

Transforming Nursing Education

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Transforming Nursing Education

*The Culturally Inclusive
Environment*

SUSAN DANDRIDGE BOSHER, PhD, MA

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Editors

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This book is dedicated to all nursing students and faculty who have felt marginalized or devalued in the nursing education system because of their race, culture, ethnicity, or language.

May this work help create a system where they and those who follow are in the center; their contribution to the profession is vital so that health and healing can be an equal possibility for all.

This book is also dedicated to the many nurse educators and leaders from countries around the world who have worked tirelessly to create a culturally inclusive environment in their institutions.

Contents

Contributors xv

Foreword by Dr. Gloria Smith xxi

Preface xxvii

Acknowledgments xxxv

PART I: UNDERSTANDING INCLUSIVITY IN THE CURRENT NURSING CULTURE 1

- 1 Inclusivity: Attending to Who Is in the Center 3**
Margaret Dexheimer Pharris
 - Waking Up to the Pervasive Existence of Racism 9
 - Sankofa: Looking Back to Move Forward 11
 - Color-Blind Racism 15
 - Lessons From the Educational Trenches 17
 - Turning the Lens Around: System Change 20
 - Recommendations for Nurse Educators 21
 - Recommendations for Nursing Education Administrators 22
 - Questions for Dialogue 23

- 2 The Power of Nurse Educators: Welcoming and
Unwelcoming Behaviors 27**
Susan P. Kossman
 - Minority Student Persistence in Nursing Programs 30
 - The Research Study 35
 - Results: The Nursing Education Experience 37
 - Implications and Recommendations for Nurse Educators 53
 - Conclusion 55
 - Questions for Dialogue 56

- 3 Addressing Race and Culture in Nurse Education 61**
Stuart Nairn
- Race and Language 62
 Multiculturalism and Antiracism in Nursing 68
 Essentialising Culture, Social Structure,
 and the Problem of Racism 70
 Recommendations for Challenging Racism 73
 Questions for Dialogue 75
- 4 Minority Nurses: A Story of Resilience and Perseverance 79**
Donna Hill-Ciil
- Becoming a Nurse: Lessons Learned 79
 Becoming a Nurse Educator: Lessons Learned 85
 Keys to Educating the Minority Student:
 The Theory of Multiple Intelligences 94
 The Importance of Clinical Success 97
 Recommendations for Success! 97
 Questions for Dialogue 98

PART II: PEDAGOGICAL INNOVATIONS IN NURSING EDUCATION 101

- 5 Coming Home to Nursing Education for a Hmong
 Student, Hmong Nurse, and Hmong Nurse Educator 103**
Avonne Yang
- Experience of Being a Hmong Nursing Student 104
 Transforming the Postclinical Conference 106
 Role of Minority Faculty for Students of Color 108
 Addressing Disparities in the Recruitment
 and Retention of Minority Faculty 110
 Multiple-Choice Nursing Exams:
 A Major Impediment to Success 113
 Nursing Theory Invites Me Back Home 114
 HEC Helps Frame the Experience 115
 HEC as Praxis: Creating a Culturally Inclusive
 Environment in Nursing Education 121
 Narrative Pedagogy 123
 Theory-Guided Practice: The Key to Coming Home 124
 Recommendations for Nurse Educators 124
 Recommendations for Nursing Education Administrators 125

Questions for Dialogue 126

6 **Journeying Beyond Traditional Lecture:
Using Stories to Create Context for Critical Thinking 129**

Susan Gross Forneris and Susan Ellen Campbell

Background: Perspectives on Thinking 131
 Transforming the Lecture: A Journey of Case-Based Teaching 136
 Assessing Student Thinking Through Stories 139
 Recommendations From the Journey of
 Case-Based Teaching: Road Map Corrections 144
 Conclusion 146
 Questions for Dialogue 146

7 **INDE Project: Developing a Cultural Curriculum
Within Social and Environmental Contexts 155**

Vicki P. Hines-Martin and Alona H. Pack

Introduction 156
 Cultural Diversity in Health Care 157
 University of Louisville School of Nursing:
 The Setting of the Project 157
 Description of the Initiative for Nursing Diversity
 Excellence (INDE) Project 159
 Outcomes of the INDE Project 169
 Lessons Learned From INDE 172
 Recommendations for Nurse Educators and Administrators 175
 Questions for Dialogue 176

8 **Teaching the Fluid Process of Cultural Competence at
the Graduate Level: A Constructionist Approach 179**

Barbara Jones Warren

Background for Cultural Competence in Nursing 181
 Rationale for Development of Course in Cultural Competence 182
 Theoretical Perspectives for the
 Pedagogy of Cultural Competence 184
 Moving from Cognitivism to Constructivism 186
 Development of Cultural Course Curriculum 187
 Teaching and Learning Exemplars From the Course 191
 Recommendations for Nurse Educators and Administrators 201
 Summary and Reflective Conclusions 202
 Questions for Dialogue 203

- 9** Pathways to Leadership: Developing a Culturally Competent Leadership Curriculum for American Indian Nurses 207
Lee Anne Nichols and Martha Baker
- Background 207
 - Purpose 208
 - American Indians 208
 - Mainstream Nurse Leadership 210
 - The Indian Way of Knowing 212
 - Pathways to Leadership 214
 - Teaching the Curriculum 216
 - Implementation of the Curriculum:
 - The Gathering of Nurse Leaders in June 2003 222
 - Conclusion: Giving Back 224
 - Recommendations for Nurse Educators and Administrators 224
 - Questions for Dialogue 225

PART III: ASSESSMENT PRACTICES: LEVELING THE PLAYING FIELD 229

- 10** The Role of Intentional Caring in Ameliorating Incapacitating Test Anxiety 231
Joyce Veda Abel
- Literature Review 233
 - The Students' Test Anxiety Management Program (STAMP) 240
 - Pilot Project: Program Participants 242
 - Evaluation of Pilot Project: Quantitative Data 247
 - Qualitative Data: Participant Experiences 249
 - Conclusion 251
 - Recommendations 253
 - Questions for Dialogue 255
- 11** Removing Language as a Barrier to Success on Multiple-Choice Nursing Exams 259
Susan Dandridge Boshier
- Linguistic Bias in Multiple-Choice Tests 263
 - Linguistic Modification 267
 - The Effects of Linguistic Modification on ESL Students' Comprehension of Nursing Course Test Items 269

Faculty Concerns About Linguistic Modification and the NCLEX	273
Implications for the NCLEX	274
Implications for Faculty Development	275
Conclusion	277
Recommendations for Nurse Educators and Administrators	277
Questions for Dialogue	280

**12 Innovation in Language Proficiency Assessment:
The Canadian English Language Benchmark
Assessment for Nurses (CELBAN) 285**

Lucy Epp and Catherine Lewis

Background	286
Project Description	287
CELBAN Administration	300
Recommendations for Nurse Educators	303
Conclusion	304
Questions for Dialogue	306

PART IV: PROGRAMS THAT MODEL STRUCTURAL CHANGE 311

**13 Latino Nursing Career Opportunity Program: A Project
Designed to Increase the Number of Latino Nurses 313**

Carmen Ramirez

The Nursing Shortage and Barriers for Latinos	315
Program Description: The Latino Nursing Career Opportunity Program	317
Collaboration With Community Partners	321
Program Participant Data	322
Conclusion	323
Recommendations for Nursing Education Administrators	324
Recommendations for Nurse Educators	325
Questions for Dialogue	326

14 Barriers to Success: American Indian Students in Nursing 329

Judy Jacoby

A Mentorship Model for Native American Nursing Students	331
History of the RAIN Program	332

- Description of the RAIN Program 333
 Barriers to Success for American Indian Students 335
 Native American Cultural Traditions: Storytelling,
 Narrative Epistemology, and Humor 338
 Completing the Educational Journey 340
 Recommendations for Nurse Educators 340
 Questions for Dialogue 341
- 15 It Takes a Village to Raise a Nurse 345**
Lorrie R. Davis-Dick
- Receiving the Seed of Mentorship 346
 The Marriage of Mentorship and Academia 347
 Addressing the Diversity Gap in Nursing:
 Mentoring and Evidence-Based Practice 351
 Lack of Diversity in the Nursing Education Pipeline 352
 Description of ENSC Mentoring Program 353
 Recommendations for Mentoring African
 American and Other Minority Nursing
 Students From a Holistic Perspective 358
 A Dream of Diversity in Nursing:
 Waking Up to Mentorship 359
 Questions for Dialogue 360
- 16 Facilitating Success for ESL Nursing Students in
 the Clinical Setting: Models of Learning Support 363**
Virginia Hussin
- Background 364
 The Issues 367
 The Support Initiative 368
 Recommendations From the Initiative 375
 After the Communication Workshops 375
 Future Research Areas 377
 Recommendations for Nurse Educators 378
 Questions for Dialogue 379
- 17 Workforce Improvement With International Nurses (WIN):
 Immigrant Nurses WIN Road to Licensure 387**
William W. Frank, Judith A. Andersen, and Katrina Norvell
- Program Background and Purpose 388
 Program Structure and Development 391

The Workforce Investment Act (WIA) Connection	393
The English Language Components of WIN	395
Requirements and Deadlines	401
The WIN Nursing Transition Program	404
WIN—A State-Approved Reentry Program	409
Winning Results	412
The Future of WIN	414
Recommendations for Nurse Administrators	417
Questions for Dialogue	418

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Foreword

I have often thought that no other career during my lifetime could have offered the promise of respect, fulfillment, acceptance, and opportunity for me as an individual—race, gender, and religion notwithstanding—as has nursing. Like so many other minority persons in pursuit of the American dream, of a good life, the sentiments espoused in the words of philosophical statements issued on behalf of the profession by the college of nursing I attended struck a chord. After initial contact with the school of nursing, I was convinced that I had found a niche, a place that would foster my personal development and ambitions and from which I could satisfy my drive to help my own family and community. Later, inspiration from my basic nursing program broadened my vision to include contributing to societal improvements. After 53 years in the field, I can look back and say that I was correct on all counts—I consider myself one of the “lucky ones.” All of the stars had come into alignment: personal drive; strong family support; solid basic education; strong basic nursing program; committed senior leadership in the school; strong faculty advocates and mentors; financial support; community support; high expectations from self, family, community, and faculty; and supplemental enrichment experiences.

Over the years, there have been many like me: “lucky ones.” But far too many have not been lucky; they have not fulfilled their dreams to become nurses. This nation, indeed this world, can ill afford this waste of human capital when there is an urgent and dire need for nurses worldwide. This book is about the challenges of increasing the minority presence in nursing programs, overcoming barriers, and utilizing the vast reservoir of available knowledge and experience to convert luck into anticipated outcomes for minority and culturally different students. This book is about capitalizing on diversity and difference, on maximizing human potential. It is about increasing understanding about “the others” who look different and inspiring and guiding them to fulfill their aspirations to nurture, heal, and assist people to cope with threats to health.

Transforming Nursing Education: The Culturally Inclusive Environment is timely; it is a response to the urgent need and demand for increased graduation of well-prepared nurses to practice, manage, and lead in nursing and help to sustain and improve the quality of health care delivery. Trend data and studies describe a shortage of qualified nurses and project acute shortages into the near and distant future. Many current studies recommend, in fact urge, aggressive approaches for attracting minorities into nursing as a significant means for meeting supply requirements. Support for increasing minority enrollments in schools of nursing is not new; there has been support provided by governments and private philanthropy for such initiatives for decades. The support has been more significant in some periods than others. Funding agencies have shifted priorities as other pressing demands arise and compete for dwindling resources. By now, however, we in nursing should be experts in minority recruitment, retention, and graduation; there has been more than sufficient investment by government and private philanthropy to develop and test models for minority recruitment and retention. Various incentives have been offered to encourage programs to increase minority enrollments. Research outcomes and lessons learned have been disseminated through workshops, conferences, publications, and networking under the rubric of one label after another: minority recruitment, cultural inclusion, cultural pluralism, multicultural education, and transcultural nursing, to include a few. Nursing has pioneered in the areas of minority recruitment and retention, multicultural education, and transcultural nursing; thus, it is puzzling that we still have urgent need for this book. Yet, we do! What happens to all of that information developed through years of experience, reading, debate, demonstration, and discussion? What limits the transformation from knowledge to structural change?

The authors in this book attempt to overcome the beast that poses the major barrier by giving it its proper name: *racism*. No single volume could ever be sufficient to explore the topic of racism; however, the opening section of this book succeeds in providing definition, context, and stimulation for further exploration in the matter of race and racism and its impact on nursing education. I learned a very valuable lesson in attending the 1993 *UN World Conference Against Racism, Discrimination and Xenophobia (WCAR)* held in Durban, South Africa. People from across the world attended—people of all races, cultures, religions, sexual identities, and physical and mental abilities—many of whom sought to divert or broaden the focus from simply race and racism in order to direct attention to the pain associated with their particular source of

disaffection. *Science* has proven that race has no biological reality; yet, for people who are victims of racism, prejudice, and discrimination, the social reality of being defined as “the other” is deeply experienced nevertheless. The pain is very real; the suffering is the same; and the outcomes result in inequities.

This book is targeted to nursing faculty, nursing education administrators, and graduate nursing students. The material is organized into four major sections so that one is guided from essential background information that helps set a context to case stories to methods and techniques and finally to programs that model structural change. This book contains insights, perspectives, and successful approaches drawn from the experiences of nurses from different races, cultures, and ethnicities. The case stories are poignant and powerful in their careful telling; the aspiration, bewilderment, disappointment, and finally joy and pride are revealed as the writers describe their personal journeys. The book offers an opportunity to examine the impact of discrimination on minority nursing students. It will teach some and reinforce for others that discrimination causes pain and humiliation. Some of the individuals who have suffered discrimination share how they have used their knowledge and experiences to develop approaches to eliminate or minimize similar experiences for other students who follow. Each chapter is followed by a set of questions to guide and provoke discussion that can lead to further understanding and growth.

I consider myself an experienced traveler on the journey of minority inclusion; yet, the book has raised some questions that I want to answer for myself and some that I plan to explore further with others. I have never accepted the idea that a nurse or any other health care provider can adequately and safely care for me if that person has to objectify me in order to carry out his or her responsibilities, that is, has to see me as an object rather than as a person. How can such an individual live up to the philosophy and ethics of nursing? What are the mechanisms that allow alienation yet permit “caring”? Nursing is caring *about* and caring *for* people. Does one wrap one’s self in techniques and automatic functions? Are there separate codes for caring if the recipient is “the other”? Similarly, are there separate codes for teaching if the student is “the other”? I admit that I have been taught math and chemistry adequately by persons who have discriminated against me and have even been served food by persons who were admitted racists. None of these people had professed to be committed to a profession that pledged to respect and *care* for me. Because of these questions, I found myself wishing for more case

stories from nonminority peers to give us more perspective and insights of a journey in coping with and managing White prejudice and bias toward “the other.” In addition, it would have been equally instructive had the minority nurse case stories been reflective of their own capacity to discriminate against “the other,” as well as how they have supported and been supported by “the others” who are different from themselves. Perhaps future collections of essays could further explore these manifestations of discriminatory attitudes and practices in nursing.

This book takes a step forward in uncovering the mystery that shrouds some of the ineffectiveness in securing and maintaining adequate minority enrollments. The point is made that more effective minority enrollment cannot be achieved in a vacuum; it requires an environment that is supportive and welcoming for all students. Properties of a welcoming environment are identified and underscored in *Transforming Nursing Education: The Culturally Inclusive Environment*. Faculty must believe their role is to teach, encourage, and assist all admitted students to achieve success and understand that teaching is more than facilitating students who are able to navigate solo. An environment for learning should be created in which assistance for student progression, such as tutoring, is customized and made available to those who require it; there should be little need to label students. It takes a great deal of courage and commitment by individuals and collective faculty to examine and be critical of a culture in which they are heavily invested.

Transformed nursing education is needed for a lot of reasons; creating a culturally inclusive environment is just one of them. To date, the profession has resisted by making small and often cosmetic changes, creating our own jigsaw puzzle. Transforming nursing education to a culturally inclusive enterprise requires determination and shared leadership from the collective. Administrators, faculty members, and staff alike must have a shared vision and be committed to the expressed goal of inclusion. There must be willingness to learn more about people who are different from oneself and to face one’s own prejudices or antipathies. Discussions on race, racism, xenophobia, and discrimination are likely to be thorny. They should be supported by knowledge drawn from research and scholarship as well as from the lived experience. The school of nursing must be engaged in constant struggle to avoid sanctions against members who express divergent views and unpopular opinions. Vocabulary becomes critical in engaging one another because words can become loaded in some circumstances. Drawing on published

knowledge, facts, theories, and analysis may facilitate achieving the more objective environment that is essential for discussion. *Transforming Nursing Education: The Culturally Inclusive Environment* could be a valuable tool for schools that are embarking on a course to create an inclusive environment or are seeking to improve on what has already begun. The book provides data, analytical frameworks, definitions, and lines of reasoning that can be used as points of common reference. The case stories that have been included are illuminating; their use will permit discussions of real experiences that can serve as surrogates until group members feel secure enough to relate and share their own stories. Emotions are attached to beliefs; shedding long-held beliefs takes time and is often difficult. Discussions clearly will benefit from research and scholarship; however, positive change also requires self-disclosure of beliefs, insights, fears, curiosity, opinions, and ignorance about race, culture, and difference.

This book provides rationale and support for undertaking the journey to achieve true transformation in nursing education. Along the way, readers will learn a great deal about themselves as well as learn more about how to create a dynamic, inclusive, and challenging learning environment that remains true to the purpose of graduating highly qualified nurses to meet the needs of a diverse multiracial, multicultural, multilingual society.

Gloria R. Smith, RN, MPH, PhD, FAAN, FRCN
Battle Creek, MI

Preface

Nursing texts that address cultural diversity have focused on studying and understanding the values, beliefs, and practices of clients from different cultures in an effort to create a more culturally competent workforce. It is also well documented that a diverse nursing profession is the most effective way to meet the needs of an increasingly diverse population; there has also been an obvious increase in minority and immigrant students in nursing programs. However, there has been little emphasis on implementing structural changes in nursing education to create a culturally inclusive environment that is welcoming and supportive of all students and faculty. Compared to the nursing practice workforce, the nursing education workforce is even less representative of the general population and has often been perceived by minority and immigrant students as nonsupportive and at times hostile. Our research and the work of many others point to a pressing need to diversify nursing education as well as engage in a process that dismantles discriminatory practices and reconfigures nursing education and health care delivery systems that currently disproportionately represent a privileged White¹ norm.

Rather than focus on different cultures, as if they were static and monolithic, this text turns the lens around to look at the culture of nursing education itself from the perspectives and experiences of minority and immigrant students and faculty. Through the stories that are told and the programs and initiatives that are described, the various chapters in this anthology address the urgent need for nurse educators, nurse administrators, and graduate students in nursing education to reconceptualize and redesign their pedagogical and programmatic approaches to more effectively recruit, engage, educate, and graduate nurses from underrepresented groups in the profession. This book focuses intentionally on the experiences of minority, indigenous, and immigrant students in predominantly White countries and the structural changes needed to facilitate their success. We believe that conversations about racism are

the most difficult to enter into and that often, to avoid the discomfort of those conversations, the definition of diversity is broadened without examining the reason why. Because that discomfort is necessary for transformation to take place at both the personal and institutional levels, we chose to narrow our focus so that we could delve deeply into identifying and addressing barriers faced by minority, indigenous, and immigrant students. We hope that subsequent anthologies will broaden the discussion of diversity and, thus, of inclusivity.

Increased diversity in the nursing workforce will help reduce health care disparities and provide higher quality care for the increasingly diverse populations in countries such as the United States, the United Kingdom, Canada, Australia, and New Zealand. In these countries the faculty and administration of schools of nursing are overwhelmingly White because of the history of colonization in or by these countries and the subsequent concentration of power and economic advantage in the White population. In addition to ethnic minority and indigenous groups that have been traditionally underrepresented in nursing, rapidly increasing migration from war-torn and resource-poor countries to resource-rich countries has intensified the urgent need to reshape nursing education to better meet the needs of immigrant nursing students. With the majority of nurses close to retirement age and considering the impending nursing shortage, real and meaningful systemic change seems more within our grasp than ever before. It is our hope that this book will begin a much needed dialogue about systemic transformation and the shape it might take.

This book is not meant to be a cookbook approach to structural change but rather a stimulus for thought-provoking dialogue that will lead to concrete actions from an antiracist perspective, actions that are specific to the reality of nursing education in different cultural contexts. Ideally, the stories in each chapter will allow readers to appreciate the personal dimension of students' aspirations and struggles. The questions at the end of each chapter are designed to spark dialogue and insight into ways faculty, administrators, and graduate nursing students can look within themselves and come to terms with their own racialized experiences and perspectives to create the structural changes necessary for all students to be successful. We recognize that these are challenging questions and that the issues they raise are not conclusive. We trust that readers will engage in respectful dialogue with one another, move beyond assumptions and stereotypes, and be transformed in the process. Change happens within the context of carefully listening to one another's

stories and engaging in open and safe dialogue; it is our desire that this anthology will contribute in meaningful ways to that process.

Part I, “Understanding Inclusivity in the Current Nursing Culture,” addresses the issue of racism in nursing education from both personal and institutional perspectives. In “Inclusivity: Attending to Who Is in the Center,” Margaret Dexheimer Pharris defines institutionalized, personally mediated, internalized, and colorblind racism and explicates how they permeate nursing education and practice and thus place nurses at odds with core tenets of nursing practice—such as caring, health, justice, and equal treatment. She explores the historical roots of racism and provides strategies for nurse educators to help all students identify and address racism within themselves and in practice settings. She proposes that when Whiteness is taken out of the center of the nursing education environment, everyone excels to a greater degree and becomes more vibrant and healthy. In “The Power of Nurse Educators: Welcoming and Unwelcoming Behaviors,” Susan P. Kossman gives concrete examples from her research with students and faculty of how racism manifests itself in unwelcoming behaviors; she also offers examples of welcoming behaviors that could mitigate the effects of or possibly dismantle racism in nursing-education culture. Her concept map, located in the middle of the chapter, provides a model for creating an inclusive nursing-education environment. Stuart Nairn’s chapter, “Addressing Race and Culture in Nurse Education,” delineates how race is constructed and reproduced through discursive practices in society as well as in nursing. He challenges nurse educators to expand multicultural or transcultural approaches in nursing by addressing power relations and embracing an antiracism approach. In “Minority Nurses: A Story of Resilience and Perseverance,” Donna Hill-Cill offers stories and lessons learned from nursing students whose lives have been affected by racism in nursing education and practice. Through her own practice as a nurse educator she models ways in which faculty can reach out and mentor students from diverse cultural backgrounds.

Part II, “Pedagogical Innovations in Nursing Education,” addresses ways in which faculty and administrators can effect change in curriculum and pedagogy, as well as in the structural and support systems that create the broader context of nursing education. In “Coming Home to Nursing Education for a Hmong Student, Hmong Nurse, and Hmong Nurse Educator,” Avonne Yang describes the essential ways in which minority faculty contribute to the successful outcomes of minority students in nursing programs. She raises issues of concern about unequal

demands and added stress placed on minority faculty and describes actions that administrators can take to justly compensate minority faculty. Yang also describes how narrative pedagogy and the theory of health as expanding consciousness allowed her to reconcile differences between her Hmong culture and the culture of nursing. Susan Gross Forneris and Susan Ellen Campbell, in their chapter “Journeying Beyond Traditional Lecture: Using Stories to Create Context for Critical Thinking,” discuss the role of stories in a contextual reflective case-based teaching approach to help students reflect critically on the biased assumptions they bring to clinical experiences. Similar to Yang, Forneris and Campbell use narrative pedagogy as well as guided reflection to help students learn to unpack their values and beliefs and take the perspective of “the other.” In “INDE Project: Developing a Cultural Curriculum Within Social and Environmental Contexts,” Vicki P. Hines-Martin and Alona H. Pack describe a 3-year federally funded project—Initiative for Nursing Diversity Excellence (INDE)—to increase recruitment, retention, and graduation of African American students in nursing. Various INDE initiatives include: academic and peer-mentoring support; stipends; early exposure to and academic preparation for nursing at the secondary level; and cultural awareness, sensitivity, and competence training for all nursing students and faculty with regard to client care and for faculty with regard to teaching and supporting minority students through the educational process. Barbara Jones Warren, in “Teaching the Fluid Process of Cultural Competence at the Graduate Level: A Constructionist Approach,” describes materials and techniques that she developed for a graduate-level course on cultural competence. This course uses transformative learning theory and a constructionist approach to cultural competence, which emphasizes the dynamic and fluid nature of culture. Warren also describes her use of literature about health care challenges as a means of encouraging transformative, reflective learning. Lee Anne Nichols and Martha Baker, in their chapter “Pathways to Leadership: Developing a Culturally Competent Leadership Curriculum for American Indian Nurses,” describe a curriculum—Pathways to Leadership—that was developed to educate and inspire American Indian nurses to assume leadership roles in tribal health programs. The curriculum consists of nine modules, six of which focus on general nurse leadership and three on leadership and nursing in the American Indian community. Their discussion of leadership within the American Indian community, in particular the focus on “who one is” rather than “what one does,” counters traditional notions of what constitutes effective leadership.

Part III, “Assessment Practices: Leveling the Playing Field,” describes initiatives that challenge traditional ways of assessing students by recognizing that structural change must also address bias in the ways in which students are assessed and their progression in nursing programs determined. In “The Role of Intentional Caring in Ameliorating Incapacitating Test Anxiety,” Joyce Veda Abel describes an innovative program in test anxiety management (STAMP) for nursing students with test anxiety who are in danger of failing. The program consists of four components: intentional caring, cognitive restructuring, calming techniques, and test-taking skills. Students who have participated in the program have experienced significant reductions in test anxiety and have gone on to graduate from their programs and pass the nursing licensure exam. Susan Dandridge Boshier, in her chapter “Removing Language as a Barrier to Success on Multiple-Choice Nursing Exams,” challenges nursing faculty to take a critical look at their multiple-choice tests, not only for lack of clarity but also for unnecessary linguistic complexity, both of which can hinder students’ ability to demonstrate their nursing knowledge. Principles of good test-item construction are discussed as well as principles of linguistic modification, a process by which the reading load of test items is reduced without compromising the questions’ content and integrity. In the chapter, “Innovation in Language Proficiency Assessment: The Canadian English Language Benchmark Assessment for Nurses (CELBAN),” Lucy Epp and Catherine Lewis describe the development of an occupation-specific English-language assessment for immigrant nurses seeking to reenter the nursing field in Canada. The test development process involved stakeholders and a wide range of expert consultants and included an analysis of target language use, pilot testing with the target population, and rigorous measures of reliability and validity. Such a test offers a more valid measure of immigrant nurses’ language proficiency in nursing contexts than the general academic and occupational English-language proficiency tests that are traditionally used.

Part IV, “Programs That Model Structural Change,” describes various programs that model ways in which to effect structural change in nursing education. In “Latino Nursing Career Opportunity Program: A Project Designed to Increase the Number of Latino Nurses,” Carmen Ramirez describes a program at the Catholic University of America (CUA) to increase the number of Latino nurses, the most underrepresented group among registered nurses in the United States. The program consists of a pre-entry nursing program for students in grades 7–12,

including a summer camp and other activities during the academic year to increase the visibility of nursing as a career; a comprehensive retention program for Latino nursing students at CUA; and a faculty development program to enhance skills in mentoring, advising, and teaching Latino and other minority students. Judy Jacoby, in her chapter “Barriers to Success: American Indian Students in Nursing,” describes the Recruitment/Retention of American Indians Into Nursing (RAIN) program at the University of North Dakota, the barriers to success that Native Americans have traditionally faced in their education, and the ways in which the RAIN program honors and incorporates Native American cultural traditions to facilitate the success of Native American nursing students. In “It Takes a Village to Raise a Nurse,” Lorrie R. Davis-Dick describes a mentoring program—Empowering Nursing Students in the Carolinas (ENSC)—designed to decrease the attrition rate of minority nursing students in baccalaureate-degree nursing programs. Her personal story illuminates the important role that mentors play in the educational journey of minority students. Virginia Hussin, in her chapter “Facilitating Success for ESL Nursing Students in the Clinical Setting: Models of Learning Support,” describes five levels of a learning support program that were implemented at the University of South Australia to facilitate the success of English as a Second Language (ESL) students in their clinical placements: professional development of staff; workshops for students prior to and following their placements; individual consultations with students; on-site supervision of “at risk” students; and provision of Web-based learning support materials. In “Workforce Improvement With International Nurses (WIN): Immigrant Nurses WIN Road to Licensure,” William W. Frank, Judith A. Andersen, and Katrina Norvell describe a program in Oregon to identify and prepare work-ready immigrant nurses to reenter the workforce. The program—Workforce Improvement With International Nurses (WIN)—includes: assistance with the credential review and licensure application process, courses in advanced communication and medical terminology, a Nursing Transition Program (NTP) focusing on developing critical thinking and evidence-based practice, and supervised clinical and hospital internships.

Throughout the past 3 years this book has broadened its focus from educating culturally and linguistically diverse nursing students to the culture of nursing education and its exclusionary practices. A primary influence on this evolution has been the result of a community-based collaborative action research project in North Minneapolis, a multiethnic inner-city neighborhood. This project, which was funded by the College

of St. Catherine, identified racism as the major barrier to health for people of color. These findings served as a catalyst for us to expand the focus of the anthology to look within the culture of nursing education for parallel issues that affect the success of minority, indigenous, and immigrant students. Creating this book has been a unique and exciting journey for us, one that has been deeply inspirational not only for the way in which the book evolved over time to focus on broader truths that needed to be told but also for the truths that were revealed to us by the contributing authors. In addition, while many of the authors are published scholars in their field, others are emerging scholars who are just now realizing their power and potential to effect change within nursing education. It has been a privilege to work with all of them, to encourage their personal and professional voices to emerge, and to bear witness to the many layers of stories they have to share.

Susan Dandridge Boshier and Margaret Dexheimer Pharris
St. Paul, Minnesota, U.S.A.

*March 21, 2008 (On the occasion of Nauroz—Persian
New Year—symbolizing the coming of Spring and new beginnings!)*

NOTE

1. White is capitalized throughout this book not to denote “race,” which has no biological basis, but rather to call readers’ attention to Whiteness as a sociological construct that has marginalized people of color and created exclusionary practices in educational institutions and professions. Because Whiteness is assumed to be the norm, it is too often not named. It is that unexamined assumption of White-as-the-norm that we hope to challenge by naming and capitalizing White.

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We are grateful to Springer Publishing for its commitment to this book and particularly to our Acquisitions Editor, Allan Graubard. His guidance helped us realize the dialogic possibilities of the text for systemic transformation. His enthusiasm for this project and his support encouraged us in our work. We are also grateful to Katherine Tengco, Assistant Editor at Springer Publishing, for her prompt and clear technical guidance and to Julia Rosen from Apex CoVantage for her expertise in the production phase of the book.

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Understanding
Inclusivity in the
Current Nursing Culture

PART
I

1

Inclusivity: Attending to Who Is in the Center

MARGARET DEXHEIMER PHARRIS

It had been a full day of classes, and I was eager to leave my office and head for home. As I straightened from packing my computer bag, I noticed one of the junior students hesitantly looking in from the side of my open door. “Angelleen” was a student who had stood out among an impressive cohort of peers in those first few weeks of the semester for her insightful comments and critical analysis of course content, to say nothing of the confident manner in which she spoke up in the auditorium. I welcomed her into my office. As she settled into a stuffed armchair, I took note of the slight flushing of her dark-brown cheeks. Angelleen hesitated briefly and then said, “Dr. Pharris, with all due respect, the content in our class is really, REALLY important, but I don’t want to hear it from a WHITE professor!” I was well aware that there were several layers to Angelleen’s discomfort and concern.

That week in class, the students were assigned to go to the library and watch the video series *Race: The Power of an Illusion* (Adelman, 2003), which dispels the myth of a biological basis for “race,” describes how the concept of “race” was invented and used for the economic advancement of a select group of people, and details how the institutionalization of racism into U.S. culture brought about significant economic and social disparities. The video series helps students understand that “race” is a sociological construct and that racism is a significant health threat for

people of color and, thus, of central concern to nursing. The students were also assigned to read “White Privilege: Unpacking the Invisible Knapsack” (McIntosh, 1990), to understand the myriad unearned social and economic advantages that White people enjoy every day, and “Levels of Racism: A Theoretical Framework and a Gardener’s Tale” (Jones, 2000). Jones explains that “race” is not a biological construct, and she presents a framework for understanding racism at three levels: “institutionalized, personally mediated, and internalized” (p. 1212). Institutionalized racism, also termed *systemic* racism, is defined by Jones 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. (p. 1212)

Institutionalized racism is the reason for “race” being highly correlated with poverty, stress, and environmental exposures, all of which lead to poor health outcomes. In the nursing education system, examples of institutionalized racism include consciously or unconsciously steering students of color into technical or practical nursing programs while at the same time steering White students toward professional and graduate nursing programs. Institutionalized racism is at work when there are more White people on college and university boards of directors, administrative teams, and in faculty and student bodies than there are in the communities they serve—when the percentage of Black and Brown people increases as you move down the widening hierarchical pyramid of academia from the board of directors to the community served at the base. To envision this, draw a pyramid of your institution, and for each level, use existing data to record the percentage of people of color; if there is not proportionality from the bottom to the top, dialogue and action are needed. Institutionalized racism is at play.

Personally mediated racism is defined by Jones (2000) 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” (p. 1212). This is how most people conceptualize racism. Personally mediated racism can be conscious or unconscious and can be typified by what we do and do not do. For example, a Pakeha

(White) professor assumes that a Maori student might need extra help in a course, failing to realize that this student has the highest grades in her nursing class. If the professor realizes his assumption, he at least becomes aware that he has breathed in the pollutants of racism and has some work to do. Another example is a White professor consistently interrupting a colleague of color when she or he speaks or restating what was said. At our best, we recognize this and bring it to the attention of our White colleagues to encourage them and hold them accountable for change. Personally mediated racism is one of the building blocks of institutionalized racism. There is an aspect of internalized superiority to this dynamic, which mirrors internalized racism, the next level of racism.

Internalized racism is manifest when people from stigmatized “races” begin to believe the negative messages about their intrinsic value and abilities. They stop believing in themselves and in people who look like them (Jones, 2000). Internalized racism “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” (p. 1213). Internalized racism is exemplified when faculty of color more readily accept the input and opinions of White colleagues over colleagues who look like them or when a student of color second-guesses her answers on an exam or her ability to do a clinical procedure in spite of having thoroughly studied for the task at hand. Internalized racism can be diminished through a process of critical examination (Ellis & Pharris, 2007).

To help the undergraduate nursing class Angelleen was enrolled in understand how these types of racism work together and how to deal with them as professional nurses, the course faculty used several role-plays and case scenarios. The scenario we worked on the day that Angelleen came to my office involved the students assuming the role of the nurse manager of a busy hospital unit on a day when two nurses had called in sick, several new admissions were anticipated, and a float nurse had been requested. The nurse manager witnesses the charge nurse’s response to the arrival of a Native American woman who says she was sent from her unit to help out. The charge nurse rolls her eyes and states, “Oh no! I asked for a *nurse*, not a *nursing assistant!*” The Native American woman, speaking in a soft, calm voice, informs the charge nurse that she *is* a professional nurse *and* a graduate student in nursing.

After reviewing the scenario, students are encouraged to discern how they, as the nurse manager, would attend to and support the float nurse; what kind of conversation they would have with the charge nurse;

and what actions they would consider taking to assure a healthy climate in their unit. The first level of analysis usually involves seeing personally mediated racism on the part of the charge nurse—“She’s racist! She just *assumed* that the Native American nurse was a nursing assistant!” When asked why the charge nurse might have made that assumption, the students query what the charge nurse’s previous experience might have been with Native Americans, but then as they dig deeper, they begin to question what the racial make-up of the staff is in the hospital—from the people who clean to the people in the board room. Thinking that the float nurse was a nursing assistant may be a logical error in an institution where the majority of Native American employees work as nursing assistants or in other support staff roles, rather than as professional nurses—an example of institutionalized racism. The next level of analysis involves having the students work in small groups to develop a plan to systemically identify and address institutionalized racism on the unit. Students might choose to measure patient outcomes by “race,” collect data related to recruitment and retention of nurses of color, conduct confidential surveys of patients and staff to listen to their experiences, and so forth.

The final level of analysis is to have students write down the “race” she or he envisioned the charge nurse and nurse manager to be when the scenario was first read. Even though the “race” of the charge nurse and the nurse manager was not noted when the scenario was presented, the students’ answers usually involve some assumptions and resultant self-insight. This opens the door for further dialogue and understanding of the dynamics of institutionalized racism, internalized racism (on the part of the charge nurse in the scenario if she is a person of color, or on the part of the students of color if they envisioned the charge nurse and nurse manager as White), and internalized supremacy or privilege (on the part of White students if they envisioned the charge nurse and nurse manager as White). White professors can role-model and encourage White students to take leadership in identifying and addressing situations involving racism and taking the lead to enact change at the systems level. This is not to say that faculty of color cannot or are not doing this work or are not doing it very well. They can and are. They experience greater emotional and promotional costs. Because White people are the beneficiaries of White privilege—whether they want it or realize it or not—they are morally obligated to take the lead. White faculty can and should teach students that dismantling racism is an essential nursing intervention for health. This important work is often a new concept for White students, most of whom have not spent a great deal of time

thinking about racism or their responsibility to identify and address it. The overwhelming Whiteness of the nursing culture, if not critiqued, perpetuates this blindness (Gustafson, 2007).

Students need to realize that in predominantly White countries racism is woven through the daily experience of everyone, whether it is consciously realized or not, and not only does it weaken the social fabric for all people, it is a significant health concern. An African American nurse participant in a study by Giddings (2005) demonstrates this when she states:

I'll shave down and survive in their world and as soon as 5:00 comes, I unshave and get into my world where I am my own self. So I show two faces. That's why we [African Americans] are so hypertensive. It's because we have to deal in two worlds. White folks don't. It's their world. They operate the same way in their work world, their home, and in their environment. For us it's like wearing "two hats." I become another person when I walk out my door. (p. 309)

Many studies have shown that the failure to recognize and name racism is harmful to the health of people of color (Institute of Medicine, 2002; Krieger, 1990, 2003; Williams, Neighbors, & Jackson, 2003).

The good news is that racism is a social structure, and social structures can be changed. Nurses are uniquely situated to take leadership in making this change. The first step is identifying and naming the source of the problem, which is not always easy, particularly for those who do not have the critical vision to see it. Racism has been cleverly buried in every corner of our culture; it is the warp over which the myriad threads of economic advantage have been woven.

Psychologist Beverly Daniel Tatum (1997) describes racism as being like smog—sometimes it is thick and sometimes invisible. We don't describe ourselves as smog-breathers, but we are—all of us. This means that people of color are at danger for internalizing a false sense of inferiority, while White people assume a false sense of superiority—neither is real, and this distorted sense of reality can only be broken by critical attention to the history of racism and the purpose it has served around the world. This is essential nursing knowledge.

Angelleen's concerns were more local and immediate. As a first-year nursing student, she was concerned about how she would deal with racism as a Black professional nurse when the nursing profession is overwhelmingly and disproportionately White. How had this come to be?

How much harder would she have to work than her White counterparts to succeed in the profession? Would she be safe? If White nurses cannot see the dynamics of racism at play in health care encounters, are patients of color safe in their care? Angelleen had walked into my office and brought up the fact that she didn't want to hear about racism from a *White* professor, and she obviously wanted to talk about this, but she also needed mentors and guides who looked like her. We explored and made professional connections for her to have more people to talk with about these important professional issues. I told her that my research and scholarly work have shown that racism is a major health concern and that because racism was created by White people, I, as a White person, felt compelled to take leadership in addressing it, but I am also very attentive to discerning when to step aside and when to build coalitions. Many strong and amazing leaders have risen up from racialized groups to shine a light on the path toward health, yet there is much work to be done by *all* of us. We both expressed concern that even though empirical evidence suggests that racial inequalities are not improving and perhaps even worsening, there is an increasing trend not to talk about racism—the whole “*we've dealt with this—racism no longer exists—it's time to move on*” mentality. Because this dynamic can be distorting and disorienting, Angelleen decided to begin attending the Black Nurses Association meetings where she could network and anchor herself in a supportive community of nurse leaders. Having a circle of support gives nurses the strength and wisdom needed to do the important work of creating healthier systems and maintaining their own personal health and well being.

Angelleen and I had a long talk that day and have had many long-distance phone conversations and e-mail exchanges in the years since, during which she has successfully completed graduate school and has risen to leadership in a demanding work environment. I have continued to explore how we can switch the focus of our telescopic lens on diversity to turn it back on ourselves in academia—on the nursing education system and its White culture—to make the necessary structural and relational changes for a truly inclusive environment.

Nurse scholars have led the way by constructing theoretical models for culturally competent care (Campinha-Bacote, 2003; Giger & Davidhizar 2004; Leininger, 2001; Purnell & Paulanka, 2003). This first wave of scholarly work showed us what knowledge and sensitivities were needed for us to be able to best care for our patients and their families. They gave us a mirror that reflected our own “otherness” as we viewed

“the other.” A second wave of scholarly work warned us of the danger that our diversity efforts may not only exacerbate differences and divisions but also strengthen the privileged White normative structure of nursing as long as it is at the center (Allen, 2006; Alleyne, Papadopoulos, & Tilki, 1994; Hassouneh, 2006; Markey & Tilki, 2007; Nairn, Hardy, Parumal, & Williams, 2004; Vaughan, 1997).

Hassouneh (2006) makes a strong case for antiracist pedagogy being an essential aspect of nursing curricula. Similarly, Irihapeti Ramsden (2000, 2002), who proposed the model of cultural safety for New Zealand, suggests that nurses must attend to the power relations in nursing and health service delivery and that they need to be more concerned with *life chances* than *life styles* as the underlying causes of health disparities. Collectively, nurses from around the world have the ingredients needed to make nursing rise from cultural diversity to cultural safety and inclusion. Allen (2006) warns that we cannot simply “add colour and stir” (p. 66)—it is not enough to add diversity courses or to add faculty of color, but rather we must remove White culture as the main ingredient *and* as the bowl in which we do the mixing. The remainder of this chapter will present some concepts that you as a reader might find helpful as you look inside yourself to discern what actions you could bring to the mix. Pay attention to the insights that arise within you as you read this text—those internal insights is the text for you to study most diligently.

WAKING UP TO THE PERVASIVE EXISTENCE OF RACISM

Several years ago, I was asked to join a local health center in its effort to establish a center of excellence in women’s health in the neighborhood where I live, which is predominantly African American but also Hmong, Latino, Vietnamese, American Indian, and European American. The health center staff needed a nurse with a PhD to help with the grant writing, and they asked me to develop a community-based action research program, which was a grant requirement. The grant was funded, so I recruited three brave nurse practitioner graduate students into the effort, telling them that they would not know what the topic of their thesis would be because defining the research question was up to the community. All I could promise them was a process of community engagement. They eagerly signed on. We joined with the health center staff to invite women representing 50 different organizations and places in the community where women gather to a Saturday morning meeting

to identify the major barriers to health for women and girls of color in the neighborhood. We expected 10 to 15 women to show up, but 50 came. After 4 hours of small group dialogue, the women came back together and decided they needed another Saturday morning session—there was so much to talk about. Two weeks later, 65 women gathered. After another 4 hours of small group dialogue, the eight groups came back together, and each group reported that *racism* was the greatest barrier to health for women and girls of color. We spent a year listening to women's stories about the interplay of racism, health, and well-being (Amaikwu-Rushing et al., 2005).

In the small group I participated in that day, several Black women talked about not being touched by White providers during their health exams. One Black woman told of how her knee surgeon stood close to the door as he asked her to raise and bend her knee and tell him where and when it hurt. She said he did not touch her until it was time for the surgery. As each woman shared stories from her own experience and that of her family and friends, I listened with sadness to their accounts of receiving inadequate and unequal care and the fear these experiences engendered. I wondered to what extent my patients were carrying that same fear. After I left our Saturday morning dialogue, I headed to the local trauma center where I was scheduled to work in the emergency department (ED).

Upon arrival to the ED, I took report from an excellent White nurse. She and a very fine White physician had both been caring for two young women who just happened to arrive to the ED at the same time. Both were close to 20 years of age, and both presented with 9 out of 10 flank pain, indicative of kidney stones. After receiving report, I went to assess my patients. The first young woman, a White woman, was lying on an ED bed dressed in a patient gown and wrapped in a warm blanket. She had received a significant amount of morphine through an IV that was infusing into her left arm. The second young woman, a Black woman, was in a fetal position in the procto room, was still in her street clothes, and had received nothing for pain. In an instant it hit me that I might not have noticed this inequality had I not come directly from the dialogue about racism and health care. I wondered, how much more was *I* missing? These two women had the same physician and nurse—both of whom I had always respected. Was the nurse really “excellent” and was the physician really “fine?” How did this unequal treatment slip by them? How much unequal treatment slips by *me*? Am *I* a part of this? After reading the work on unconscious discrimination by Michelle van Ryn and

colleagues (van Ryn & Burk, 2000; van Ryn & Fu, 2003), I realized that there was no way I could *not* be a part of the problem unless I did a lot of work to uncover and understand the dynamics of institutionalized racism in my clinical practice and in my work as a nurse educator.

Since that day, I have tried to make an increased effort to wake up to the dynamics of racism in the health care environment and in the education of health care professionals, particularly nurses. As a White person in the United States, I have been trained not to see racism in its myriad forms and manifestations in my life and in the lives of the patients and students with whom I work. I am not alone. The same thing has happened to light-skinned people in Canada, Australia, New Zealand, the United Kingdom, most of Europe, and much of Latin America—any country with a history of colonization and where the economy and social structure have been built on the genocide, enslavement, and exploitation of Black and Brown people. Nursing in these countries is part of the social fabric and hence has become White-controlled and defined. If we analyze how this has come to be, we will be able to create a healthier and more vibrant profession for all of us.

SANKOFA: LOOKING BACK TO MOVE FORWARD

In order to understand how racism is woven into the profession of nursing, we must first take an honest look at the collective history of the country in which we find ourselves. In order to understand why we are where we are, we must look back at where we have come from. When we look back at this history, we can disentangle ourselves from that which does not nurture the health of our students and the populations we serve. Ideally, this process becomes a source of decolonization and transformation. For example, a truthful look at the recorded history of nursing would take the profession back 2,000 and 1,000 years, respectively, before the time of Florence Nightingale. In 250 B.C. the first formal school of nursing was established for men in India (O'Lynn, 2007) and during the time of the Prophet Muhammad, Rufaidah bint Sa'ad established restorative and preventive nursing care for soldiers and the general population (Anionwu, 2006). (Rufaidah bint Sa'ad is also referred to in the nursing literature as Rufaida Al-Asalmiya, see for example, Aldossary, While, and Barriball [2008].) Engaging in a more expansive view of the history of nursing systems and leadership broadens perspectives of what nursing has and can be.

In outlining important principles of leadership, Bordas (2007) presents the image of Sankofa, the mythical West African bird that is always presented looking over its back toward the past. Sankofa invites us to learn from the wisdom and insights gained from an examination of our history. Sankofa reminds us that “our roots ground and nourish us, hold us firm when the winds of change howl, and offer perspective about what is lasting and significant” (Bordas, 2007, p. 28). In the Akan language of West Africa, the concept of Sankofa is translated to mean: “it is not taboo to go back and fetch what you forgot” (W.E.B. Dubois Learning Center, n.d.). Often the bird is symbolized with an egg in its mouth to represent the potential that can be birthed in the future from the process of looking back to the past.

In looking back from our various country perspectives, we find that the history of colonization changed our relationship with the earth from that of steward to subjugator, which “set the stage for an economic system that allowed the using up and abusing of natural and human resources” (Bordas, 2007, p. 34). In the process of looking back honestly, we acknowledge not only the violence and degradation, but we also uncover cultural treasures that can be invested to create a much richer and healthier future. Bordas (2007) states:

When the past is reconstructed in the bright light of honesty—or at least when everyone’s story is told—we can begin restructuring leadership from a Eurocentric form to one that’s more diverse and inclusive. We can construct a new leadership covenant that reflects and respects the history and culture of all. (p. 32)

There is a certain excitement and exhilarating hope in the process of transforming our culture to one that is inclusive—where Whiteness is not the center, nor the norm. International nurses witnessed this quality of excitement and hope in London in 1999 during the centennial celebration of the International Council of Nurses. The vibrancy of the Democratic Nursing Organisation of South Africa (DENOSA) permeated the gathering. They presented an assertive, spirited collective of Black and White nurses whose positive energy drew everyone in. I sat down with several DENOSA members during a break and asked how they had come to such strong solidarity as a professional organization. They explained that it was only through the truth commission process that this was possible. The first step was to tell of the atrocities and to fully listen to the effects of apartheid. A Black nurse told me that she

had returned to South Africa prior to the dismantling of apartheid after completing her professional nursing education in the United Kingdom. When she returned, she was supervised by a White nursing assistant who made more money than she did. It took a lot of honest dialogue to heal the wounds and repair the deep divisions. The values embraced by DENOSA are excellence and professionalism, humility, collectivism, solidarity, and unity; they are democratic, nonracial, and nonsexist (www.denosa.org.za). The warp of the fabric of nursing culture is much stronger if it is woven from our collective values in a way that reveals the truth.

As a quest for truth, when I was preparing to teach a graduate nursing theory course last fall, I began researching what became of the men and women of color who might have been among the established nurse theorists. I came across the story of Susie Walking Bear Yellowtail, who graduated from Boston City Hospital School of Nursing in 1923 to become the first Native American registered nurse. After graduating, she returned to the Crow Reservation to work for the Bureau of Indian Affairs Hospital where she soon realized that White surgeons were performing nonconsent sterilization surgeries on Crow women. By necessity, she spent the rest of her career educating the public on the abuses experienced by Native American people and advocating for improved health care service for Native Americans. Susie Walking Bear Yellowtail did not have the luxury of the reflective life of a theorist; she had to respond to the immediate and urgent needs of her community (Cohen, 1999).

Reviewing the works of Carnegie (1991, 2000), Davis (1999), Hine (1989), Robinson (2004), Seacole and Salih (1857/2005), Staupers (1961), and Washington (2006) gave me greater insight into the pressing social justice demands on the time and energy of nurse leaders of color and the discrimination they have battled on a daily basis. One example is that of Mary Grant Seacole, a Black Jamaican woman who, prior to the formation of schools of nursing in Jamaica, served in Panama and Cuba to help curb the spread of cholera and yellow fever epidemics and to care for those who fell sick. When the Crimean War broke out in 1853, Ms. Seacole petitioned to join the nurses being sent by the British government. She offered her vast knowledge of disease containment and treatment to aid in protecting soldiers in the British Army, many of whom were from Jamaica. In spite of having letters of support from British army physicians and the wife of the secretary of war, she was turned down because she was Black. Undeterred, Ms. Seacole financed her own way to make

the 3,000-mile journey. Once there, she petitioned Florence Nightingale to join the Angel Band of military nurses, but Nightingale refused to give her a position. Seacole established Spring Hill, a lodging house with nutritious food and a place for the troops to come and heal on the outskirts of the battlefield. She brought knowledge of cures for dysentery and was cited by many military officers for her quick and thorough healing practices. Seacole worked tirelessly during the day at the lodging house, and then at nightfall, she headed to the battlefield to rescue and treat fallen soldiers. After the Crimean War ended, Seacole returned home, injured and economically poor, but rich in the satisfaction that she had made a difference in the lives of hundreds of soldiers (Carnegie, 2000; Robinson, 2004; Seacole & Salih, 1857/2005).

From the perspective of another island nation, New Zealand, nurse scholar Irihapeti Merenia Ramsden (2002) recounts how health disparities have risen for the indigenous people of New Zealand after the efflux of people from the United Kingdom in the 1830s. Ramsden points out that by the time she was born, slightly more than 100 years later, “the land had been largely stripped of native people, trees and birds” (p. 14). She draws on a report from a U.S. Fulbright research scholar, David Ausubel, who was in New Zealand from 1957–1958:

One of the most surprising but also one of the most prevalent attitudes toward Maoris [*sic*] that I encountered in New Zealand was a feeling of complete and utter indifference about the welfare of the Maori people. Many persons hardly seemed aware that Maori persons existed and apparently cared even less . . . They took Maoris for granted as part of the general environment in much the same manner as they did telephone poles except for some vague awareness that the former were somewhat more of a tourist attraction. (Ausubel, as cited in Ramsden, 2002, p. 15)

Ramsden (2002) documents the difficulty of teaching about cultural safety and the power dynamics inherent in every nursing encounter when the nursing education environment does not recognize the history of marginalized people and encourages assimilation and denial of difference. Students and faculty in all countries repeatedly state in one way or the other, “I respect everyone” or “I care for everyone equally!” or “There’s no racism here!” The fact is that marginalized groups of people see a different reality than people from the dominant culture.

Countless volumes could be filled with the painful stories of what students and faculty of color have suffered in predominantly White

schools of nursing in New Zealand, Canada, Australia, the United States, the United Kingdom, and in other parts of the world. Hassouneh (2006) points out:

Over the years, I have observed that many white faculty are comfortably oblivious to the realities of racism. In addition, faculty responses to anti-racist pedagogy suggest that many would like to stay that way. Efforts to raise issues related to racism and Eurocentrism in faculty meetings and other forums are usually not well received, and faculty of color who raise these issues are often ignored, discounted, and/or pathologized. (p. 260)

In addressing the ethics of diversity, Sorrell (2003) stresses the importance of people from the dominant culture listening in the “thin place” or the place where the natural and sacred worlds merge and where seen and unseen realities share common ground. She cautions against “benumbing” (para. 7), which is the failure to slow down and create the open space for intimate listening to the suffering of others. Rather, Sorrell asserts, we must work to hear, understand, and honor the entirety of the experience of marginalized people. It is in this open listening that potential for transformation and action arise.

One would think that schools of nursing would be places where no one is *benumbed*, where all faculty and students would feel known and appreciated for who they are, and where antiracism pedagogy would be embraced at the center of the curriculum. Yet, this is not the norm, although it could be. Many White faculty and administrators continue to believe that racism is a thing of the past and not an issue of central concern to the work they do. To understand why this is so, we turn to the work of sociologists who have studied the stratification of “races” in society and the purpose this serves.

COLOR-BLIND RACISM

If “race” was created to advance the economic gain of a privileged few, in other words, people who colonized and exploited the land, resources, and human labor of Black and Brown people, how can racism still be present in countries that have enacted strong civil rights legislation? Rosenberg (2004) asserts that a new racial consciousness is arising—one that avoids direct discourse centered on race, while safeguarding racial privilege. Bonilla-Silva (2006) has termed this new brand of racism

color-blind racism, which he points out “otherizes softly” and involves “smiling face discrimination” (p. 3). In other words, the Latina applicant for a nursing faculty position is not hired, but she is treated very nicely as she is turned away in favor of a White candidate who is less qualified for the job but “would need less mentoring.” In this situation, the mentoring that is most needed is likely the mentoring of the faculty on the search committee and the dean who made the hiring decision; yet, this is rarely recognized. Bonilla-Silva states that “the beauty of this new ideology is that it aids in the maintenance of White privilege without fanfare, without naming those who it subjects and those who it rewards” (pp. 3–4).

Moreover, there is an increasing tri-racial order emerging, which Bonilla-Silva (2006) labels as the “Whites,” “Honorary Whites,” and “Collective Blacks,” stratified by skin color, with “the maintenance of systemic White privilege accomplished socially, economically, and politically through institutional, covert, and apparently nonracial practices” (p. 183). A smoke screen is created when a few people of color are invited into the “White” power structure; yet, the structure never changes the reality and suffering of the people at the bottom. Bonilla-Silva refers to this as the “Latin Americanization” of racial order in the United States and states that “this ideology, which is the norm all over Latin America, denies the salience of race, scorns those who talk about race, and increasingly proclaims that ‘We are all Americans’” (p. 184). We need only to look back at the historical roots of this system, starting with the arrival of Hernán Cortés on the shores of Mesoamerica, who with his soldiers for two decades committed acts of genocide, violation, and enslavement before Pope Paul III finally proclaimed in 1537 that the indigenous people of the Americas do indeed have souls. By this time, a system was well in place to ensure the flow of gold, silver, cacao, and other riches to Europe, mined and harvested by an enslaved Brown indigenous people whose land and culture had been devastated. The Pope’s decree had little effect; the new economic system was well in place, and the concept of “race” was developed to justify it. Over the centuries, the myth of race has been promoted by scientists and become part of our collective culture and consciousness (Graves, 2002).

As race relations have become globalized, color-blind racism has become prevalent in most Western nations. Markers of this new racial order include the refusal to measure “race,” particularly as it relates to assessing for equal outcomes, intense denial of the existence of racism, smiling-face discrimination that is disorienting and dispiriting to its victims, and stratification of jobs from menial to managerial by skin

tone. The effects of this ideology, if it is not recognized, challenged, and changed, will include increasing economic and health disparities by “race.” The nature of color-blind racism is that it negates reality in favor of myth. In order to see reality, we need to be able to measure it. Accurate data are essential.

Nurses are in a position to bring light to healthy racial-identity development and the creation of sound social policy; nurse educators can lead the way. We can begin by listening, researching, recognizing the problem, educating ourselves on possible solutions, developing the space and means of carrying out bold conversations, and committing to change the nursing education environment based on the data we collect. We can do so in a way that names the agent that needs to be changed. For example, there is a difference between saying, “Immigrant students are more likely to be steered toward technical nursing programs than equally qualified native-born peers” and “Academic counselors are more likely to steer immigrant students toward technical programs than native-born students, whom they tend to steer toward professional degrees.” We need active sentences with subjects as agents in our data reports, so that we can focus our interventions. We also need sound data that have been analyzed for all possible correlates. We can determine where change is needed and measure our progress through designing research projects that assess equal outcomes for students and faculty by “race” and ethnicity, which is necessary to ensure structural change.

LESSONS FROM THE EDUCATIONAL TRENCHES

So, there I am, trying to do some background reading for this chapter, and I had forgotten about lunch. I go into the cafeteria, buy lunch, and sit at one of the back tables facing the windows so as not to be distracted. I am one paragraph into my reading when a woman comes and asks if she can join me. I'm thinking, “Can't she see that I'm busy?” as I clear a space and put my work away, thinking that maybe there is something else I am to learn today. She introduces herself as a new faculty member in another discipline, having just completed graduate school at a prestigious university out East. I ask her how teaching is going for her and note that I am taking extra interest in her well-being because she is Black and we're in a historically White institution. An African American colleague whom I love and respect dearly—one of the most brilliant people I know—joins us for lunch. I'm pleased to have the distraction and the camaraderie, which is much more interesting than the great book I was reading, and I am glad that these

two good women are connecting. My colleague had just come from being a guest speaker at a global search for justice course and recounted, “I feel like I came in at minus 10 and had to work my way up to zero with these students, just because I am a Black woman. The way they looked at me was like, ‘show me that you have something to say that I don’t know!’ It is just so exhausting!”

Nurse administrators, particularly at historically White colleges and universities in predominantly White countries, need to realize the added burden and stress placed on faculty of color and compensate and support them accordingly. They also need to have a critical lens through which to analyze student evaluations. After coteaching four courses with Black colleagues, I have come to realize the extent to which my excellent student evaluations reflect the wave of White privilege I have been riding. This has been a painful realization, but the data are there. Even though the White colleagues I have taught with are excellent, my Black colleagues invest more intellectual and emotional energy into the course; yet, when I coteach a course with a Black colleague, we come out with lower student evaluations. For one course, it was the very same students I taught the semester before and from whom I had received outstanding evaluations. Color-blind racism is tenaciously and pervasively present, and it carries an institutional, personal, and internalized edge. One of the most painful realizations is that the lower evaluations are not only from White students or from students who do not have the capacity to critically analyze the dynamics. They are also from students of color and students who demonstrate critical thinking in other areas. To help students critically think about the dynamics of racism in clinical practice and in nursing education, we have developed courses for graduate nurse education students and graduate nurse practitioner and nurse leader students at the College of St. Catherine. These courses deal specifically with the dynamics of color-blind racism so that students don’t carry it with them into the clinical or classroom setting.

In an *Inclusivity in Nursing Practice* course developed by LaVonne Moore, RN, MA, CNP, MS, CNM, and me, nurse practitioner students work to bring color-blind racism to the surface and determine a plan to create an inclusive nursing practice and health care environment. As concrete evidence of the existence of racism in the health care environment, we present an overview of racial and ethnic health disparities that persist after all social, age, and economic indicators have been held constant. Social and economic indicators are analyzed as concrete exemplars

of racism in society. Readings, exercises, and films are used to bring racism to the conscious surface so that students can analyze the power dynamics and determine how to dismantle racism in its many forms in their personal and professional lives.

A tool we have found helpful in bringing racism to students' conscious awareness is a racial moments journal exercise that was developed by Dr. Terri Karis (in press). We ask students to keep a journal as they go about their day-to-day activities. When "race" comes to their awareness, whether through an interaction, thought, or feeling, they are to observe it and document it as soon as they get a chance. We instruct them not to change it or judge it, but rather to simply record: (a) what is the situation? (b) who is involved? (c) what are the thoughts, feelings and/or words spoken? and (d) as a reflection afterward, how do you understand what happened? What were your thoughts and feelings that came after the initial thoughts or feelings? We collect the journals and provide feedback twice during the semester. The students also reflect on the most significant things they learned about race and about themselves through the racial moments journal exercise (Karis, in press). In addition, we use Blackboard, a Web-based tool for dialogue outside of the classroom, for the students to post their synthesis of the readings and class content and to dialogue with one another. Even the most entrenched "*racism doesn't exist anymore*" belief-holders usually move along to a deeper understanding by the end of the course.

Research on the racial moments journal has demonstrated that students are willing to pay attention to race-related thoughts, feelings, and behaviors—even when it gets uncomfortable; they begin to develop conscious awareness of what was a previously unconscious racialized worldview; begin to understand themselves better and are more able to take on the perspective of *the other*; develop an understanding of how pervasive the White norm is and how it shapes their worldview; and apply the new information they have gained to life encounters (Karis, in press). By the end of our courses, we have found White students able to more comfortably take on the role of an ally and all students articulating how they can take leadership in changing the system so that it is more inclusive. Dr. Beverly Tatum (1994) describes the role of the White ally as being willing to:

speaking up against systems of oppression, and challenge other Whites to do the same. Teaching about racism needs to shift from an exploration of victims and victimizers to that of empowered people of color and their White

allies, creating the possibility for working together as partners in the establishment of a more just society. (p. 474)

In summary, synthesizing the wisdom from the nursing literature with educational experience has led to an understanding of inclusivity in nursing education as evidenced by: classrooms, clinical conferences, and faculty meetings where students, faculty, and administrators openly talk about, identify, and address how to deal with racial discrimination and power differentials; curricular materials and processes that tell the truthful story of the creation and perpetuation of the concept of race and how it affects people's health; instructional and assessment materials that do not favor a White norm; a clearly stated and well-known process for reporting and addressing racial discrimination; an approach to knowledge that critiques its sources and employs multiple learning strategies; a commitment to engaging multiple perspectives and positions in democratic discourse and relationships; equal participation of students and faculty across racial and ethnic categories; and proportional demographic representation of the community at all levels, from the board of trustees to the administration, faculty, support staff, students, and environmental and promotional images of the university or college.

TURNING THE LENS AROUND: SYSTEM CHANGE

This chapter has explored various ways in which racism is manifest in the nursing education environment. It is important to understand the different kinds of racism, to know and teach the history and experiences of marginalized populations in your country and community, to have courageous and honest conversations about racism and how to teach students to dismantle it, and to work against color-blind racism in all of its forms. We need to find bold new ways to welcome students and faculty to the center of the educational community, even if that means that some of us must step aside. Most importantly, we need to dismantle the White hierarchical structure and replace it with a much stronger and more vibrant circular and collective model. This process will lead us to core tenets of nursing practice—caring, health, justice, and equal treatment—so that we can embrace them with renewed integrity.

At the College of St. Catherine, we have numerous programs to support students of color—from high school step-ahead programs and scholarships where high school students of color are mentored and

welcomed into the educational environment and develop lasting collegial friendships—to the Community Health Nursing Student Internship Program where nursing students of color work with strong nurse leaders who look like them in leadership development positions, while serving as a role-model to encourage youth in the community to enter nursing as a profession. We have created Spanish, Somali, and Hmong language videos about college life so that students' families can understand the support our students need to succeed in college. While these and other programs are immensely important, the most important thing we can do is to analyze the college structure for institutionalized racism and work to change it—to talk about and change those spaces that continue to be White spaces, where White privilege thrives as if it were the natural order of things. Just as Juana Bordas (2007) promises, when we take Whiteness out of the center, we all excel to a greater degree, we all become more vibrant and healthy, and we all can reach a horizon of the human spirit not previously imagined. Our students deserve no less.

RECOMMENDATIONS FOR NURSE EDUCATORS

1. Listen across racial lines. Listen intently. Listen with your eyes, ears, mind, heart, and soul. Analyze the data that document disparities. Develop healthy, mutual relationships. If you are uncomfortable with or find yourself stereotyping a certain group of people, develop a meaningful relationship with people from that group. Think about who is around your dining room table during celebrations. Do they look like your colleagues, your students, and the community you serve? If not, reflect on why not, and think about how you can widen your circle.
2. Develop a process to review your curricula for cultural inclusion. You may want to analyze use of the Fair Representation of Diversity Content (FRDC) tool (Scisney-Matlock, McCloud, & Barnard, 2001) and the Byrne Guide (Byrne, Weddle, Davis, & McGinnis, 2003) as you design the process you will use.
3. Take part in antiracism education seminars and sessions.
4. Learn the history and listen to the experiences of students in your school of nursing.
5. Organize small study circles to meet and talk about how to dismantle racism in your educational environment.

6. Dialogue with colleagues about how you as a faculty talk about “race” and racism. What are you modeling for your students?
7. Discuss how you help students move through racialized encounters in the health care clinical setting and in the educational environment.
8. When students make stereotypical or discriminatory comments in class or clinical settings, do not be silent. Address the importance of not making generalizations or hurtful comments. If identifying and addressing the dynamics of racism are taught on day one as essential nursing knowledge, it will be natural for you and the students to embrace these as teachable moments. A democratic classroom can not exist without this practice.

RECOMMENDATIONS FOR NURSING EDUCATION ADMINISTRATORS

1. Routinely measure rates of student retention and graduation and employment, promotion, and tenure of faculty at your institution by “race” and ethnicity. Compare the demographic makeup of the community your school serves with the demographics of your student body, faculty, and administration. Dialogue and analysis for change are needed if your faculty and students do not represent the community you serve, if there are disparate rates of retention and graduation for students, or if there are disparate rates of employment, promotion, and tenure of faculty.
2. Assess whether faculty of color at your institution are being asked to speak at college events, serve on committees, and attend to students of color to a greater extent than White faculty and ensure that there is just compensation for this work. When faculty of color in predominantly White institutions are asked to take visible positions, this may be indicative of an administration that is more interested in aesthetic diversity than full diversity, and it leaves faculty members feeling valued mostly for the color of their skin, which means only a part of them is being accepted.
3. Assess how you can adequately support faculty to address students’ needs to learn about racism and to work through racialized issues that arise in clinical and educational settings.
4. If you are White, consider how you are supporting faculty of color in your institution. Do you know the stresses they are

experiencing and the demands on their time? What are the power differentials that prevent them from coming to you? How are you removing those barriers? If you are a person of color, are you feeling additional pressure to succeed, and do you feel as though you cannot adequately support your faculty of color because of it? If so, how can you care for and advocate for yourself and your faculty? Where do you get your support?

QUESTIONS FOR DIALOGUE

1. What ideas or concepts did you find most meaningful in this chapter? Identify your insights and questions to bring to a dialogue with your colleagues.
2. List all the nursing leaders you know from nursing textbooks. What percent are White? Review your textbooks and other teaching materials for full inclusion. What messages might unconsciously be planted in students' minds? Dialogue with colleagues about how you could review your curricula for inclusivity. You may want to start by identifying evidence of inclusivity as listed at the end of the "Lessons from the Educational Trenches" section of this chapter.
3. The term *race* continues to be used despite the widespread acceptance that it is a biologically meaningless term. Why do you think this is the case? Provide examples from the nursing literature and your observations on how *race* is used or misused.
4. Dialogue with colleagues about how you might better introduce dismantling racism as a nursing health intervention. How do you teach students to identify racism and to deal with it when they experience it? Hold a dialogue for administration and faculty to identify what support is needed to better do this work and what policies and curricular changes you want to put in place.
5. How is color-blind racism manifested at your institution? Describe specific examples and dialogue with colleagues about what structural changes need to be made within your program.
6. At your institution, what hard data do you or could you collect to measure the need for structural change, such as: (a) equal recruitment, retention, and graduation of students; (b) differential treatment and experiences for faculty of color; and (c) other aspects of institutionalized racism? Be careful of excuses

and/or rationalizations that faculty and administrators often raise to minimize the experience of minorities and to avoid the need to address structural change—collect hard data to direct your structural change.

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