



Contents lists available at ScienceDirect

The Journal for Nurse Practitioners

journal homepage: www.npjjournal.org



By Faculty for Faculty

The Decolonization of Nursing Education

Michelle Zappas, Benita Walton-Moss, Cynthia Sanchez, Janett A. Hildebrand,
Tracie Kirkland

ABSTRACT

Keywords:
diversity
nursing education

In the era of COVID-19, coupled with a community in tune to Black lives, the call to action is now. It is now time to stop, listen, and be intentional in efforts to create sustainable policies and programs that shape the ability to deliver culturally competent care to diverse patients, families, professionals, and communities. Our recommendations for how faculty and academia can decolonize nursing education are delineated in this article. All nursing schools and departments should form a diversity, equity, and inclusion (DEI) committee, if they have not already done so. DEI committees can help thread Social Determinants of Health throughout the curriculum, highlight and address microaggressions, and develop formal and informal mentorship programs. As nurses, we must continue the discussion of race with humility but without denial and defensiveness. Subtle racist biases may be unintentionally internalized, and it is our moral and ethical responsibility to recognize these and fight them so that they do not result in prejudicial policy, practice, research, and education. Faculty should celebrate diversity through an exchange of ideas and open communication despite differences in race, gender, sexual orientation, religion, age, social class, or disability.

Published by Elsevier Inc.

The recent, senseless murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and others have set into motion a global antiracist revolution. In response institutions, including higher education, organizations, and companies, have developed statements pledging their promise to fight racial injustice. During this dynamic time of heightened awareness, many of us are wondering how we can transform the performative nature of these statements into a formative plan. The recent events have underscored, yet again, that systemic and institutional racism continues to exist in our country. Systemic racism encompasses lack of access, inferior medical treatment, limited economic opportunities, environmental safety, educational resources, and a discriminatory judicial system that have left Black, Indigenous, and People of Color (BIPOC) communities disadvantaged for far too long.

One of the central tenets of nursing is to do no harm. Yet the prevalence of racism, implicit bias, and social disparities within our health care system harm our BIPOC patients, families and communities. The field of nursing is not immune to institutional biases. The profession is predominantly White in the United States, and White nurses tend to hold more powerful and profitable clinical and leadership positions.¹ Seventy-three to 81 percent of nurses in the United States identify as White,^{2,3} and 81% of nursing faculty are White.⁴ There is a privileged fragility that comes with being in the dominant group. White fragility describes the defensive, reactionary, disbelieving behaviors that White people display when their ideas about race and racism are challenged.⁵

Nursing has an obligation to dismantle racism based on a social justice and ethical ethos. Our call as nurses has always been to serve the health and well-being of the community. Combating racial injustice and inequities in our health care system requires a dedicated effort. It necessitates that we, as health care providers, community advocates, educators, liaisons, and citizens, listen, learn, and relearn. Equal and quality health care is a human right for all. Let's continue the antiracist discourse regarding social positionalities to uphold our social responsibility to the patient. What follows is “by faculty, for faculty,” outlining our recommendations on how we may improve the health of patients who have been institutionalized, excluded, and dehumanized. These include (1) examining of nursing curricula and integrating of social determinants of health (SDoH), (2) understanding and actively combating microaggressions, and (3) exploring opportunities for mentorship and advancement of minority faculty and students.

Curricular Changes and Social Determinants of Health

Racial health inequities include poor access, delayed diagnosis, misdiagnosis, underdiagnosis, and undertreatment.⁶ Deeply rooted in the historical atrocities such as Tuskegee and Henrietta Lax exists an inherent mistrust of the medical community, which can result in

delayed access to care. There are also larger systems and policies that play a role in establishing and perpetuating health disparities including zoning policies and redlining. Black people are more likely to live in environmentally unsafe areas and less likely to have sufficient health insurance, access to primary care providers, quality nutrition, and places to exercise.⁶

These health disparities have become even more apparent during the COVID-19 pandemic. African Americans comprise 13% of the US population and are disproportionately affected by COVID-19. A recent Centers for Disease Control and Prevention *Morbidity and Mortality Weekly Report* reported race and ethnicity data from 580 patients hospitalized with lab-confirmed COVID-19.⁷ Forty-five percent of individuals were White, compared with 59% of individuals in the surrounding community.⁷ Thirty-three percent of patients who were hospitalized were Black, compared with 18% in the community.⁷ Among deaths related to COVID NYC data categorized the death rate among Black/African Americans at 92.3 per 100,000 population, Latinx represents 74.3, White 45.2, and Asian 34.5.⁷ In short, the Black community is more likely to be severely affected and die from COVID compared with their white, Latinx, and Asian counterparts.

In 2013, Sasha Abramsky's *The American Way of Poverty. How the Other Half Still Lives*⁸ revisited Michael Harrington's *The Other America. Poverty in the United States*, written in 1962, and found that the plight of the poor remained unchanged and the financial collapse of 2008 absorbed more individuals into the fold of poverty. The current COVID-19 crisis has extended the arm of poverty to reach victims that are even more vulnerable. The literature is replete on the health care divide shaped by SDoH. Blighted communities cultivate chronic disease with poor outcomes, subsidized housing, homelessness, crime and violence, food insecurity, high unemployment rates, and substandard educational programs. Disadvantaged communities abet a cycle of scarcity, discrimination, and hopelessness that stunts life trajectories because of the lack of social habitus necessary to transition beyond the borders of impoverishment.

The Chronic Care Model provides a framework that incorporates SDoH in the context of community and health systems to engage patients to improve outcomes.⁹ As one of the largest groups in the health care profession, nurses touch the patient in all care settings: homes, schools, community centers, outpatient clinics, extended care facilities, and hospitals. Given our wide reach, nurses have the ability to influence health disparities related to social determinants by addressing them with an upstream approach. This requires all levels of nursing education to consider modifiable, contextual factors responsible for illness, including social injustice and inequality.

Nursing curricula in general does not address racism. It is non-inclusive and perpetuates dominant norms, specifically Eurocentric normativity.¹ A critical defect in curricula is the portrayal of race as a biologic rather than a social construct.¹ This has been denounced since the 1950s; however, race continues to be depicted as a risk factor or even causal of a disease.¹ Health disparities may seem as though they are the result of race if SDoH does not remain a curricular focus.¹ Blanchet Garneau, Browne, and Varcoe¹⁰ outlined a critical antidiscriminatory pedagogy (CADP) as a way to decolonize the curricula. To illustrate how to do this, they gave an example of how diabetes education can be transformed with CADP:

For example, educators teaching about diabetes from a CADP would integrate attention to power dynamics at the outset by underlining the role of poverty and racial discrimination in the etiology of diabetes, and the intersecting factors such as low income, racism, and gendered inequities that can limit food security and access to health care. Such education would draw attention to the evidence base regarding the global epidemic of diabetes among

Indigenous people and the colonial epigenetic factors underlying that epidemic.

Nursing faculty at all levels, from associate's degree to doctoral level, can start by the SDoH throughout the curriculum in a proactive, sustainable way. Framing disease from a CADP is one way; examining case studies used in learning is another. Keeton suggested that race and ethnicity, which have been included as an essential component to introduce case scenarios, may in fact, be superfluous. Including race and or ethnicity along with age and gender in the introduction of the case teaches the student to begin the clinical reasoning process that race is equally relevant. There are several layers to this practice being problematic. There is a lack of evidence that race and ethnicity have an influence on the outcome, and introducing it in the case stem may lead students to look for associations where none exists. Race or ethnicity can be included where necessary in the social history, along with occupation or living situation, and if race is included in a case scenario, evidence-based context as to why it is relevant should be provided.¹¹ The accompanying Table synthesizes the recommendations of the US Preventative Services Task Force with American Diabetes Association, American Urological Association, the Eighth Joint National Committee, and other national guidelines in terms of when recommended screening and treatment variations exist based on race and ethnicity.

Faculty should ensure that there are evidence-based reasons for their inclusion of race or ethnicity in a case scenario for the purposes of discussion of genomics that influence treatment or prevention screening, health disparities, or the cumulative epigenetic effects due to generations of exposure to discrimination and injustice. Faculty who want to diversify their case scenarios may inadvertently (or purposefully) reinforce misinformed stereotypes about racial or ethnic groups that can be seen as offensive by students and other faculty and resulting in microaggressions targeting BIPOC. Canales describes this as exclusionary "Othering"—utilizing the power within the relationships for subordination and domination.¹²

Canales described the process of understanding and interacting with those perceived as different from ourselves as Othering. She posited that the opportunity is present in dealing within groups of people to be exclusionary as in the preceding example, or to be inclusionary and use the power within the relationships for transformation and coalition building. Exclusionary Othering frequently is influenced by the visibility of one's Otherness; it can be skin color, accent, language, age, gender, or gender identity. These attributes can become stigmatizing features that are discredited. The costs of exclusionary othering are often marginalization, internalized oppression, and exclusion. In the context of health care systems, this can lead to poor health outcomes.¹²

Inclusionary Othering, by contrast, encompasses connecting as allies; difference is used as tool to bridge connections. We see ourselves and Others and perceive how different lives and experiences are connected, then work together to achieve common ground. Strategies that faculty can employ to move away from exclusion toward inclusion are to create opportunities for students to interact directly with communities of Others. Empowerment of those perceived as Others will occur when nurses respect and value their abilities, strengths, and experiences. Mutual empowerment can be attained through inclusion. Supporting students' recognition of knowing that we are connected and engaging Others is work that requires a long-term faculty commitment. This can be achieved through dialogues, engagement across established borders, and self-reflection.¹³

McGibbon et al posited that this process involves affirming indigenous knowledge to reveal the richness of worldviews,

Table
Recommended Screening and Treatment Variations Based on Race and Ethnicity^a

	Signs and Symptoms Are Different for Racial/Ethnic Groups	Screening Recommendations Are Different for Racial/Ethnic Groups	Treatment is Different for Racial/Ethnic Groups	Risk Is Affected by Race/Ethnicity
Hypertension	No	No	Yes	Yes
Diabetes	No	Yes	No	Yes
Breast cancer	No	No	No	Yes
Obesity	No	Yes	No	Yes
Alcoholism	No	No	No	Yes
Cervical cancer	No	No	No	Yes
Lung cancer	No	No	No	Yes
Colon cancer	No	No	No	Yes
Prostate cancer	No	Yes	No	Yes
Depression	No	No	No	Yes

^a Source: U.S. Preventive Services Task Force.²²

teachings, and experiences.¹⁴ They assert that the vast knowledge and experiences of those that Canales would refer to as Others has been systematically excluded from Eurocentric knowledge systems. One of the most forceful beliefs that supports the persistence of colonialism in nursing is that colonialism is a thing of the past, and because it happened a long time ago, it is over. There are no historical relations of power, and those who are marginalized should just “get over it”; we are all being treated equally. The structural racism in nursing is almost imperceptible and is related to privilege. Western science dominates nursing education, and historical accounts of the evolution of nursing as a profession facilitates the impression that Black and Indigenous nurses did not contribute to the leadership and evolution of nursing.

McGibbon et al also reiterated the assertion of Canales that nursing faculty have a responsibility to expose colonizing ideologies and to influence their students in their learning and practice environments.¹⁴ This work is difficult and involves role-modeling humility, as well as sharing one’s own shortcomings and biases. We need to make a commitment to deconstructing the colonizing values and structures in our methodology, our curricula, our practices, and our policies and procedures. We also need to introduce knowledge of the processes of public policy, how it is implemented and evaluated into nursing at the undergraduate level, and integrate it into nursing curricula.

Microaggressions

Microaggressions are the context in which BIPOC live and work in their daily lives. The concept includes offensive put-downs, invalidations, and demeaning behavior; these can be personal interactions through verbal or nonverbal communication, or they may be delivered environmentally through the media, educational curriculum, TV programming, monuments, mascots, offensive symbols, and through cyber victimization.¹⁵ Microaggressions can be purposeful to hurt and “keep in their place” BIPOC, or can be unintentionally delivered by well-intentioned White Americans who may be ignorant of the fact that they are engaging in racially demeaning behavior. The hostile environment that microaggressions create can affect education, employment, and health care.¹⁵

Macroaggressions involve the systemic racism that exists in institutions and the racial microaggressions that are contained within them. According to Huber and Solórzano, the ideology justifies the subordination of the interests of the nondominant group to that of the dominant group.¹⁶ Macroaggressions provide the ideological platform and structure to justify the actions of racism. In 1988, Judge Robert Carter in his reflection of *Brown v. Board* (1954) US Supreme Court decision used the metaphor of racial segregation

as the symptom and White supremacy the disease. Microaggressions go further than the perpetrator–target interaction; the acts themselves have a purpose, whether they are committed consciously or not, to maintain and substantiate a larger system of racial domination.¹⁶

Overt discrimination and subtle microaggressions have contributed to the stress-related biological changes causing illness.¹⁷ Chronic increases in cortisol is the major contributory hormone resulting in posttraumatic stress disorder, anxiety, depression, and gastrointestinal, endocrine, and cardiovascular illness.¹⁷ Microaggressions have many downstream effects and can affect future generations. In a systematic review of 25 studies, Nowak, Anderson, Mackos, and Gillespie found associations between maternal stress and epigenetic modifications to offspring DNA.¹⁸ The authors found that maternal perceived stress, anxiety, or depression were important determinants of maternal and infant health. They posited that these epigenetic changes increase preterm births and have long-term implications for the socioemotional well-being in children.

Nurse educators feel ill prepared to facilitate challenging discussions on key topics of “power, privilege, dominance, and institutionalized racism.”¹ Nursing faculty, predominantly White, lack the language, skills and confidence to address the topics that are critical in dismantling racism and teaching a decolonized curriculum.¹ It is imperative that nursing faculty find their voice to speak out against social injustice, even when they are the unwitting participant in the microaggressions that burden BIPOC. BIPOC and White allies need to take action to diminish and deflect microaggressions in the academic setting. When dealing directly with the perpetrator one can challenge stereotypes, broaden the ascribed trait to a universal human behavior; ask for clarification, express disagreement, state values and set limits, interrupt, and redirect. Strategies for disarming institutional macroaggressions are to boycott or protest the institution, request meetings with leadership, or notify the press or other media outlets.¹⁵

Other actions nursing faculty can take are to engage professional and personal development as they relate to cultural intelligence, racism, and facilitating challenging discussions. Faculty should work to familiarize themselves with antiracism literature. Departments can invite antiracist scholars and activists for student, faculty, preceptor, and staff trainings. Regularly scheduled open forums to discuss diversity, equity, and inclusion may help establish a safe place for the academic community. Communication lines among faculty, staff, and student that are open and safe for all to express their thoughts and feelings can help provide an inclusive environment in academia. As US Supreme Court Justice Sonia Sotomayor stated in her 2014 dissent to the decision to uphold the on the use of race in college admissions¹⁹:

The way to stop discrimination on the basis of race is to speak openly and candidly on the subject of race ... we ought not sit back and wish away, rather than confront, the racial inequality that exists in our society.

Mentorship

Mentoring is broadly defined as a relationship between a seasoned and experienced person (the mentor) with another of less experience (the mentee) for the purpose of facilitating the success of the mentee. Mentoring is widely hailed as a critical means through which those persons with little experience can be successful. Multiple formal mentoring programs are developed and implemented across the nation as a key approach to increasing the numbers of underrepresented persons, typically persons of color, as faculty in academia or as students in undergraduate and graduate programs. With the recent disturbing and distressing events involving race, there is no better time to revisit the components that make a successful mentoring relationship. There is overwhelming evidence supporting the beneficial experiences and health outcomes when providers of the same ethnicity treat minority patients. Along those same lines, there is consensus that minority nurse faculty role models contribute to the success of their students with similar racial and ethnic identities.²⁰

First, a mentor to a student/novice faculty from an underrepresented minority needs to concede that bias, whether conscious or unconscious, is ingrained in everyone. If anyone doubts this, they need only take one of Harvard's Implicit Association Tests (<https://implicit.harvard.edu/implicit/takeatest.html>). No one wants to think of themselves as a racist, but to represent oneself as totally unbiased (conscious or otherwise) is simply wrong and impedes the mentor's ability to truly facilitate the mentee's success. It is only when mentors acknowledge their biases that authentic conversations can begin between the mentor and mentee. Asking what could be perceived as inappropriate or insensitive questions is not easy, especially from a person who clearly has some power or privilege that the other does not. In turn, the mentee should be open to all questions and consider them as honest attempts to learn. Mentoring is a 2-way relationship where learning is reciprocal between the parties.

Mentorship is a way to increase and retain workforce diversity in all levels of nursing and health care: clinical practice, research, and academia. Williams and Cooper strategized about building communities of opportunity to help mitigate adverse effects that propagate racial inequities in health.²¹ There is need for resources in developing community participatory research engagement in addressing the inequities of healthcare services, including the lack of access healthcare and need for continuity of services in optimizing health outcomes. Furthermore, research should include sustained beneficial changes rather than temporary interventions that dissipate after researchers gather data and return to their scholarship.

Underrepresentation of minority nursing faculty in largely White academic institutions hinders the success of minority students in nursing.²⁰ Representation of underrepresented minorities throughout all areas of health care is needed to advance a more inclusive environment to advance education and improve outcomes in marginalized populations. Initiatives aimed at increasing BIPOC faculty, staff, and student recruitment should be a departmental priority. Relatedly, the hiring, retention, and promotion processes need to be examined and improved to advance BIPOC representation in academia. Other opportunities for mentorship, such as pipeline programs at elementary and high school levels, should also be examined and explored.

Conclusions

In the era of COVID-19, coupled with a global community attuned to Black Lives, the call to action is now. It is now time to stop, listen, and be intentional in efforts to create sustainable policies and programs that help dismantle racism and shape the ability to deliver quality care to diverse patients, families, professionals, and communities. Nurse educators can also create community engagement on a micro level. All schools should form a diversity, equity, and inclusion (DEI) committee, if they have not already done so. DEI committees can help thread SDoH throughout the curriculum, highlight and address microaggressions, and develop formal and informal mentorship programs. As nurses, we can continue this discussion with humility and without denial or defensiveness. Subtle racist biases may be unintentionally internalized, and it is our moral and ethical responsibility to recognize these and fight them so that they do not result in prejudicial policy, practice, research, and education. Faculty can celebrate diversity through an exchange of ideas and open communication despite differences in race, gender, sexual orientation, religion, age, social class or disability.

References

- Bell B. White dominance in nursing education: a target for anti-racist efforts. *Nurs Inq.* 2020. <https://onlineibrary.wiley.com/doi/abs/10.1111/nin.12379>. Accessed September 17, 2020.
- Health Resources and Services Administration. Nursing workforce projections by ethnicity and race 2014–2030. National Center for Health Workforce Analysis; 2017. <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/hrsa-bhw-rn-lpn-factsheet-12-17.pdf>. Accessed October 8, 2020.
- Carson-Newman University. By the numbers: nursing statistics 2020. 2020. <https://onlinenursing.cn.edu/news/nursing-by-the-numbers>. Accessed October 8, 2020.
- National League for Nursing. Disposition of full-time nurse educators by race-ethnicity-2017. <http://www.nln.org/docs/default-source/default-document-library/disposition-of-full-time-nurse-educators-by-race-ethnicity-2017.pdf?sfvrsn=0>. Accessed September 17, 2020.
- DiAngelo R. *White Fragility: Why It's So Hard for White People to Talk About Racism*. Boston: Beacon Press; 2018.
- Hall JM, Fields B. Continuing the conversation in nursing on race and racism. *Nurs Outlook.* 2013;61:164–173. <https://doi.org/10.1016/j.outlook.2012.11.006>.
- Centers for Disease Control and Prevention. Coronavirus disease 2019 (COVID-19): racial and ethnic minority groups. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>. Accessed June 17, 2020.
- Abramsky S. *The American Way of Poverty, How the Other Half Still Lives*. New York: National Books; 2013.
- Bierman AS, Dunn JR. Swimming upstream: access, health outcomes, and the social determinants of health. *J Gen Intern Med.* 2006;21:99–100.
- Blanchet Gameau A, Browne AJ, Varcoe C. Drawing on antiracist approaches toward a critical antidiscriminatory pedagogy for nursing. *Nurs Inq.* 2018;25. <https://doi.org/10.1111/nin.12211>.
- Keeton VF. What's race got to do with it? A close look at the misuse of race in case-based nursing education. *Nurse Educ.* 2019;45:122–124.
- Canales MK. Othering: toward an understanding of difference. *Adv Nurs Sci.* 2000;22:16–31.
- Canales MK. Othering: Difference understood? A 10-year analysis and critique of the nursing literature. *Adv Nurs Sci.* 2010;33:15–34.
- McGibbon E, Mulaudzi FM, Didham P, Barton S, Sochan A. Toward decolonizing nursing: the colonization of nursing and strategies for increasing the counter-narrative. *Nurs Inq.* 2014;21:179–191.
- Sue DW, Alsaidi S, Awad MN, Glaeser E, Calle CZ, Mendez N. Disarming racial microaggressions: microintervention strategies for targets, White allies, and bystanders. *Am Psychol.* 2019;74:128–142. <https://doi.org/10.1037/amp0000296>.
- Huber L, Solórzano DL. Racial microaggressions as a tool for critical race research. *Race Ethnic Educ.* 2015;18:297–320.
- Hall JM, Fields B. Race and microaggressions in nursing knowledge. *Adv Nurs Sci.* 2012;35:25–38. <https://doi.org/10.1097/ANS.0b013e3182433b70>.
- Nowak AL, Anderson CM, Mackos AR, Neiman E, Gillespie SL. Stress during pregnancy and epigenetic modifications to offspring DNA: a systematic review of associations and implications for preterm birth. *J Perinat Neonatal Nurs.* 2020;34:134–145.
- Sotomayor, S. Sotomayor accuses colleagues of trying to "wish away" racial inequality. *Washington Post.* April 22, 2014. https://www.washingtonpost.com/politics/sotomayor-accuses-colleagues-of-trying-to-wish-away-racial-inequality/2014/04/22/e5892f90-ca49-11e3-93eb-6c0037d4e2ad_story.html. Accessed July 17, 2020.
- Njie-Carr VPS, Niemann YF, Sharps P. *Disparities in the Academy: Accounting for the Elephant*. Pittsburgh, PA: Dorrance Publishing Co.; 2020.

21. Williams DR, Cooper LA. Reducing racial inequities in health: using what we already know to take action. *Int J Environ Res Public Health*. 2019;16:606. <https://doi.org/10.3390/ijerph16040606>.
22. U.S. Preventive Services Task Force. Recommendation Topics. 2020. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics>. Accessed October 2, 2020.

Michelle Zappas, DNP, FNP-BC, is a clinical associate professor, University of Southern California, Department of Nursing, Los Angeles, CA. She can be contacted at Zappas@USC.edu.

USC.edu. Benita Walton-Moss, PhD, FNP-BC, is a clinical associate professor, University of Southern California, Department of Nursing, Los Angeles, CA. Cynthia Sanchez, DNP, FNP-C, is a clinical assistant professor, University of Southern California, Department of Nursing, Los Angeles, CA. Janett A. Hildebrand, PhD, FNP-BC, is a clinical assistant professor, University of Southern California, Department of Nursing, Los Angeles, CA. Tracie Kirkland, DNP, ANP-BC, PNP-BC, is a clinical associate professor, University of Southern California, Department of Nursing, Los Angeles, CA.

In compliance with standard ethical guidelines, the authors report no relationships with business or industry that would pose a conflict of interest.