifying relationships between *race* and health outcomes, nurse scientists should be developing and implementing new research methodologies that further our understanding of how *racism* drives inequitable health outcomes (Mclemore et al., 2019; Trent et al., 2019).

We call on nurse educators to advance antiracist practice within nursing education. Increasing the diversity of the nursing workforce is an initial step. A diverse healthcare workforce is one way to improve access and quality of healthcare, and decrease health disparities (Bouye, McCleary, & Williams, 2016; Institute of Medicine, 2004). Faculty and academic institutions must provide financial and academic resources to optimize equity and maximize student support, retention, and success. To aid inclusivity, nursing programs should develop plans and accompanying supportive structures with ongoing evaluation to address the needs of students harmed by racism. Faculty must confront their own biases and incorporate antiracist pedagogy into their curriculum by encouraging reflexivity, reflective writing, and welcoming difficult conversations in the classroom (Thurber, Harbin, & Bandy, 2019). The application of critical antidiscriminatory pedagogy offers a path for reforming nursing education. Rooted in social justice to address health inequities, critical antidiscriminatory pedagogy builds the capacity of nurses to identify and counteract racism through an intersectional perspective and, through transformative learning, utilize this new perspective in antiracist practice (Blanchet Garneau, Browne, & Varcoe, 2018).

Racism is an epidemic. COVID-19 and police violence are just two examples of how racism disproportionately harms Black Americans. Our call for antiracist nursing practice requires examining ourselves, the institutions where we work, and the racist policies that perpetuate health disparities and their social determinants. Rather than race neutral or culturally competent care, antiracist practice actively stands against racism. We must face the epidemic of racism head-on by applying rigorous changes to nursing practice, research, and education, and, as is always true with our profession, do this with empathy and respect.

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