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# Racism and Nursing Leadership in Massachusetts

## *A Mixed-Methods Study*

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**BACKGROUND:** Nursing in the United States has evolved within the same historical context that has reproduced and spread racism worldwide. Nurse administrators are integral to the quality of nurses' practice and play a key role in eliminating racial injustice in places of work.

**PURPOSE:** Using a feminist and critical race feminist framework, this study examined Massachusetts nurses' experiences of racism in their places of work, focusing on nurse administrators' influence on the nonadministrator (staff nurse) experience of racism experiences before and after George Floyd's death.

**METHODS:** An investigator-developed, electronic survey was sent to Massachusetts professional nursing organizations for distribution to their members in 2021. Two hundred nineteen nurse respondents completed Likert-scale and open-ended branching logic survey questions to yield the quantitative and qualitative data analyzed for this mixed-methods study.

**FINDINGS:** Nurse administrators were: 1) more likely than staff nurses to state that policies and meetings to address racism and diversity, equity, and inclusion had taken place before and after George Floyd's murder; and 2) less likely than staff nurses to directly experience racism at the hands of a colleague or a superior. Nurse administrators influence staff nurses' experiences of racism.

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Race-based thinking, the belief that people can be categorized based on their physical features, has led to the devaluation of people of color for centuries.[1,2] Racially motivated prejudices are deeply entrenched in social practices worldwide.[3] They lend "a veneer of legitimacy to prejudice."[4]

Nursing is not immune to the demeaning impact of oppressive race-based behaviors and beliefs. Despite a notable professional commitment to serving all people,[5] nurses' actions as well as nursing's practice context have overtly and covertly acted to condone, foster, and reproduce racism worldwide. Nursing's formal, bureaucratic structure with its notions of the benefit of whiteness,[6] superiority,[5] and rankism (social practices that engage those in power in the shared denigration and exploitation of others to ensure that those who hold power—most often those

in the dominant social group—maintain their power continues to perpetuate racism in nursing practice.[7] Study findings reported here describe how nurse administrators in Massachusetts influenced staff nurses' experiences with racism.

## Racism: Viewed Through a Critical Race Feminism Lens

Feminism and critical race feminism (CRF) provide the framework for this study. Feminist theory attends to issues of inequality and inequity where they intersect along race, gender, sex, and class and addresses the power dynamics among nurse leaders and staff despite gender and/or race.[8] Rooted in critical race theory (CRT), which posits that racism is so embedded in the social and political institutions that is accepted and normalized within our daily lives.[9,10] CRF extends this paradigm and recognizes that women of color voices are often excluded in the examination of racial discrimination within traditional CRT.[11] Therefore, both theories provide a lens for examining and understanding racism and discrimination, as well as the power dynamics among the study participants.

## Background

The events in spring 2020, including the murder of George Floyd in May and the disproportionate impact of COVID-19 on communities of color, produced a "watershed moment" for nursing.[12] Although these complex events heightened awareness and attitudes about racism, beliefs and practices about diverse individuals remained deeply ingrained, and real change in behavior did not materialize. The pro-race sentiment quickly faded, falling victim to the inertia that has maintained racist hierarchies worldwide over generations.

In nursing, as elsewhere, racism continues to flourish. Findings of numerous studies suggest that healthcare providers may unintentionally practice in ways that foster racism; Wilkins and colleagues[13] noted "the nobleness of medicine and nursing has long provided a cover" for perpetuating racism. Moreover, racism's embeddedness in communicating, thinking, and acting has limited access to leadership positions in nursing for people of color. The aim of this study was to describe the influence of antiracist policies and nurse administrators' behaviors and actions on Massachusetts nurses' experiences of racism.

## Methods

Following approval by the Mass General Brigham institutional review board, investigators forwarded an investigator-developed, electronic survey to professional nursing organizations throughout the Commonwealth of Massachusetts: American Nurses Association Massachusetts, the Organization of Nurse Leaders, the New England Regional Black Nursing Association, Cape Verdean Nurses Association, Philippine Nurses Association of New England, and the Hispanic Nurses Association. The conveying email requested nursing organization leaders to distribute the invitation to participate in the survey with their membership. Individuals were then able to click on a secure deidentified coded link to the REDCap (Vanderbilt University, Nashville, Tennessee) survey. Instructions requested respondents answer questions that described their experiences with racism within their organizations before and after the murder of George Floyd, and completion of survey implied consent. Survey questions were developed by the research team according to psychometric principles and methodological concepts.[14] Construct validity was assessed by having a group of 15 independent nurse administrators and staff nurses complete the survey.[15] Extensive discussions and subjective judgment were used to address whether the questions measured what they were intended to measure. Qualitative data were reviewed by 2 teams of raters to identify consistency between interpretations.

The survey comprised 14 demographic items and 40, 4-item Likert scale questions that incorporated 17 branching logic open-ended questions. Quantitative data were analyzed for frequency distribution, logistic regressions, and odds ratios. Qualitative data were analyzed using the constant comparative method.[16] Qualitative data were evaluated by a team member utilizing the NVivo 12 platform (Lumivero, Denver, CO). Triangulation of the qualitative data was completed and resulted in a 97.6% agreement between themes that emerged from the traditional and the NVivo approaches.

### Demographics

Two hundred nineteen nurses completed the online survey. Women represented 83% of survey respondents (n = 182). Female respondents' mean age was 45 years. The mean age of participating men was 37 years (Supplemental Digital Content 1, http://links.lww.com/JONA/B112). Reported races were 66% (n = 145) Caucasian, 21% (n = 45) African American, and 13% (n = 29) other (Supplemental Digital Content 2, http://links.lww.com/JONA/B113). Degree attainment was reported as 31% (n = 67) baccalaureate degree, 32% (n = 69) master's degree, and 22% (n = 47) doctoral degree. Sixty-eight percent (n = 150) of respondents reported annual incomes of $50,000 to > $150,000. Sixty-nine percent (n = 149) reported practicing in an urban location (Supplemental Digital Content 3, http://links.lww.com/JONA/B114); 31%

(n = 66) reported being in nursing administrative roles (Supplemental Digital Content 4, http://links.lww.com/JONA/B115).

### Findings

Gaps between policy expectations and appropriate practice responses described in the literature were identified in the analyses. Specifically, study data suggested that administrators' experiences and practices often served to influence staff member respondents' experiences of racism.

## "All Talk and No Action"

Quantitative analyses conducted for this study suggested that nurse administrator respondents were more likely than staff nurse respondents to report that policies were in place to address racism both before (78% vs 61%, $P = 0.0180$) and after May 2020 (77% vs 69%, $P = 0.2531$). The association between pre– and post–May 2020 findings remained significant when the comparison was adjusted for race (Black vs White; odds ratio [OR], 2.25; 95% confidence interval [CI], 1.14-4.45; $P = 0.0197$). Despite organizational policies, respondents' narratives spoke to the overall ineffectiveness, noting "the new movement is nice but nothing new. Lots of words. Lots of 'conversations' and attempt at policy change but no real action" and "the employers have some initiatives but the people most racist, especially leaders, never attend."

In addition, respondent comments suggested that there was little follow-up of policy expectations and that policies represented rules without attendant action and relevant change and suggested the need for active nursing leadership: "I figured out that the system is designed to perpetuate racism.… The leadership in charge of supervisors came up with excuses for her behavior to protect her by stating ongoing identified problems mostly affecting Black Indigenous people of color (BIPOC) as simply systemic 'communication issues' within the department." Overall, respondent comments collectively suggested a sense of futility regarding effective leadership for antiracist change.

## "Nothing Would Be Resolved"—Unchanging Leadership Practices

Quantitative study data suggested that after May 2020, nurse administrators were more likely than nonadministrators to report that meetings were held to discuss racism policies (72% vs 43%, $P = 0.0002$). This association remained significant (OR, 3.22; 95% CI, 1.67–6.18; $P = 0.0004$) when adjusted for race (Black vs White). Moreover, relative to nursing staff members, nurse administrators were more likely to report that the meetings had been held to discuss diversity, equity, and inclusion (DEI) (71% vs 45%, $P = 0.0006$). This comparison remained significant (OR, 2.92; 95% CI, 1.54-5.55; $P = 0.0010$), as well when adjusted for race (Black vs White).

Concomitantly, qualitative data suggested that policy development and informational meetings failed to result in meaningful change. One respondent indicated that without leadership change, nothing else would change: "keep(ing) the same leaders but roll(ing) out these major changes, my opinion is that nothing really will change."

Study data indicated that nurse administrators were less likely to report experiencing racism than were nonadministrators both before May 2020 (17% vs 34%, $P = 0.0135$) and after May 2020 (18% vs 23%, $P = 0.0473$). Nurse administrators were also less likely to report experiencing racism by a supervisor than nonadministrators both before (15% vs 32%, $P = 0.0120$) and after May 2020 (13% vs 26%, $P = 0.0445$). Although the number of Black nurse administrators was small (n = 9), they were more likely than White nurse administrators to experience racism by a supervisor (33% vs 10%, $P = 0.1033$). This suggests that nurse administrators may be insulated from the challenges of racism experienced by staff.

Prior to May 2020, Black nurses, regardless of work role, were more likely to report personally experiencing racism by supervisor than were White nurses (OR, 4.03; 95% CI, 1.89-8.58; $P = 0.0003$). This finding remained significant after May 2020 (OR, 2.73; 95% CI, 1.26-5.91; $P = 0.0003$). Experiences of racism left many participants feeling not heard, voiceless, and/or not valued. Nurse administrators' lack of action was expressed by respondents: "Nothing would be resolved by reporting, there would be retaliation from management" and "My experience in reporting racism to leadership who are often White has yielded an indifference to the racism and no action." Finally, given the significance of nurse leaders' inaction in eliminating racism, one respondent commented: "Leadership was involved in the racism/discrimination."

## Discussion

Participants' voices clearly highlighted the systemic racism embedded in their daily work. Study data demonstrated that just relying on policies, procedures, and meetings has yet to foster effective change. Consistent with published findings as noted previously, findings of this study suggested that organizational policies and procedures designed to address and rectify racist acts were ineffective on their own. There is a need for "recognizing and committing to call(ing) out racism and address(ing) it head on"[17,18]; otherwise, well-intentioned statements will not change organizational

culture. As important, leaders whose experiences do not match those of the staff they supervise may be ill-prepared to understand and support staff members' lived experiences.

Study results demonstrated the embedded nature of racism in nursing showing that, in many cases, nurse administrators' behaviors stymied efforts to change the patterns of interaction and behavior established and reinforced by features of workplace contexts. Further, study results suggested implications for strengthening nurse leaders' influence on racism.

### Implications for Nurse Leaders

Findings of this study indicate that nursing administrators can make important contributions to stemming racism in nursing and addressing the needs and concerns of staff nurses. Moreover, data suggested that White participants and those in administrative roles were more likely to endorse beliefs that racism and DEI policies and procedures were positively incorporated within the clinical environment, unlike Black participants who reported a different experience. Change begins with nurse administrators whose actions define the tenor and the nature of relationships among the people they supervise. Effective leadership must include establishing trust and psychological safety, building inclusive nursing teams, utilizing effective communication strategies, and creating healthy work environments.[19,20] Change is effective when nurse leaders ensure that all staff, especially diverse nurses, are seen, heard, and, most importantly, empowered and supported to address racist acts that have and continue to be ignored.

Results demonstrated that Black nurses were more likely to have experienced racism from a colleague than White nurses or nurses in other racial groups both before and after the George Floyd murder. In addition, Black nurses reported feeling marginalized, voiceless, discouraged, and sometimes lacking faith and confidence in their organizations. Black nurse administrators reported experiencing racist attitudes and actions to a greater degree than White nurse administrators and to a lesser degree than their staff nurse counterparts. Now more than ever, strong nursing leadership is essential in managing the growing complexity in healthcare. Nurse leaders shape the culture of their units and departments through their actions. They are responsible for creating a workplace where all nursing staff feel safe, valued, appreciated, and supported and can voice their concerns. This is essential to creating a sense of belonging and supports job satisfaction and staff retention.

Despite numerous expressed commitments to change in the immediate aftermath of George Floyd's 2020 murder, little meaningful change in nursing regarding racism has been enacted, according to these study participants. Workplace systems continue to perpetuate racism, especially when most nurse administrators are White.[21] The National Commission to Address Racism in Nursing details the concept of seniority, in which racist structural and systemic practices advantage White nurses.[22]

Rankism[7] and racism have led to disparities in the quality of care for diverse patients. Furthermore, it has limited access for diverse individuals to positions of leadership and authority in organizations.[20] Participants suggested the significance of leadership behaviors that foster inclusion, open and effective communication, and healthy work-life balance to undermine the "cultural conditioning" that has acted for centuries to subtly, but powerfully perpetuate racism. As one study respondent shared, "I had been actively involved with supporting BIPOC and anyone that was marginalized for many years. Social justice, diversity, and inclusion will only succeed if leadership is evaluated. If the plan is to keep the same leaders but roll out these major changes, my opinion is that nothing really will change."

### Limitations

This study has several limitations. First, this convenience sample was recruited from a single state in the Northeast United States. Survey participation was limited to nurses from professional nursing organizations who received a recruitment email. The survey consisted of self-report measures. Although statistically significant, the sample size was small, and much of the sample identified as female and White.[21] A more diverse sample by gender and race may have yielded different results. The number of minority respondents who did not identify as Black or Latinx was too few to differentiate common themes.

## Conclusion

Nursing's formal, bureaucratic structure has and continues to perpetuate nurses' racist practices, despite a notable professional commitment to serving all people. Massive social change, including heightened attention to racial insensitivity, followed in the aftermath of George Floyd's murder. Fittingly, in healthcare institutions, antiracist policies proliferated in response to the death of George Floyd and other Black Americans. The roles policies played in securing lasting, antiracist social change, however, remain unclear.[23] Policies' eventual outcomes are significantly influenced by the ways in which they are implemented.[24]

Additional research is needed to elucidate the pervasiveness of racism and examine how organizations can successfully create environments in which racism is eliminated. A cultural shift is required to combat the deleterious consequences of racial aggression, unequal treatment, and discrimination at all levels

of nursing, particularly in nursing leadership.[15] This is especially critical as we as nurses face a nursing shortage and a more diverse patient population. Beyond merely developing policies that assert goals of change in organizations, effective leaders must incorporate all voices in defining and acting on racism while steadily moving forward and not reverting to "because we've always done it this way."



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