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Achieving Health Equity Through Eradicating Structural Racism in the United States: A Call to Action for Nursing Leadership

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Abstract

Purpose: To advocate for strategic actions by U.S. nursing leadership that denote the presence, customs, and implications of racism that has been institutionalized within the structures of U.S. nursing leadership and the profession.
Organizing Constructs: A racial equity framework is used to examine the barriers to quality health care and equitable health outcomes and to present evidence-based actions to dismantle structural inequities embedded in the nursing profession.
Methods: This article was developed through a comprehensive literature review and synthesis of relevant research, data, peer-reviewed literature, government reports, and organizational guidelines.
Findings: A commitment by U.S. nursing leadership to eradicate structural racism in nursing must be made in order to effect sustainable transformative change toward more equitable systems of health care.
Conclusions: This article presents recommendations for nursing leadership in the United States to renew its commitment to quality health care through dismantling structural racism at all levels of direct and systems nursing practice and education, at the bedside, and in the boardrooms.
Clinical Relevance: Structural racism in nursing and health care also persists globally as a key social determinant of health. Its elimination aligns with international health care and nursing's policy priorities, yet change can only occur when senior leaders clearly understand it as a key barrier to health, and commit to transformative change in how their "systems" work. These recommendations can also be culturally adapted by global nursing for use in antiracism work.

Motivating health equity is requisite given starkly disparate health outcomes among black and brown racialized populations compared to white populations in the United States. Racial justice and improving health equity take on a significant role in the work of racial minority nurses (Beard & Julion, 2016). Representation of racial minority populations in nursing remains disproportionate when compared to the representation of white populations in nursing O'Connor and colleagues (2019) reported that 85%

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of nursing faculty nationally are white, and the landscape in which nurses operate requires them to have constructive and bold conversations and self-reflection on racism given that nursing academia strives to not only embody an inclusive educational space but to prepare professional nurses who can deliver equitable care for a diverse population. Given the nature of white supremacy in the United States, historical, personal, social, political, and institutional norms support inequities through structural racism, to perpetuate health disparity and foster social injustice (Hardeman, Medina, & Kozhimannil, 2016).

Structural racism is sometimes confused with institutionalized racism, which characterizes the policies, norms, and practices built into businesses, schools, or organizations that put black and brown racialized students, staff, or patients at a significant disadvantage (The Aspen Institute, 2016; Hardeman et al., 2016). By contrast, as Figure 1 illustrates, structural racism integrates institutional racism into a wider, systemic confluence of personal,

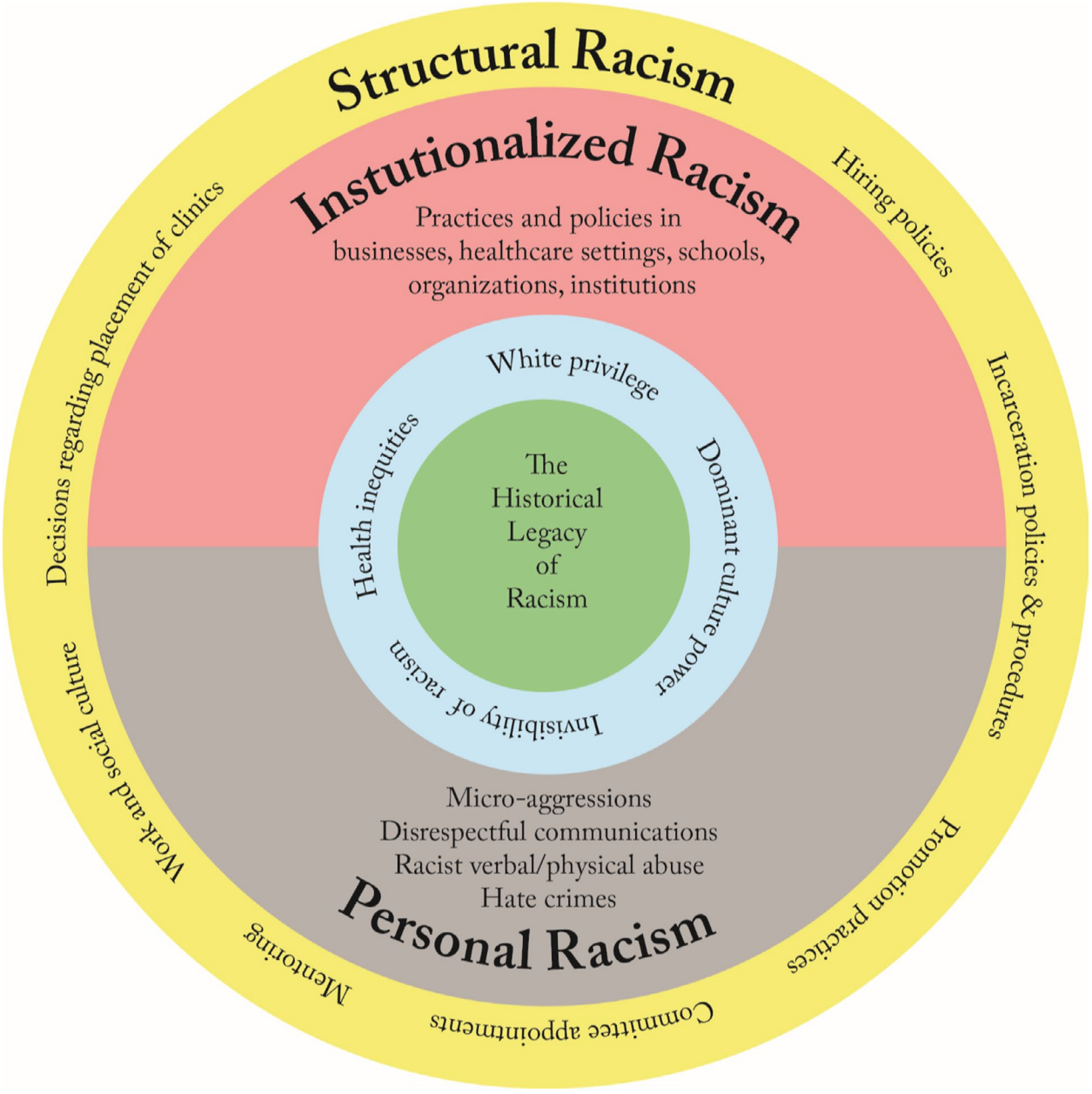

Figure 1. Intersectionality of racism in the United States. [Corrections added on October 22, 2020, after first online publication. The figure 1 has been added in the proof.] [Colour figure can be viewed at wileyonlinelibrary.com]

interpersonal, intentional, invisible, and other levels of racism that have permeated the structures of everyday life in the United States, its cultural practices, and norms to perpetuate inequities and injustices for persons not identified as white (The Aspen Institute, 2016). These structures are operationalized in nursing, since they also parallel structural racism in society. Progress to address healthcare equity requires a core focus on nursing leaderships' commitment to act aligned with promoting racial justice; however, action is likely influenced by their perceptions of the factors contributing to inequity. Action steps framed around structural racism and implications for professional nurses have not been adequately addressed (Cox, 2019; Hardeman, Murphy, Karbeah, & Kozhimannil, 2018). The common practice of teaching about cultural competence and social determinants of health has not resulted in action to alleviate inequities or promote racial justice. Even if afforded, awareness or knowing about it is not enough—being able to act and promote change towards achieving health equity is paramount. The purpose of this article is to present recommendations for U.S. nursing leadership to address these factors followed by a brief examination of structural racism in health care and nursing as a major barrier to true social justice and health equity. Then in a call to action for nursing leadership in all areas of nursing practice we present strategies for nursing leadership to implement now—to identify and dismantle structural racism in the U.S. nursing profession—in order to achieve progress toward health equity in all domains of healthcare practice: education, research, business, and delivery.

Recommendations for U.S. Nursing Leadership

These recommendations advocate for change within the structures of nursing at the micro and macro levels of professional interaction, behavioral expectations, system policies, and institutional practices. It is vital that these recommendations do not create a check the right box phenomenon. Honest assessment and understanding are required to examine how health equity can be undermined and inequity perpetuated in each area. Recommendations include:

1. Developing approaches for nurses to use critical self-reflection and lifelong learning to understand structural and institutional racism including other systems of marginalization and oppression. Nurses have been averse to discussing racism because of its ongoing focus on the individual patient; consequently, racism is perceived merely as interpersonal (O'Connor et al., 2019; Thurman, Johnson, & Sumpter, 2019).
2. Incorporating opportunities for difficult racial conversations to occur within the profession with senior, qualified guidance and support (Acosta & Ackerman-Barger, 2017; Waite & Nardi, 2017). Employing empathy is inadequate, and conflict avoidance is frequently a professional expectation in nursing that functions as an obstacle to challenging but needed conversations (Thurman et al., 2019).
3. Strengthening commitment by nursing leadership in academia, business, and clinical practice to require innovative strategies to significantly increase diversity of nurses in these areas (Beard & Julion, 2016; Waite & Nardi, 2017).
4. Evaluating the outcomes of outreach strategies to increase the presence, inclusion, and engagement of racial minorities in all areas and levels of nursing, including policy, research, and organizational decision making.
5. Most importantly, prioritizing the creation and continuation of opportunities that enable liberating pedagogical practices that diametrically reduce racism and other forms of systemic discrimination (DiAngelo, 2010; Zembylas, 2012). These practices can promote action toward achieving racial justice, a key component of health equity.

In the United States, "Racism encompasses a web of actions, beliefs, and economic, political, social, and cultural structures, all of which allocate privilege, resources, and power to benefit the dominant racial group—in the United States, people classified as white—at the expense of all others." Thurman et al., 2019, p. 91. Racism is a major social determinant of population health that is not recognized as such in the nation's Healthy People objectives (Gee, 2016). Achieving health equity necessitates that we appraise and annihilate the social systems that create injustice, for example, racism. Evidence is clear that racism deserves a stronger focus by the U.S. Department of Health and Human Services since it significantly influences education, social and community contexts, health and healthcare, neighborhood environments, and economic stability, its five social determinants of health (Paradies et al., 2015; Waite, Sawyer, & Waite, 2020). For example, health inequities can be deemed an indicator of the health of race relations: "racism makes people sick" (Gee, 2016, p. 3). It is the enduring racism in the United States that needs to be acknowledged, challenged, and dismantled in order to reach the U.S. government's stated goal of health equity for all (Waite & Nardi, 2017).

The term race is used in much of health care as a demographic classification of population outcomes

for social determinants of health. However, this use of the term race as a demographic classification has long been called into question, since race is a social construct. Racism is a significant culprit in perpetuating prejudicial attitudes and in producing and supporting health inequities. Racism is also inherent in the construction of race as a social category; therefore, racism and health inequities should be a focus in education, research, and policy changes, not merely race and health (Thurman et al., 2019). As the social scientist Michael Yudell said in a study of the biologic basis of race, it is not now recognized as a biologic determinant: "If you make clinical predictions based on somebody's race, you're going to be wrong a good chunk of the time" (Yudell, as cited in Gannon, 2016, ¶11; Yudell, Roberts, DeSalle & Tishkoff, 2016).

The way forward, then, is for all nurses, especially nurses in leadership positions in health care, to gain critical self-awareness about racial inequities and to critically examine the social structures, patterns of behaviors, and automatic, implicit biases that support racism in the nursing profession. Antiracism thought recognizes that inequitable power relations are present in society and pervade every domain. Antiracism also necessitates some form of action rather than passivity. Lack of entrée to positional power and spaces where critical decisions are made limits accessibility for nurses from black and brown racial backgrounds. These nurses can only have genuine and enduring equity when all nurses make a reflective, honest, and critical examination of the ways wherein the normal, seemingly impartial mechanisms of most institutions or professional groups advantage the dominant group while visible minorities encounter deep-seated challenges. Nurses must have seats at the table to shape numerous areas, including the institution's hiring and interview process, promotion or tenure, provision of job assignments, patient outcomes, patient satisfaction, evaluation methods, development of position descriptions, and organizational culture (Brathwaite, 2018; Coghill, 2019). Nurse leaders who strive towards racial equity can be exceptionally effective with aiding to set and communicate priorities, foster buy-in throughout the organization, supply vital resources, and extend mechanisms that champion for accountability. Being privy to this space allows for self-analysis and greater transparency to systemic issues that are often obscured. Systems can be exposed that do not reward competence and hard work but lean towards being vulnerable to nepotism and bias (Hiranandani, 2012).

As noted by Gabriella Gutiérrez y Muh and colleagues in DiAngelo (2017), "When the people in power receive a mandate to search out excellence, the first place they look is to people like themselves, and too often that is also where the search ends" (p. 562). Thus, an integral step that action leaders should consider when initiating a hiring process is to identify the veiled features of dominance that are rooted but go nameless in the position description. When varied perspectives are brought to fold, especially knowledge of systems including the structural and historical realities of racism, they must be deconstructed to see harm induced; no new hire is planned in a neutral vein. For instance, if the employment notice states that X hospital or X academic institution promotes diversity, the hiring committee must establish well-defined foci by operationalizing the term. Also, demonstrable confirmation should be implemented to ascertain that the applicant has advanced (instead of merely values) diversity efforts. This can be done by various strategic actions, such as examining who is present and who is not in attendance at critical meetings in terms of diversity representation, and using an integrated viewpoint, which accounts for more than mere opinion or feeling. Hiring decisions must be grounded in how applicants have demonstrated their ability to situate nursing knowledge in a social (cultural, historical) context.

Structural changes that work towards racial equity in the nursing profession require multilayered, multidimensional, and ongoing efforts from numerous key stakeholders because it is a highly complex issue. To date, responses from nursing, health, and educational organizations have emphasized the need for increased diversity for nursing students and faculty, and nurses in practice. Some examples are "The Future of Nursing" (Campaign for Action, 2010); "The Future of Nursing: Leading Change, Advancing Health" (Committee on the RWJF Initiative on the Future of Nursing, 2010); "Enhancing Diversity in the Nursing Workforce Fact Sheet" (American Association of Colleges of Nursing, 2015); and the American Academy of Nursing's 2017–2020 Strategic Plan, which aims to strengthen its commitment to diversity and inclusion (American Academy of Nursing, n.d.). However, this sampling of programs and many others do not directly address entrenched structural racial inequities as a core contributor to health inequities (Oppenheimer, 2001).

Advancing health equity is identified as a policy priority for professional nursing (Cox, 2019), as it is for other healthcare organizations. Structural racism in nursing and healthcare is a key social influencer of health, and its elimination should also align with professional nursing's policy priorities. Nursing leadership is responsible for improving racial equity and assuring health equity practice and outcomes by fostering mindsets and helping managers and teams to address structural racism in their organizations and institutions.

Call to Action: Strategic Actions to Dismantle Structural Racism in Nursing

Structural changes that work towards racial equity in the nursing profession require multilayered, multidimensional, and ongoing efforts from numerous key stakeholders because it is a highly complex issue. If racial equity plays a key role in achieving health equity, then strategic workforce planning, with a focus on intentional engagement and inclusion of underrepresented races, is a social responsibility. Generating a workforce capacity of well-educated nurses of black and brown racial backgrounds starts with intentional, targeted recruitment and retention strategies based on principles of equity and racial justice and continues with clear pathways to leadership positions within the profession. Moreover, leadership from all racial groups, including whites, must be prepared to address structural racism by having critical conversations on topics such as power, privilege, dominance, and institutionalized racism. Professional and experiential development on these topics is requisite in order to carry this work out successfully. Without effective tools, nursing professionals and leadership may have fears related to revealing personal biases or prejudices, or failing to be able to govern contexts where people are located that they oversee, along with lack of skills and knowledge, to recognize or understand difficult discussion dynamics (O'Conner et al., 2019).

Specific recommendations are provided to support the development of a more racially inclusive nursing workforce and nursing leadership pipeline, with built-in supports and outcome evaluation processes structurally in place for sustainability and replication of results.

- Nursing leadership support and commitment is necessary to building a culture of racial equity by creating partnerships to identify and address all levels of racism, from personal to structural. This calls for nursing leadership to learn the history and context of structural racism in the United States and its effects on all persons, especially racialized black and brown individuals.
- Examination of one's organization's hiring and promotion, professional development, team power dynamics, and other critical program, management, funding, and operations decisions for implicit bias. Racial initiatives with sustainability goals, such as the Kellogg Foundation–funded "The Business Case for Racial Equity: A Strategy for Growth" Au: Western States Center (2020) is not in the reference list. Please supply full source info there, or delete this in-text citation. (Turner, 2018), are needed so that resources, including consultants, leadership and training programs, and one-on-one mentoring and coaching, are available to grow racial staff in their full capacity.
- A regular organizational assessment is necessary to determine if written goals are in place and used to discover and dismantle racism in the organization, to determine if racially black and brown individuals have decision-making powers in the organization, and if they are included in the process, its proposals, and its funded initiatives. For example, Western States Center (2020) has an antiracist organizational assessment resource guide included in its "Antiracism Resource Book."
- A Health in All Policies (HiAP; Rudolph, Caplan, Ben-Moshe, & Dillon, 2013) approach to achieving both a racial and a health equity culture. The World Health Organization () advocates the use of HiAP to improve population health, target the determinants of health, and improve sustainability of health nationally and locally. The Centers for Disease Control (2016) also advocates HiAP to achieve National Prevention Strategy and Healthy People 2020 goals.
- Organizations must clarify to staff and administrators how antiracism strategies are applied when designing pathways to promotion, recruitment of racially diverse nurses as faculty and to leadership roles, and in expected professional conduct of all nurses.
- Nursing professional organizations should allocate resources for implementing and expanding sustainable mentorship programs using best practices for racially diverse nursing student bodies, administrators, faculty, and clinical nurses to support goal-directed trajectories.
- Deans, directors, and department chairs are urged to enhance their undergraduate and graduate education curriculum with the inclusion of antiracist frameworks that focus on self-reflection and awareness, and practices that help to provide a meaningful framing of human interaction, support, and guidance through emotionally difficult conversations and situations around race and racism when faced with "troubled knowledge" (Zembylas, 2012). Such frameworks include Critical Race Theory, Decolonizing Theory, Race Equity Culture, or others such as Strategic Empathy or Cultural Humility.
- Identifying and stopping microaggressions in the classroom as they happen improves awareness and acceptance in a whole-campus climate.
- Having a focus on diversity that is clear to students and staff, and promoting racial justice in the school mission statement. This can be done by adding it to the mission statement if it is absent

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or operationalizing the extant social justice mission by using readily available racial equity tools to implement strategies and measure their impact on racial equity.
- Strive for an open and nurturing institutional environment in which diversity and inclusion are endorsed, embraced, and welcomed—all of these goals can support building a more equitable community and can minimize microaggressions (National League for Nursing, 2016).
- In academia, valuing and supporting diverse scholarship and research within the tenure and promotion (T&P) process. This can be done in many ways. One is to link diverse scholarship to the social or racial justice mission of the campus in the school's written policies for tenure and promotion, communicate these expectations to all faculty, and then use those expectations when evaluating T&P portfolios.
- In the academic setting, ensure that all students are provided opportunities to care for diverse populations with respect. In rural or small communities, many types of virtual communication and care strategies, including telehealth, can now be used to ensure no student is left out of a chance to expand their horizons. These clinical practice experiences challenge biases (National League for Nursing, 2016) and advocate for the elimination of structural inequities.
- Senior leadership are encouraged to identify nurse-experts in their organizations with the background and understanding to advocate for the adaptation of these recommendations in all domains of nursing practice. These recommendations should be enacted in global and governmental health, nursing, and communicable disease organizations, including the American Nursing Association, American Colleges of Nursing, International Council of Nursing, World Health Organization, the CDC, and the American Academy of Nursing.
- Financial resources specifically used to promote equity in nursing education and practice, especially for attracting and supporting racially diverse populations, are necessary to develop and sustain initiatives over time, until they are ingrained expectations for us all. This strategy would provide the added benefit of shaping public policy to promote equity by overcoming financial barriers to change (Ellis, 2019). These actions all build the foundation for racial justice and health equity in nursing education and practice.

Conclusions

Decision makers have authority and structural power to set the mechanisms and strategies for shaping meaning (invisible power), setting the agenda (hidden power), and observable decision making (visible power). By the promotion of racial justice, problems and issues linked with racism will no longer be repressed when decisions are made, and it will not be prevented from entering the minds and consciousness of individuals involved (invisible power). As such, advocacy for patients related to health disparities shape meaning by linking racism as a key mechanism to health outcomes (National Academy of Sciences, 2017). Moreover, promoting racial equity influences who attains access to the decision-making table and what appears on the agenda (hidden power). Thus, to address health disparities, deracinating, or eradicating, root causes of health inequity should be a central agenda item. The perceptible and definable facets of power include the official policies, structures, and procedures of decision making (visible power; VeneKlasen & Miller, 2002).

To effect positive long-standing change regarding racial equity work in the nursing profession in the United States, a path including an awareness of racial inequity is required. Understanding why racial inequity exists must be acknowledged and an authentic commitment for transforming towards racial equity is warranted (Desmond & Emirbayer, 2012). These steps do not compel a majority to prevail; on the contrary an incensed, determined sector eager to ignite brushfires in people's minds can alter our current trajectory. Remember that during the U.S. Civil Rights Movement, most people regardless of race were bystanders while a core faction of staunch activists thrusted the country forward. This 80/20 phenomenon (80% of social change is brought about by 20% of the population) can also become a reality for nurses determined to promote racial equity at all levels of the profession, including those in the pipeline (Desmond & Emirbayer, 2012). We must desire genuinely for such a change to become reality.

Even as ample evidence identifies the need for, and benefits of, increased racial diversity and inclusion within nursing and health care, our history reflects the ongoing challenges of achieving racial equity within the United States and globally. Leaders of organizations responsible for defining and responding to the public dialogue about racial inequity remain reluctant to commit to intentional strategies to combat structural racism as a root contributor of health disparities. The ability to make needed changes is significantly hindered by long-standing societal attitudes and structural barriers. Structural racism presents hidden but robust barriers to equity in curricula and pedagogy, recruitment, hiring, and mentorship policies and practices in nursing. Those inequities are enacted in explicit and, most

insidiously, implicit mechanisms that must be named and addressed within our organizations at the micro (individual) and macro (policies and practices) levels. Barriers to a more diverse nursing profession representative of its patient population must be intentionally identified, critically examined, dismantled, and removed from the profession.

This call to action provides guidelines for nursing education, business, clinical practice, and organizational leadership to work together now towards mitigating racial inequities, a key social determinant of health, through the recognition and transformation of structural racism within the profession. An intentional focus on dismantling structural racism is an essential approach in advancing health equity and wellness and improving population health and patient-centered care. Nursing leaders in all domains of practice are called to engage strategically in the change process towards realizing health equity, more productivity, and better outcomes for health and healthcare delivery for all. A foundation for intentional change requires making a commitment to enhancing racial literacy and learning and implementing the process for dialogue about difficult racial topics, expanding where these conversations can take place, and inclusion of racially diverse populations in the decision-making process at all levels of healthcare and nursing practice. The targeted action steps presented in this call to action challenge U.S. nursing leadership to fuel the change needed to realize the goal of health equity at all levels of direct and systems nursing practice and education, at the bedside, and in the boardrooms. Racism in health care and nursing persists as a key global health problem, directly addressed by many countries and healthcare organizations, including the United Nations (2017); global health organizations (Global Health Council, 2020), and national professional nurses organizations such as the Registered Nurses Organization of Ontario (2002). These recommendations can be used as points of discussion and further exploration, culturally adapted for use globally to produce the transformational change needed to realize universal social justice, equity, and human rights for all people.

Clinical Resources

- Anti-Defamation League. Suggested resources on race and racism. https://chicago.adl.org/race-and-racism-resources/
- American Nurses Association. Minority Fellowship Program. https://www.nursingworld.org/practice-policy/workforce/minority-fellowship-program/
- National Juvenile Justice Network. Antiracist organizational assessments. https://www.njjn.org/uploads/Anti-Racism_Organizational_Assessments_1.pdf
- Racial Equity Tools. Organizational change processes. https://www.racialequitytools.org/act/strategies/organizational-change-processes
- United Nations. International decade for people of African descent: 2015–2024. https://www.un.org/en/observances/decade-people-african-descent
- World Health Organization. Health in all policies: Framework for country action. https://www.who.int/healthpromotion/frameworkforcountryaction/en/

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