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Continuing the conversation in nursing on race and racism

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ABSTRACT

Nursing values include diversity and a commitment to the elimination of health disparities. However, nursing comprises predominantly white, female nurses. The authors explore structural and interpersonal sources of disparities experienced by black persons, including white privilege. Here, the authors advocate for a continuation of the racism conversation, specifically among white nurses. Racial disadvantages stem from structural inequalities from daily slights, and usually unintended subtle racism toward black people on the part of white people, including white nurses. By raising consciousness on how we propagate subtle racism, nursing can progress faster in eliminating health disparities. Topics include postracialism, colorblindness, institutional racism, white privilege, health disparities, clinical encounters, subtle racism, and racial microaggressions. Suggestions for open dialogue, historical awareness, education, research, and practice are highlighted. Difficulties involved in confronting racism and white privilege are explored.

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> *To begin for good is to begin in the inalienable possession of oneself. It is then to be unable to turn back; it is to set sail and cut the moorings…run through the adventure to its end.*
>
> Emmanuel Levinas (Levinas, 1978 [1947] p. 15)

During Senator Barack Obama's Presidential campaign, criticism of his involvement with African American liberation theologian, Rev. Jeremiah Wright, surfaced in response to circulation of a short video clip that some interpreted as unpatriotic and disturbing. Then-candidate Obama responded to the uproar with an unprecedented address about the need for the U.S. citizenry to engage in dialogue about questions of race and racism, emphasizing that much progress still needs to be made.

Four years hence, however, issues regarding race remain difficult to breach in conversation. The speaker fears characterization as "playing the race card," or disruptively "injecting" race into a discourse. This silences those with legitimate needs to discuss race-related experience, forces people of color (POC) to accept still-present structural racism, and advances a depoliticizing ideology that we are now living in a "postracial" society (Cho, 2009; Hesse, 2010; Lum, 2009; Robinson, 2009; Roediger, 2008; Wise, 2010). Hence, talk of race is seen as socially problematic and avoided as deviating from the values of universality, colorblindness, and diversity. Some maintain that racism is diminishing and that black and white people no longer differ in terms of opportunity; any disadvantage to black people has been offset by time,

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affirmative action, and social programs that have presumably "equalized" racial groups (M. Hunter, 2010; Wise, 2010). The abandonment of these programs signifies and is justified by the notion that the United States is "postracial." Look around you. Is this so?

Purpose and Scope

This article is an analysis of how structural and interpersonal racism in general, and in nursing encounters, alienates black persons as "others;" and a discussion of how subtle racism contributes to racial health disparities. On the basis of scholarship, as well as the authors' informed opinions about how racism can be overcome in nursing, the ultimate goal is eliminating racial health disparities. To that end, the authors support dialogue among all racial groups, and all audiences are welcome to read this. To clarify, the first author (here forward referred to as "I") is of Irish heritage and identifies and is categorized as "white." The second author is of African American heritage and identifies and is categorized as "black."

Our intent is to show the need for a white-to-white conversation, not to evoke guilt, anger, and fear, although these feelings often emerge for white people in discussing racism. The idea of a separate dialogue among white nurses came from the authors' three years of discourse as a team. The second author was conscientious so that white ideology as experienced or viewed through the lens of black people was included and to make the dialogue as effective as possible. She does not speak for all black people or black nurses. As colleagues, the two authors have collaborated on a narrative study of black adults' experiences of subtle racism and an article on racial microaggressions (Authors).

The conversation on racism in health and nursing has been disproportionately carried by nurses of color for some time (Drevdahl, 2001; Drevdahl, Phillips, & Taylor, 2006; Giger, 2000; Giger & Jones, 2007; Hassouneh-Phillips & Beckett, 2003; Taylor, 2005; Taylor, Mackin, & Oldenburg, 2008; Underwood et al., 2004, 2005; Underwood, Powe, Canales, Meade, & Im, 2004). Wise and Sue recommend that white people talk to each other about how they have participated in racism (Sue, 2003; Wise, 2008). Thus, white nurses need to talk with other white nurses about how marginalizing racial disparities are perpetuated in nursing practices, the development of knowledge, and education. A separate conversation among white nurses will raise consciousness about white privilege and its consequences in health care. This has a threefold purpose: to heighten awareness about the life-encompassing and cumulative stress effects interpersonal and structural racism has on the daily experiences of black persons in the United States; to facilitate improvements in the nurse–patient relationships between white nurses and black patients, because white nurses would then be more aware of how privilege works in the power dynamics of health care interactions; and to explore historical white privilege that underlies many black people's misgivings and mistrust of health care institutions. The ultimate goal is elimination of racial health disparities, and this conversation would be one step in that direction. Henceforward then, the term "we" refers to white nurses.

I narrow the scope from POC in general to focus on black and white persons' experiences. Slavery and Jim Crowism have played out in U.S. history with specific, severe, and lasting effects. Interpersonally, racism includes stereotypes based on skin color and bodily features and not ethnicity or heritage (as in African American). In a Gallup poll, the majority of black people sampled had no preference between the terms (Newport, 2007). Immigration from Africa has tripled since 1990, making the referent, "African," problematic. The term black includes those not of African ethnic heritage. "African American" recalls the history of being enslaved and also shows pride. However, "black" also captures the memory of oppression and pride, as in "Black is Beautiful" and "Black Liberation" (McWhorter, 2004). White is used instead of Caucasian; Caucasian refers to Asiatic people from the Caucasoid region and thus is inaccurate (Painter, 2010).

Black persons feel pressure to explain racism, or to teach white persons about it; but that is not their responsibility (Allen, 2006; Hassouneh-Phillips & Beckett, 2003; Hassouneh, 2006, 2008; Sue, 2003; 2010; Sue et al., 2007), nor should black persons endure the daily subtle slights, insults, and dehumanization they experience in interacting with white persons, including in counseling settings (Constantine, 2007; Hall & Fields, 2012; Sue, et al., 2007). Black people understand white privilege and structural and interpersonal racism all too well. Survival of marginalized persons means knowing the intricacies of the dominant majority behavior (Hall, Stevens, & Meleis, 1994; Hall & Fields, 2012). White people, however, can stay fairly distant from knowledge of experiences of the marginalized because the majority of white peoples' survival does not depend on it (Sue, 2003; Wise, 2008). This is an example of white privilege. White privilege, an advantage of which most white people are not consciously aware, refers to the unearned benefits of wealth, power, and status gained at the historical and current expense of POC (Sue, 2003; Allen, 2006). A conversation among white nurses at this point will raise consciousness and help us (white nurses), to speak up and hold one another accountable for the ways in which we knowingly or unknowingly contribute to the marginalization of black people (Wise, 2008).

Gender is relevant in racial health disparities, but the interaction of race and gender is beyond the scope of this article. POC (e.g., black, Latino/a, Asian, Pacific Islander, Native American Indian) are treated in various way on the basis of gradations of color, in