2441 **Racism in Nursing: Practice**
2442
2443 **Work Environment**
2444 Diversity, Equity, and Inclusion (DEI) touches every part of a healthcare organization,
2445 acknowledges the value of many voices, and holds the wellbeing of nurses as central to a
2446 positive clinical environment. Nurses' intent to stay at an organization is associated with how
2447 they perceive the value their employer, managers, and peers place on diversity and inclusion. A
2448 successful healthcare workplace must have an inclusive environment and offer safe spaces for
2449 courageous conversations where nurses can discuss racism openly and explore how
2450 unconscious bias can negatively impact their decisions. Retention and recruitment of nurses is
2451 directly related to whether the work environment is diverse and inclusive. Organizations have a
2452 responsibility to mitigate barriers hindering these values and must respond to overt racism as
2453 part of systemic change needed to address health disparities, especially in marginalized
2454 communities (Caldwell, et al., 2021)
2455
2456 A study among health care leaders found that only 8% of individuals on hospital boards and
2457 executive leadership positions are Black, 3% are Hispanic, 1% are American Indian or Alaskan
2458 Native. (Institute for Diversity in Health Management, Health Research & Educational Trust,
2459 2016) A healthcare organization can improve the diversity climate by employing targeted goals
2460 to recruit and retain more historically marginalized BIPOC nurses. Targeted goals might include
2461 promoting individuals from known excluded groups into leadership positions. Investing in
2462 diverse leadership may help to cultivate a culturally responsive healthcare organization and
2463 begin to eliminate health disparities.
2464
2465 Racism in the nursing practice environment presents overtly when BIPOC nurses are subject to
2466 assignment changes at the request of patients and family seeking care from non-BIPOC or white
2467 nurses. Racism in nursing is also covert through microaggressions in the form of insults, slights,
2468 and presumptions of lack of competence and ability that has resulted in barriers hindering
2469 progression within the profession. In either case, the emotional harm experienced by the nurse
2470 should not be underestimated. When patients express racist behavior, nurses may experience a
2471 conflict between preserving their humanity and providing care (Vogel, 2018). Organizational
2472 leadership and support are key if institutions are to truly fulfill an antiracist mission
2473 (Rasmussen, & Garran, 2016). The American Nurses Association (ANA) recommends: "Nurse
2474 managers, supervisors, and administrators must assess policies to ensure support of
2475 inclusiveness, civility, and mutual respect, acknowledging that the lack of such policies may
2476 result in environments that fail to sustain high-quality, effective, efficient, and safe health care
2477 practices." (ANA, 2010)
2478
2479 Nurse leaders are in the position to address racism, bullying, incivility, and discrimination from
2480 peers, faculty, and patients by offering tools for nurses to use when confronted by micro- and

macroaggressions such as bullying, which can result in lowered self-esteem, high anxiety, many levels of depression, fear, and isolation if not addressed. Healthcare systems can confront incivility and bullying by having nurse leaders provide education and tools to nurses that encourage them to exert upstander behavior and intervene when they witnessed bullying. Microaggressions, forms of bullying, convey negative messages about distinctive groups of people. (Sue, 2010; Torino, et al., 2019)

Disruptive behavior, such as racism, can have widespread influence on a healthcare system and nurses need to be cognizant of this issue. The impact of these disruptive behaviors threatens not only patient safety, but also the wellbeing of nurses and their ability to perform competently in their jobs. Hospital leadership and nurse managers must demonstrate a concern for the frequency of disruptive behaviors and implement a clear outlined plan to address them. Colleagues and hospital administration cannot ignore, dismiss, or explain away such occurrences. If disruptive behaviors are not addressed, nurses may experience role conflict and a sense of betrayal, which may serve to compound moral distress (Stone & Ajayl, 2013).

Health care organizations must foster foundational values that support a zero-tolerance culture for racism. The following is an example of how one large multi-site healthcare system has a zero tolerance for disruptive behaviors and the actions of nurse managers to observe and mitigate incivility. This organization expects nurse managers to be on their units and observe behaviors, especially at shift change. The nurse managers watch for nonverbal signs, such as raising eyebrows, making faces, etc., and stress a team (all of us) instead of an individual issue. Nurse managers are expected to mitigate disruptive behaviors such as nursing refusing to work with a particular nurse, ignoring a call to help with a patient that requires multiple nurses, and ostracizing a nurse without explanation. To support 'zero tolerance' the healthcare system put in place several strategies for nurse managers to follow: observe staff in action, conduct new nurse surveys to understand engagement (do you always feel welcome?). Nurse managers also set clear expectations with nursing teams about behaviors that are acceptable and those that are not acceptable. The also stress the importance of all nurses finding out facts of a complaint before reacting. The healthcare systems stress the importance of education of all nurses about appropriate behaviors. One nurse manager addresses appropriate behaviors during her monthly meetings where she dedicates 30 minutes to this discussion. "Nurse leaders are part of the access and delivery of equitable health care regardless of location of the care provided. As such, nurse leaders have a role in recognizing and mitigating care inequities. Nurse leaders must be continually aware of triggers that indicate when they should take action and counter bias by interrupting a situation." (Stamps, 2021)

Consequences of disruptive behaviors in nursing can lead to decrease in morale and affect retention, cause burnout, and can indirectly affect patient safety. In 2009 the Joint Commission (JC) instituted a leadership standard mandating that facilities seeking accreditation institute

DRAFT

2521 policies to address disruptive behaviors among healthcare workers. Disruptive behaviors
2522 include overt and covert actions that are displayed by any healthcare worker and that threaten
2523 the performance of the healthcare team (TJC, 2008). Most frequently reported behaviors
2524 include emotional-verbal abuse. Disruptive behaviors threaten patient well-being due to a
2525 breakdown in communication and collaboration (Longo, 2010). In a study of 4,539 healthcare
2526 workers, 67% felt there was a linkage between disruptive behaviors and adverse events, 71%
2527 felt there was such a linkage with medication errors, and 27% felt there was a linkage with
2528 patient mortality (Rosenstein & O'Daniel, 2008)
2529
2530 Health care institutions must view racism as a preventable harm and address it with the same
2531 fervency devoted to other preventable harms that have been prioritized for decades. Prior
2532 attempts to address racism in health care, institutions have not resulted in sustained cultural
2533 change because conscious and unconscious racial biases have not been addressed (Watson and
2534 Malcolm, 2021).
2535
2536 **Dual Harm**
2537 Racism is an assault on the human spirit (Defining Racism, 2021) from the interplay
2538 (intersection) of biases, discriminations, classism, colorism, micro and macroaggressions, and
2539 the legacy of historical trauma. Racism causes *dual harm* for both the nurse and the patient, in
2540 at least three dimensions of health care:(1) impacting patient care, thought processes, and
2541 communications of all healthcare providers to each other, their patients, and themselves; (2)
2542 influencing patient care of historically marginalized, racialized patients by guiding assessment
2543 and treatment decisions, promoting racialized stereotypes, and severely limiting patient
2544 accessibility to quality health care; (3) harming historically marginalized nurses through
2545 internalizing racial stereotypes, stigmas and racist labels, causing moral distress, job
2546 dissatisfaction, and career invisibility and stagnation.
2547
2548 It is a core nursing responsibility to protect the humanity, dignity and human rights of all
2549 patients and colleagues, yet harm persists from an ethical practice and patient safety
2550 perspective. According to all nine precepts of the ANA Code of Ethics, (Brunt, 2016) as ethics
2551 are breached, patients and families suffer. This is especially true for the historically
2552 marginalized with chronic health conditions such as hypertension, asthma, diabetes, heart
2553 failure, kidney disease and COVID 19 (Williams et al., 2010; Webb Hooper et al., 2020). In the
2554 BIPOC population, these conditions are often at higher rates, beginning earlier and treated later
2555 than their White counterparts, with poorer outcomes (Ignaczak & Hobbes, 2020). In addition,
2556 risk assessments that are based on a faulty belief that different races have intrinsically different
2557 biologies contribute to faculty diagnoses and treatment (Bailey, Feldman, and Bassett, 2021).
2558
2559 Nurses who are racialized (the act of grouping marginalized populations or people together
2560 under a racial category or racist ideology/ism (*Racialize*, 2021) experience racism as an

DRAFT

historical trauma originating from suppression and oppression, White privilege, and the systemic racism embedded in the mainstream culture. As one BIPOC nurse educator stated, “with an… overwhelming sense of solitude…the struggle to see my own reflection or likeness in the nursing professorate has been particularly sobering” (Thompson, 2021, p. A1). The same pervasive racism within nursing, characterized by bias, microaggressions, white privilege and bullying (Dawson, 2021) is also implicated in the health inequities faced by the patients BIPOC nurses care for. This *dual harm* from racial trauma is also implicated in moral injury, described as “damage to our very souls” (Khan, 2021), and increased willingness to leave the profession (AMH Healthcare, 2019).

Racism is a preventable harm and can be mitigated by intentional actions to change belief systems and social and organizational practices that contribute to *dual harm* from structural racism, which is invisible unless one looks for it, as it is ingrained in the structures, beliefs, policies and practices of our healthcare system (Nardi et al., 2020). Policies must be in place for responding to inappropriate behavior towards historically disadvantaged nurses and patients. Protocols that follow root cause and debriefing processes for harmful behavior scenarios should be developed, tested and taught, with expectations for their proper use made clear to all who manage or teach nurses in all levels and areas of nursing practice. Nursing practice begins with education, including an antiracism curriculum that prepares students at all levels and specialties for the care of an increasingly diverse population in the U.S. Educators must familiarize themselves with the antiracism frameworks for use in curriculum design, with real world situations and case studies for discussion and resolution at all education levels. These and other antiracism actions must be in place to prevent entrenched and pervasive dual harm to nurses and their patients in all areas and levels of healthcare

Inequity of Policy, Practice, Opportunity

In 1987 The Hudson Institute created a stir with its report *Workforce 2000: Work and Workers for the 21st Century* (1987, Johnson & Packer). There are two trends from that report that inform the issues of diversity, equity and inclusion today. Standing in the timeline of 1987, the writers accurately forecasted that by end of the 20th century the workforce would disrupt what was then the status quo by becoming older more female and more disadvantaged. “Only 15% of the new entrants to the labor force by the year 2000 would be native white males compared to 47% in that category today.” (p. xiii) One other anticipated trend highlighted that service industry jobs would hold a commanding position and would require a more educated workforce operating at a higher skill level. The report recommended that policy makers had several tasks before them; two of which were: the integration of Black and Hispanic workers fully into the economy and the improvement of educational preparation of all workers. What were once 1987 probabilities are now social realities.

DRAFT

The Covid Pandemic is rightly considered an epoch in human history. The “before times” are a line of demarcation for current attention to calls for change related to social justice, social inequities and systemic and structural racism. The designation of systemic racism as a public health crisis is singularly significant. Whether declared a “serious public threat” by the CDC and the AMA or a “public health crisis” by the APHA, strong appeals for change that is intentional through strategy, policy, advocacy and leadership is at the forefront of insistence for substantive change. What is now in place for the health services workforce, its leadership and its care design has failed to yield what is expected. Inequities, inequalities, disparities that exemplify race-based differences in data related to morbidity and mortality rates have become intolerable. What is especially insupportable is the availability of evidence establishing the issues (Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, 2003) effective interventions (In the Nation’s Compelling Interest: Ensuring Diversity in the Health-Care Workforce, 2004) and Organizational design to address a multicultural society in need of health services (Culturally and Linguistically Appropriate Services, 2000).

Dr. Martin Luther King spoke of the concept he called gradualism. The word connotes the many slow small steps taken to reach a large, visionary goal. Bias and discrimination have haunted nursing since the days when minority nurses were segregated within the profession and its opportunities. One fellowship expressed the inclusive vision for nursing as the individual experience of the Our pursuit of excellence not impeded by race or any aspect of identity. That this pursuit was for the benefit of the common good and to enable those who come together for the acquisition of knowledge, skills and competencies, the opportunity to pursue their own vision of practice from a position of superior performance. That the goal of such excellence welcomed innovative thinking informed by a broad range of values, beliefs and ethical principles. (Hausman Fellowship) The ultimate goal is the intentional creation of a positive academic and employment environment for the BIPOC professional.

The following recommendations are suggested as an outline for the way forward in addressing diversity, equity and inclusion in the nursing workforce, the work environment in which care is delivered and the learning environment in which nursing education is delivered.

Nursing Education and its Learning Environment

Holistic Admission and Learning Environment

a) Factor in social determinants of educational preparation for college such as BIPOC dominant public-school systems, housing and food stability, school to prison pipeline ethos, etc as part of a holistic admission process
b) Establish Peer Support Group as part of school infrastructure for the BIPOC student to provide psychological and emotional support and safe space to discuss race- based challenges in campus life (AHANA, African, Hispanic, Asian, Native American)

DRAFT

c) Designate a DEI Ombudsman as part of School Leadership to monitor equity in school policies, review and intervene in individual problem
d) Provide expertise based Mentoring specific to the racial identity needs of the BIPOC student
e) Require DEI Training for Faculty and School Leadership
f) Track attrition and admission data for BIPOC students

BIPOC Workforce Recruitment, Retention and Career Progress

a) Establish curriculum for the non-BIPOC leader that teaches management skills needed for a multicultural workforce. This should include pointers on antiracism practices, managing raced based conversations to avoid “tip toeing” behavior, communication triggers in a diverse environment, culture-based interpretations of valued organizational behaviors to increase recognition of the BIPOC employee with potential, etc
b) Mentoring and Career Progression of Diverse staff. Track employees who have received awards, lead projects, participate in committees, pursue education in a particular area, support for BIPOC principle investigators, demonstrate behaviors that show a strong desire for success.
c) Monitor and increase BIPOC hires from internships, fellowships, workforce development programs.
d) Establish Employee Resource Affinity Groups aligned with Human Resources. This group helps build resumes by providing event planning skills, project management experience, presentation skills, finance management etc. It also provides safe space for transparency related to work life in the white dominant organization for the BIPOC professional.
e) Designate a DEI officer to oversee strategy, serve as a specific employee resource

Policy

Organizations operate through rules and procedures that maintain coherence related a specific agenda. Needed in nursing today is an accountability agenda that speaks to the reality of BIPOC specific issues. The incorporation of that reality into policy, procedures and practices that govern decision making is the long-standing lag in bringing change to problems of bias, discrimination and racism in the profession. Implementing strategies designed to address the presence and effects of racism requires the following actions:

a) Implementing Operational definitions related to the issues and meaningful to the setting committed to dismantling racism.
b) Set up an organizational plan with buy in from leadership, staff and employees with built in accountability for outcomes
c) Establish DEI as a programmatic approach with a line item in the organizational budget to make the work sustainable.

Nursing Burnout

DRAFT

2679 Burn out in Nursing is a well-documented subject. It is the major cause of Nurses leaving a
2680 particular position, institution, or our profession. Studies report that 31.5 percent of nurses left
2681 their job because of burnout in 2018. Compared to approximately 17% of nurses in 2007 cited
2682 burnout as the reason for leaving. (JAMA, 2021) In Nursing occupational stress, and subsequent
2683 compassion fatigue, moral distress are factors for all nurses. Factors that ultimately contribute
2684 to individual burnout. Despite this evidence, little has changed in health care delivery and the
2685 role of registered nurses. The prolonged COVID – 19 Pandemic, Social Injustice, and the Nursing
2686 shortage has further complicated matters. A study comparing understaffing of nurses in New
2687 York and Illinois was associated with increased odds of burnout amidst high patient volumes
2688 and pandemic-related anxiety. (Lasater, BMJ Qual Saf)
2689
2690 We can extrapolate findings from the fields of Psychology and Sociology to understand the
2691 impact of racism on BIPOC nurses given the limited number of studies on racism in nursing.
2692 Racism presents itself in different forms: Individual, Interpersonal, Institutional, and structural.
2693 For anyone experiencing racism, it can be a chronic source of psychological and physiological
2694 distress. We know mental and physical stress leads to burnout. Burnout brought on by racism.
2695
2696 A well sited study by Brondolo et al., 2009 found that participants experienced
2697 repeated exposure to racism, as often as weekly. Additionally, the study showed that
2698 participants experienced racism regardless of socioeconomic status, which supports the
2699 assertion that professionals/persons with higher education (e.g., nurses) are not exempt from
2700 exposure to racism. The study also found that Black/African American participants experienced
2701 more lifetime, i.e. chronic, exposure to racism than others. (Byers, Nursing Outlook)
2702
2703 The unspoken truth. During the ANA Commission on Racism in Nursing's open forum, real life
2704 experiences of racism were discussed. Multiple personal accounts of missed promotions,
2705 inappropriate co-workers, and managers has driven many BIPOC nurses to burnout.
2706
2707 Organizational leaders should understand that burnout tends to increase liability exposure,
2708 reduce patient satisfaction levels, and heighten reputational risk. Mitigation of stress (Burnout)
2709 in the workplace improves job satisfaction, retention, and patient outcomes.
2710
2711 **Breach of Ethical Obligations**
2712 The Code of Ethics for Nurses with Interpretive Statements (ANA, 2015) serves as the
2713 foundational ethical standard for values, norms and obligations of the nursing profession. By its
2714 very nature, racism is antithetical to the ethical ideals of the profession in its inherent
2715 perpetuation of disrespect, unfairness and harm. Code provisions and interpretive statements
2716 articulate explicit requirements for all nurses at the levels of individual as well as collective
2717 activities. As moral agents obligated by the Code in their practice, nurses have the
2718 responsibility to uphold these established and non-negotiable professional standards.

The nine Code provisions are broad and non-contextual, and accompanying interpretive statements provide more specific guidance in the application of each provision, including values and obligations which apply to all nurses – regardless of role, setting, or type of practice. Numerous provisions and associated interpretive statements articulate values and obligations that directly prohibit individual racist behaviors and attitudes as well as systematic racial inequities and injustice.

Although not a comprehensive list, relevant Code provisions include: Provision 1 – *The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.* Respect for human dignity and rights must underlie all nursing practice and be extended to all persons regardless of individual differences and in every professional relationship; Provision 5 – *The nurse owes the same duties to self as others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.* While this provision speaks primarily to extending the same duties to ourselves as others, the principle of according moral respect and dignity to all human beings regardless of personal attributes or life situation is at its core. It also speaks to striving for personal growth and excellence in nursing practice by routinely evaluating personal performance and learning about concerns, controversies and ethics relevant to standards of professional practice as well as themselves; Provision 6 – *The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.* Obligations under this provision relate not only to doing what is right, but doing no harm and treating people fairly – including professional colleagues – and the necessity for all nurses to help construct environments that foster ethical practice and professional fulfillment.

The realities and impact of racism in the workplace as described by nurses who have directly experienced it are reflected throughout this Commission's Report. Racism in the workplace contributes to preventable harm, moral distress and discrimination which the Code obligates nurses to advocate against. Nurse perpetrators as well as enablers of racism undermine respect and human dignity of BIPOC nurses who strive to provide safe, effective care to their patients. BIPOC nurses may also experience racist behaviors and attitudes emerging from patients and require support from nursing colleagues, management and leadership to mitigate potential harm. Finally, assuring efforts to establish and implement equitable policies, practice and professional opportunities for all nurses are a necessary part of establishing a culture and workplace where all nurses are treated fairly.

DRAFT

2757 **References**

2758 ANA. The Nurse's Role in Addressing Discrimination: Protecting and Promoting Inclusive
2759 Strategies in Practice Settings, Policy, and Advocacy. Position Statement. 2018. Retrieved from:
2760 www.nursingworld.org.
2761
2762 Caldwell E, Duffy N, Stamps D. The challenges of lagging diversity and inclusion in health care.
2763 *Advances in Clinical Medical Research and Healthcare Delivery*. 2021; 1(1): Article 7.
2764
2765 Institute for Diversity in Health Management, Health Research & Educational Trust. Diversity
2766 and Disparities. Retrieved from:
2767 https://ifdhe.aha.org/system/files/media/file/2020/03/Diversity_Disparities2016_final.pdg.
2768
2769 Rasmussen BM, Garran AM. In the line of duty: racism in health care. *Soc Work*.
2770 2016;61(2):175-177.
2771
2772 Sue DW. Racial Microaggressions in everyday life. *American Psychologist*. 2007. Retrieved from:
2773 https://www.cpedv.org/sites/main/files/file-attachments/how_to_be_an_effective_ally-
2774 lessons_learned_microaggressions.pdf
2775
2776 Torino G, Rivera D, Capodilupo C, et al. Microaggression Theory: Influence and Implications.
2777 2019. Hoboken, NJ: John Wiley & Sons.
2778
2779 Vogel L. Doctors on their own when dealing with racism from patients. *Canadian Medical*
2780 *Association Journal*. 2018;190(37):118-119.
2781
2782 Wheeler M, de Bourmont S, Paul-Emile K, et al. Physician and trainee experiences with patient
2783 bias. *JAMA* Intern Med. 2019;179:1678.
2784
2785 Joint Commission. Behaviors that undermine a culture of safety. Sentinel Event Alert. 2008.
2786 Retrieved from: https://www.jointcommission.org/-/media/tjc/documents/resources/patient-
2787 safety-topics/sentinel-event/sea_40.pdf
2788
2789 Longo J. Combating disruptive behaviors: strategies to promote a healthy work environment.
2790 *OJIN*. 2010;15(1):Manuscript 5
2791
2792 Rosenstein AH, O'Daniel M. A Survey of the Impact of Disruptive Behaviors and Communication
2793 Defects on Patient Safety. *Joint Commission Journal on Quality and Patient Safety*. 2008;
2794 34:464-471.
2795

DRAFT

2796 Stamps DC. Nursing leadership must confront implicit bias as a barrier to diversity in health care
2797 today. *Nurse Leader*. 2021. Article in Press.
2798
2799 Stone TE, Ajayl C. There comes a time when silence is betrayal: racism and nursing. *Nursing and*
2800 *Health Sciences*. 2013 ; 15(4): 407-409.
2801
2802 Watson L, Malcolm M. Racism as a preventable harm. *Nurs Adm*. 2021;45(4):302-310. Retrieved
2803 from: https://pubmed.ncbi.nlm.nih.gov/34469388.
2804
2805 AMH Healthcare. (2019). *2019 Survey of Registered Nurses: A Challenging Decade Ahead*.
2806 Retrieved from 2019 AMN Healthcare Survey of Registered Nurses: A Challenging Decade
2807 Ahead
2808
2809 Bailey, Z., Feldman, J. & Bassett, M. (2021). How structural racism works-racist policies as a root
2810 cause of U.S. racial health inequities. *New England Journal of Medicine*.384 (8). 768-773. How
2811 Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities |
2812 NEJM
2813
2814 Brunt, B. (2016). EVERYDAY ETHICS: A look at ANA's updated Code of Ethics and the everyday
2815 challenges nurses face. *Ohio Nurses Review*, *91*(2), 14–16.
2816
2817 Dawson, (Spring 2021). Letter from the President: Professional-based mental health issues
2818 among nurses. *NBNA News.* p. 7-8. NBNA Spring 2021 Mental Health Additions Proof05.pdf
2819
2820 *Defining Racism*. (2021). American Nurses Association.
2821 https://www.nursingworld.org/~49f737/globalassets/practiceandpolicy/workforce/commission
2822 -to-address-racism/final-defining-racism-june-2021.pdf
2823
2824 Ignaczak, N. M., & Hobbes, M. (2020, April 8). *Black People Are Dying Of COVID-19 At Alarming*
2825 *Rates. Here's Why.* HuffPost. https://www.huffpost.com/entry/black-people-are-dying-of-
2826 covid-19-at-alarming-rates-heres-why_n_5e8cdb76c5b62459a930512a
2827
2828 Khan, A. (2021) Moral Injury and Systemic Betrayal in the United States. *Science and Philosophy*
2829 Moral Injury and Systemic Betrayal in the United States | by Amanda J. Khan | Science and
2830 Philosophy | Medium
2831
2832 Nardi, D., Waite, R., Nowak, M., Hatcher, B., Hines-Martin, V., & Stacciarini, J.-M. R. (2020).
2833
2834 Achieving Health Equity Through Eradicating Structural Racism in the United States: A Call to
2835 Action for Nursing Leadership. *Journal of Nursing Scholarship: An Official Publication of Sigma*

2836 *Theta Tau International Honor Society of Nursing*, *52*(6), 696–704.
2837 https://doi.org/10.1111/jnu.12602
2838 *Racialize*. (2021). https://www.merriam-webster.com/dictionary/racialize
2839
2840 Thompson. (2021). Increasing racial/ethnic diversification of nursing faculty in higher ed is
2841 needed now. *Journal of Professional Nursing*, *37*(4), A1–A3.
2842 https://doi.org/10.1016/j.profnurs.2021.05.007
2843
2844 Webb Hooper, M., Nápoles, A. M., & Pérez-Stable, E. J. (2020). COVID-19 and Racial/Ethnic
2845 Disparities. *JAMA*, *323*(24), 2466–2467. https://doi.org/10.1001/jama.2020.8598
2846
2847 Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status,
2848 and health: Complexities, ongoing challenges, and research opportunities. *Annals of the New*
2849 *York Academy of Sciences*, *1186*, 69–101. PubMed. https://doi.org/10.1111/j.1749-
2850 6632.2009.05339.x
2851
2852 American Nurses Association. (2015). Code of ethics for nurses. American Nurses Publishing:
2853 Washington, D.C.
2854 Megha K. Shah, MD, MSc; Nikhila Gandrakota, MBBS, MPH; Jeannie P. Cimiotti, PhD, RN; Neena
2855 Ghose, MD, MS; Miranda Moore, PhD; Mohammed K. Ali, MBChB, MSc, MBA Prevalence of and
2856 Factors Associated with Nurse Burnout in the US. JAMA
2857
2858 Ophelia M. Byers, DNP, APRN, WHNP-BC, NEA-BC, CPXP, Joyce J. Fitzpatrick, PhD, MBA, RN,
2859 FAAN, Patricia E. McDonald, PhD, APRN, Germaine C. Nelson, DNP, MBA, RN, NEA-BC, CEN,
2860 CPXP. Giving while grieving: Racism-related stress and psychological resilience in Black/African
2861 American registered nurses. Nursing Outlook 2021
2862
2863 Lasater KB, Aiken LH, Sloane DM, French R, Martin B, Reneau K, Alexander M, McHugh MD.
2864 Chronic hospital nurse understaffing meets COVID-19: an observational study. BMJ Qual Saf.
2865 2021 Aug;30(8):639-647. doi: 10.1136/bmjqs-2020-011512. Epub 2020 Aug 18. PMID:
2866 32817399; PMCID: PMC7443196.

DRAFT