Journal of Professional Nursing 35 (2017) 18–25

Contents lists available at ScienceDirect

Journal of Professional Nursing

Nursing colonialism in America: Implications for nursing leadership

Roberta Waite [a,*], Deena Nardi [b]

[a] Academic Integration and Evaluation of Community Programs, Doctoral Nursing Practice Department, College of Nursing and Health Professions, Drexel University, Philadelphia, PA, United States
[b] Doctor of Nursing Practice Program, University of St. Francis, Joliet, IL, United States

ARTICLE INFO

Article history:
Received 22 April 2017
Revised 4 December 2017
Accepted 20 December 2017

Keywords:
American colonialism
Racism
Nursing leadership

ABSTRACT

The purpose of this paper is to explore the nurse leader's role in understanding the impact of American colonialism – specifically racism, a product of colonialism – as a key determinant in shaping the education of nursing students and its influence on practicing nurses. American values have been grounded in its colonialism and continue to be influential in shaping beliefs, attitudes, behaviors, and policies within the United States. Like racism, American colonialism depends on its perceived death for its survival – this is its paradox. Historic roots of the nursing profession evolved within this context of American colonialism which has shaped the lens of individuals who are the leaders and practitioners in our profession. Therefore, it is important to examine strategies that challenge and decolonize the nursing profession and to become an accomplice, clarifying and addressing inclusion/exclusion in our profession's leadership machine including: hiring/promotion practices, confrontation of White silence, critiquing design and dissemination of knowledge development, and fostering widespread change in nursing education/curriculum. Understanding the invisible internalization and manifestation of racism within our profession must be addressed if we are to advance the integrity and quality of education and practice in the nursing profession and to promote equity of healthcare among all individuals in the United States.

The plague of racism is insidious, entering into our minds as smoothly and quietly and invisibly as floating airborne microbes enter into our bodies to find lifelong purchase in our bloodstreams.
[Maya Angelou (2014)]

Introduction

The purpose of this paper is threefold: (1) to advocate that nurse leaders gain an improved understanding of the link between and deep institutionalization of American colonialism, racism, and oppression and their normalization in the United States (US); (2) to relate that racism is a key determinant in shaping the education of nursing students influencing the perspectives and behaviors of practicing nurses; and (3) to describe the key role of nurse leadership in decolonizing the nursing profession. Regardless of shallow transformations in the US, American colonialism's deep-seated structural characteristics have persisted across time including establishing an economic and political power base with the aim of achieving wealth, territory, and dominion of one group over another (Hardeman, Medina, & Kozhimanni, 2016). Colonizers' (White elite) wealth has occurred as a result of "genocidal murder" and "brutal enslavement," which anchors American colonialism. Similar circumstances have endured over time and have been protected even today, as a result of "physical violence, psychic terrorism and psycho-economic manipulation" (Williams et al., 2010, p. 159). Thus, the location of economics is within the range of strategies implemented to preserve command amid those to be conquered (Williams et al., 2010).

The legacy of this nation's foundations of western colonialism has greatly impacted and influenced individuals within the US including the development of the nursing profession. We do not discount the impact of gender oppression in the nursing profession with its resultant economic consequences. The nursing professions' origins were structured within an established hierarchy, and nurses continue to be oppressed by those practicing medicine who are predominantly White men who are placed at the top of this hierarchy (Rooddehghan, ParsaYekta, & Nasrabadi, 2015). Within the experience of oppression, the dominant group has the power to control and silence the other group thereby promoting a systematic, pervasive, and recurring inequitable relationship (Rooddehghan et al., 2015).

Like racism, American colonialism depends on its perceived death for its survival-this is its paradox (Jackson, 2009). Intentional focus on the remnants of American colonialism, racism, and oppression must be recognized among those in nursing leadership positions. These are not

* Corresponding author at: Doctoral Nursing Practice Department, CNHP, Drexel University, Three Parkway, Office 707, MS 1044, 1601-16645 Cherry Street, Philadelphia, PA 19102, United States.
E-mail address: rlw26@drexel.edu (R. Waite).

https://doi.org/10.1016/j.profnurs.2017.12.013
8755-7223/

antiquated concepts, and they are currently active in US culture. They influence nursing education and its values and practices which do not remedy health disparities and health inequities effectively within society. In order to improve nursing leadership's practice and policy development, it will be necessary to conduct a critical analysis of the construction of knowledge that has influenced the cultural discourses within socio-political and historical contexts. Furthermore, it is important to recognize and redress the mode of thought about American colonialism given its present-day pernicious effects on the mindset and behaviors of professional nurses. Intentional, clear, and direct action is needed to eliminate complicity in the maintenance of the effects of colonialism within the nursing profession.

American colonialism and racism are inextricably linked; racism is "a built-in and natural product [of colonialism], essential to the social construction of an otherwise illegitimate and privileged access to property and power" (Go, 2004, p.36). There is a need to confront the covert internalization and expression of racism within the nursing profession. This confrontation is necessary to support critique of our educational practices; furthermore, an evaluation is required on how the profession implements an anti-racist approach where nursing leaders "walk the walk; don't just talk the talk" in all aspects of their work (Dale, 2014, p. 261). It is important to understand that nursing faculty and leaders cannot teach and practice what they do not know. Therefore, it is paramount that we are informed more comprehensively and critically about our history to avoid the unconscious embodiment of the partisan, tainted, sanitized, and opportunely forgotten history that promulgated racism. Nurse leaders and educators must not view this knowledge of American colonialism as an *event* conveniently perceived as a singular historical moment. Rather, nurse leaders must accurately see it as it is—a systemic enduring *structure* that influences everything in the US including professional nursing practice. Transparency about the persistence of racism and its effects on the nursing profession is necessary in order to control the destiny we seek to have (Trueman, Mills, & Usher, 2011). The broader foundation of American colonialism, which embeds a system of racism and maintains white supremacy, affects everyone in society including nurses who often enter our profession as a calling because they care and want to improve the health of all people (Patel, 2015; Schroeder & DiAngelo, 2010). Decolonizing the minds of professional nurses will require courage, intentional actions, and an appreciation of the history that set us on this path.

Laying the groundwork: American colonialism, racism, and oppression in the US

> "*The colonized are caught in the tightly knit web of colonialism.*"
> [(Fanon, 1963, p. 15)]

American colonization, manifested through configurations of power, was instrumental in the construction of the concept of race; in addition, it has been used to justify inequitable power relations between settlers and Native Americans as well as persons of African, Hispanic, and Asian descent. The invention of an "Other" or "the colonized," supported the practice of leaders of empires to classify themselves as colonizers (Beavis et al., 2015). "Othering" of a culture is not only complicit in racism and American colonialism, it has created and has been breeding inequality, to some extent, by positioning people differentially within the ethnoracial ranking that is prominent within the US (Viruell-Fuentes, Miranda, & Abdulrahi, 2012). Sinclair and Albert (2008) asserted that Western culture has a tendency to perceive Indigenous peoples, and certainly other racial minority social groups, as the Other. This has contributed to the destructive speech that the Other embodies all things repulsive and undesirable. Beavis et al. (2015) have also acknowledged that the term 'culture,' frequently used when discussing race, was created to label non-European individuals as inferior, barbaric, and uncivilized. Through a process of terrorism, American colonizers successfully forced assimilation to their values and subjugation. This power disparity has allowed American colonizers to strip African and Indigenous people of their beliefs, language, families and identities and to force these people to subsist under the colonizers' inflicted suffering (Henderson, 2000).

Power is "the capacity to exert force on or over something or someone" while oppression is "the exercise of authority or power in a burdensome, cruel, or unjust manner" (Hoyt, 2012, p. 225). Power must be understood at its multiple levels and contexts in order to fully understand our US health system (Williams et al., 2010). The forcible, dominant qualities of power, as well as its obscurity, allows for implementation as a means of control by creating and upholding authority and legitimacy. Given its elusive basis, power can only be realized through the use of a system that upholds its ability to sustain control. As such, it should not be viewed as individually-based; rather, it is profoundly collective, and it codifies its fundamental nature within societal institutions (Williams et al., 2010). Power is integral to maintaining health disparities and must be examined critically given its influence on healthcare and health outcomes. This critical examination includes (i) the function of macrosystems, and (ii) the systematic historical and contextual factors that affect and determine power systems and relationships to health systems and outcomes. Predictably, colonialism implies a power inequality where the colonizer dominates the colonized using whatever is necessary such as violence, brutality, and terror (physically, mentally, financially, politically, educationally, spiritually, and eventually, culturally; Williams et al., 2010). In the end, American colonialism governs the perceptual development of those colonized, warping culture, so that it is defined and endorsed through the reality of colonialism. American colonialism "is the entire conquest of land and people. That is all" (Fanon, 1963, p. 14).

Contesting present-day ideals stemming from American colonialism among those in nursing leadership positions requires intentional deconstruction of white elite knowledge systems that are grounded in the construct of colonialism and has been embedded in the minds of the larger Anglo American culture (e.g., identity, practices, and attitudes towards the Other) and which has universally permeated human nature in the US. Structural and systemic inequities that inform socio-determinants of health result from the pervasiveness of domination and oppression that has sustained the hierarchy of white privilege (Hardeman et al., 2016). This embedded process is entangled into a collective conscience that influences everyone at some level; professional nurses are not excluded (Thésée & Carr, 2012). A recent report from the Human Rights Network (2010), an established group of human and civil rights organizations in the US, provides an illustration of this pervasiveness in the US. They state in their joint report to the United Nations Periodic Review that discrimination in the US "permeates all aspects of life and extends to all communities of color" (Human Rights Network, 2010, p. 6). This means that when concerns arise, we must be deliberate and thoughtful in bringing attention to the systemic, far-reaching tentacles of American colonialism that are lodged deeply in our individual consciousness and are easily obscured due to its normalization historically and currently (Thésée & Carr, 2012).

As long as American colonialism is an unmarked standard and professed to be obsolete and irrelevant, it can hide and transform itself and can carry on without obstruction. As noted above, like racism, American colonialism depends on its perceived death for its survival and that this is its paradox. Race and racial hierarchy, importantly, fails to exist outside this paradigm of colonialism. Race, conversely, is a reality in America's world order constructed through colonialism. Nursing professionals must have a foundational understanding of race relations and racism, as professional nursing in the US began with an institutional bias against Blacks and their marginalization continues to be seen at every level, particularly in nursing leadership positions (Barbee, 1993).

Racism: a determinant in shaping professional nursing

Racism is a "multilevel system of inequality profiting white people at the expense of people of color… racism [is] embedded in all aspects of

society and the socialization process" (Schroeder & DiAngelo, 2010, p. 244). Racism cannot be simply relegated to having prejudice, bias, or discrimination based on perceptions of skin color or nationality. These views of racism have prominence in the real world and are all central ingredients in racism's recipe. However, holding just this conception of racism is incomplete and misleading, as these ingredients are merely symptoms and expressions of the greater phenomenon (Jackson, 2009). Similarly, Bonilla-Silva stated that racism is "institutionalized and based on a system in which the white majority 'raises its social position by exploiting, controlling, and keeping down others who are categorized in racial or ethnic terms (Jackson, 2009, p.163).'" Thus, individual prejudices and racial hostility are not required for the racial order to operate. Research on racism in professional nursing is required, as Baptiste (2015) has reported that there is a misleading and incorrect notion that racism and discrimination are not apparent in healthcare and, more explicitly, that it does not exist in the nursing profession.

Context must be considered, otherwise it formulates all forms of racism to appear equal, which is not reality, and it argues that colorblindness will ameliorate racism. Colorblindness ignores race, and it obstructs the process needed to first eliminate racism (Harrell et al., 2011). Colorblindness makes racism indestructible (Jackson, 2009). Most professional nurses in the US are within the dominant, majority, privileged white population (Hall & Fields, 2013). Accordingly, nurse leaders must take a more deliberate proactive stance on the preparation of the next generation of nurses in understanding the root factors that shape health disparities and health inequity. It is necessary to move beyond a focus on cultural competence alone, as this merely promotes a color-blind mentality that "eclipses the significance of institutionalized racism" (Joseph, 2015, p. 8). For cultural competence to realize its potential, professional nurses must have a critical understanding about the fundamental socio-political and economic processes of power, privilege, and institutional racism that produce, support, and maintain prevailing health disparities. Pollitt (2016) has asserted that activism from each and every professional nurse is necessary to halt racism and discrimination in both health services and the healthcare system; we cannot fail to realize that racism is a socio-determinant of health outcomes. Taken together, racism informs an individual's life opportunities and access to valued resources in society, critical to one's health, social well-being, and the ability to live one's life with dignity and grace (Rajaram & Beckworth, 2014).

Racism does not move fluidly, one day profiting whites and on another day aiding individuals of color (DiAngelo, 2011). The way in which power flows between whites and individuals of color is historic, normalized, and profoundly rooted in the US (DiAngelo, 2011). A core dimension of racism is whiteness—a position of structural advantage or superiority, race (skin) privilege and socially constructed so that individuals accepted as 'white' gain access to more power, contributing to unearned privilege that does not necessitate that they self-identify as any racial or ethnic identity. Thus, white skin is emblematic of systemic white privilege, bestowing distinct indelible and irrefutable advantages to individuals having it versus those who do not. Rabaka (2007) describes this embeddedness as follows: "whiteness is the ownership of the earth forever and ever, Amen!" (2007 p. 3) Whiteness is also a standpoint; specifically, whiteness is a location from which white people see themselves, others, and society (DiAngelo, 2011). Because whiteness is viewed as a collection of cultural practices that are typically rendered invisible and unnamed, it is important to realize that whiteness is dynamic, relational, and operational at all times and on many levels (DiAngelo, 2011). Obscuring whiteness allows individuals the privilege of not having to reflect consciously on their own identity, making their bodies and their locations normative in a social system structured around race as well as other social dissimilarities (Van Herk, Smith, & Andrew, 2011).

As a microcosm of the larger society, these processes and practices within the nursing profession are influenced through its membership – primarily women with white skin whose values, beliefs, perspectives, and experiences have shaped their thoughts and relationships through their lived experience and further shaped their individual consciousness (Puzan, 2003). Nurses act from discrete, adaptable, and relational places of power. When looking at aspects of power and whiteness, we have certainly realized and appreciated how gender, class, and race intersect in the nursing profession; especially as most American nurses are white women from middle and working class backgrounds. In addition to the codified regulations that direct nurses' behavior, their behavior is further directed through the fluid social practices of daily life such as "acting white" (i.e., values, beliefs, and practices of the dominant white culture) which is essential for full assimilation into the nursing profession for all its members (regardless of color)—students, faculty, and clinical nurses (Puzan, 2003).

Nurse leaders must urge their colleagues and students to characterize, name, contest, and transform the norms, traditions, structures, and establishments that preserve white supremacy through continued effects of American colonialism (Scammell & Olumide, 2011). Bery (2014) stated that white supremacy "is the existent structures, institutions, and practices of racist domination that are vigorously re/produced through the disabling of non-white power and anti-blackness" (p. 335). Furthermore, white supremacy persists when race dynamics are rendered invisible and not addressed, thereby advancing whites and whiteness to the top of the racial hierarchy (Matias, Viesca, Garrison-Wade, Tandon, & Galindo, 2014). White supremacy, more importantly, serves as the bond that links racism to both colonialism and capitalism (Rabaka, 2007; Sinclair & Albert, 2008). Critical to this analysis is one's realization that the presence, meaning, and consequences of white supremacy are essential to an examination of the role of institutional power, specifically within the nursing profession. Nurses need to understand the ways that power dynamics function at the micro level between practitioners, between practitioners and their patients, and systemically at the leadership level. White supremacy is oppressive and dynamic, and it produces circumstances that form a person's way of being in the world. Nurses must be cognizant that this too reinforces the creation of whiteness as a racial system, epistemology, and practice within our society, individuals, and consequently, within our professional field (Bery, 2014).

For instance, cultural colonialism imparts that the experiences of racial minority groups, appraised against the prevailing dominant norms, tend to be judged without considering their historical and socio-political context. Therefore, the experience and culture of the dominant power group becomes universal and is used to predicate norms, casting these as representative of all humanity. This occurs, for example, in practice, research, development of educational material, and policy development. This applies clearly to the profession of nursing, influencing decision-making (e.g., academic content and relevant areas to pursue in research) and acceptability of what is perceived as "normal." We are also confronted with using stereotypes to mark those outside of the norm while simultaneously rendering their experiences and perspectives invisible (Sinclair & Albert, 2008). The present-day political climate establishes subliminal conditions that sustain the structures and tools of American colonialism reinforcing its lifeblood—systematic racism and oppression. Collective denial and a culture of silence sustains these subliminal conditions that impact American society at large, including those in nursing leadership positions. This silence may not be deliberate; however, racism and oppression may be levied and perpetuated through both obvious and subtle practices.

Modern-day pedagogy in nursing does not attend to this silence regarding anti-oppression beyond a theoretical understanding of issues (if that). Personal engagement and commitment of nurse leaders, faculty, students, and practitioners are not mandated (Sinclair & Albert, 2008). Accordingly, we can deceive ourselves and think that because we are nurses we are, consequently, non-racist and non-oppressive, as our code of ethics and academic institutions declare they are staunch believers of this ideology. We allow ourselves to be victims of the forces of American colonialism, racism, and oppression that propagate a culture of silence, and we will, essentially, be doing nothing. Talk alone cannot transform deeply embedded behaviors and policies (Sinclair & Albert,

2008). To that end, nurses in leadership positions must elevate their critical consciousness, become more reflective, solicit introspective questions, and reassess the anti-oppressive discourse that is directing perspectives and practices. For instance, this might include when (i) minority faculty members are contested on skills, (ii) retention of minority faculty members is a concern for nursing leadership, and (iii) minority students are engaged considerably less than non-minority students (Sinclair & Albert, 2008).

Nursing colonialism and its persistence in nursing leadership

The nursing profession is not ahistorical; this is critical to understanding the persistence of colonialism as a factor that impacts nursing education and practice today. Modern nursing as a profession has a relatively recent beginning; Florence Nightingale founded the first formalized training school for nurses at St. Thomas Hospital in London in 1860 (Daily Mail Reporter, 2011). Nightingale selected small contingents of white European women of the 'right calibre' (e.g., character) to train for one year (Daily Mail Reporter, 2011 ¶ 1). This was at a time when England and the other European powers of Spain, France, and the Netherlands had been establishing numerous territories (colonies) and conducting the slave trade across the North and South American, Asian, Australian, and African continents and throughout the Caribbean since the 17th century (DiAngelo, 2011). When Nightingale founded St. Thomas Hospital, England had abolished slavery (the law called for gradual abolishment) in all British colonies only 27 years earlier in 1833 (Reuters, 2007). In the US, President Lincoln had yet to issue the Emancipation Proclamation (1863) and the Civil War (1861–1865) had not yet begun (History Channel, 2017). Since that time, nursing practice as an "all-white female profession" has persisted, in many forms and iterations (Minority Nurse Staff, 2013a, ¶ 10). In 1878, Mary Mahoney, the first Black professional nurse in the US, was admitted to a nursing education program in a New England hospital under a policy that limited admissions to other than White European Americans to one African American and one Jewish student for each training class (Minority Nurse Staff, 2013b), and she became the first Black professional nurse in the US.

In 1896, just eighteen years later, the first professional nursing organization in North America, the Nurses Associated Alumnae of the United States and Canada, was founded, and in 1911, the organization evolved into the American Nurses Association (ANA, 2017a). However, the organization refused to include or support nurses of color. Because of this entrenched exclusionary practice, excluded nurses initiated their own organizations. The National Association of Colored Graduate Nurses was founded in 1908 to promote the welfare of Black nurses, challenge racial discrimination, and win integration of Black nurses into nursing schools, nursing jobs, and nursing organizations (African American Registry, 2013).

The National Association of Colored Graduate Nurses successfully lobbied to open the Army Nurse Corp to Black nurses during World War I. During this time, more state nursing associations in the south admitted Black nurses to membership, except for some of ANA's state chapters including Florida, Maryland, Oklahoma, Mississippi, West Virginia, Kentucky, Alabama, and Louisiana (Northrup, 1950). In 1951, when the ANA agreed to completely integrate Black nurses into its organization, the National Association of Colored Graduate Nurses disbanded (African American Registry, 2013). However, twenty years later, little had changed; in 1971, the National Black Nurses Association was formed to promote equality, access, and inclusion in the ANA noting that Black nurses had "very little presence and influence in the leadership of the American Nurses Association," (National Black Nurses Association, 2014, ¶4). This problem persisted, and by 2000, a comparative study of the small number of minority nurses in leadership positions in nursing and healthcare organizations called this persistent status quo a national problem (Schmeidling, 2000). Incorporated in 1998, The National Coalition of Ethnic Minority Nurse Associations (NCEMNA) gave voice to the over 350, 000 nurses in five ethnic minority nursing organizations and advocated for equity and justice for minority nurses and their ethnic minority patient populations (NCEMNA, 2017).

To date, in 2017, there have been 35 ANA Presidents; since its founding in 1911, only two of them (5.7%) were other than White European Americans (ANA, 2017b). (Note: We derived this information first from the referenced ANA website to obtain the listing of presidents, then searched for biographic information for each past president.). In 1978, the first Black nurse was elected President of ANA, Dr. Barbara Nichols – 14 years after Congress passed the Civil Rights Act and 7 years after the National Black Nurses Association was formed. The second minority President of the ANA was Dr. Beverly Malone. During her career, Dr. Malone served as President of ANA, Deputy Assistant Secretary of Health, United States Department of Health & Human Services, and General Secretary of the Royal College of Nursing in London (Wright, 2006). She had been quite candid about her need as a person of color to confront her experiences of prejudice and judgements. In an interview in London, she said "I know that in leadership it is really not about me as a person. There is a critique of the role and how I do it. But there is also that of me being in the role-which is about me being African American. I have learned to deal with that (Wright, 2006, p. 2)." The Venn diagram highlights outcomes of the interaction of racism and persistent colonialism on American Nursing (Fig. 1).

Nursing leadership-strategies to decolonize the nursing profession

When aiming for decolonization, it is pivotal to avoid discarding the deleterious effects of colonization so quickly that the predominant underlying causes and effects of contemporary problems are not washed away without consideration of the systemic, all-encompassing tentacles that have locked onto human consciousness (Thésée & Carr, 2012). It is disingenuous for nurse leaders to ask that other nurses reflect on the colonizing nature of their nursing practice without doing so themselves. Only then can leaders advocate and model how best to navigate the inevitable tension that arises between government needs and community needs. Moreover, as individuals within the nursing profession who now recognize the interdependence of American colonialism, racism, and oppression and apply a race, class, and gender evaluation in all matters of our being – only then can nurse leaders more confidently participate in the decolonization of the nursing profession.

In examining American colonialism within nursing education and practice, McGibbon, Mulaudzi, Didham, Bartond, and Sochan (2014) observed that "working toward decolonizing nursing includes a commitment to exposing colonizing ideologies, values and structures embedded in nursing curricula, teaching methodologies and professional development" (p. 186). As nurse leaders and role models, we acknowledge that the theory and practice of our profession has evolved within a Eurocentric context of colonialism and that humility and risk-taking are ethical responsibilities required to face our own biases and limitations in relation to decolonization (National League for Nursing, 2016). Thus the first step is to learn the meaning and importance of becoming an accomplice.

Illustrated by the distinguished poet and activist Maya Angelou's quote which opens this paper, colonialism and its companion racism function as social cancer cells, inserting themselves steadily and inexorably into our private lives. Therefore, to be excised, it must first be searched for and identified. This action requires personal recognition and examination using the very actions of reflective practice that are taught as the hallmarks of nursing practice. Only then can nurse leaders take the individual and collective measures needed to legitimize their advocacy. Becoming an accomplice to deconstruct white supremacy is key. When nursing leaders fight back or forward, together, with persons working to decolonize and mobilize anti-oppressive and anti-racist practices and policies, they become complicit in a struggle and movement towards liberation—we are then accomplices. The goal for nurse leaders is not to simply unlearn oppression. Rather the goal is to understand the

importance of securing resources and material support to promote liberation efforts and to act on this understanding. Furthermore, mobilization of these efforts is not based on personal guilt or shame (Indigenous Action, 2014). A nurse leader accomplice strategizes with, not for, to help or support others and engages intentionally in difficult, disturbing, and challenging discussions. Nurse leaders who are accomplices recognize that no one has a responsibility to provide them information to promote their understanding of American colonialism. Accomplices seek to learn and understand the enduring effects of American colonialism because they are accountable and responsible for confronting these issues.

Nurse leaders who become accomplices are then emboldened to take public actions and promote initiatives that present solutions to the problem of the invisibility of minority nurses in leadership positions in the local and national arenas of our healthcare system. These individual measures include the following examples of action steps:

Become an accomplice

Optimize inclusion

Optimize inclusion in your own workplace – from the informal discussion gatherings within nursing units, company departments, and lunch tables to appointments on committees, nominations for office, and staff opinion leaders. Think critically about the nursing leadership machine (i.e., leadership development system) at your place of practice. Identify how and where nurses play a part in maintaining the leadership machine and how they learn to fit into the leadership machine (Coffman, Putman, Adkisson, Kriner, & Monaghan, 2016). Gain a better understanding of how the leadership machine's process shifts the perceptions of interactions and communications to detect systemic racism when it occurs. This allows accomplices the opportunity to guide actions that support, mentor, and help nurses of color keep their voices and to stake their place in the organization.

Critique organizations' public persona

Examine and change your company's or school's hiring and promotion practices – analyze the human resources' procedures for hiring and management of new faculty, executives, advanced practice registered nurse providers, staff, and board members. Critique print and social media sources that your marketing and human resource departments use to advertise positions and organizational services. In what venues are they advertising? Which pictures of community, faculty, staff, and/or nurse leaders are they choosing for these advertisements? Pictures in advertising are used for visual cues and can also be used as code to say, "This is us, if you are like us, come and join us!" This also communicates to readers that if you do not look like the pictures, you are the Other, and as the Other, readers often choose to stay away.

Examine organizations' process of knowledge development

Critique and challenge the process of colonialism in knowledge development – ensure that a broader set of perspectives are included in your educational and practice settings. An accomplice recognizes where there is the absence of perspectives in the development of nursing knowledge that are other than those from white Anglo- American culture. This narrow perspective of knowledge is then disseminated in such media as documents and policy papers, editorials and position papers, research, and newsletters from your workplace or organization. Change in these practices is accomplished by purposely including nurse leaders of color and those having an antiracist lens into work, policy making, research design and dissemination of findings, program evaluation, and writing groups. This is important, for example, since nursing research is not impartial, apolitical, or ahistorical, and nursing is regulated by dominant discourses. Thus, colonialism must be recognized through these perspectives as a primary determinant of health, affecting health outcomes and collective well-being.

Challenge white silence

Recognize and challenge white silence as the enabler of racism – the nurse leader who is an accomplice challenges white silence when it is seen, heard, or felt. Self-reflection practices will strengthen your ability to recognize when you are censoring your own speech from fear of being marginalized or criticized, or if you detect a lack of validation for your perceptions. If you are not a person of color, seek to become an ally or accomplice with your colleagues in the minority in your school, organization, or place of business. Learn about anti-oppression frameworks and anti-oppressive pedagogy that faculty and other nurses can take to challenge racist statements and practices and partner with others to work towards a more just workforce environment. Recognize that diversity training or cultural sensitivity training is not enough to challenge the discomfort many nursing leaders experience in confronting or engaging in discussions about racism. The default response is then to avoid it. Instead, advocate for specific, intentional workplace training in reflecting on racism, talking about racism and responding to racist practices for executives, faculty, and staff.

Identify and change ethnocentric education curriculum

Recognize and change the processes of American colonialism as reflected in the content and experience of nurse education – if you are a nurse educator or plan to be one, recognize that widespread curricular change is needed in nursing education. Learn about the role of nurses in perpetuating American colonialism in nursing organizations, schools of education, and through hiring practices. Help your students broaden their perspective with questions that examine their personal perspectives on race and the role it plays in their lives and in healthcare. You can include questions such as: Have you ever witnessed racism in healthcare? Have you ever witnessed racism in nursing practice? What learning journey are you on? As you learn about yourself and your patients, how would you describe your journey to another nurse? How do you empower yourself? When and how do you empower other nurses? Assess the role that primary health care plays in the program of study, whether it is integrated throughout as in true patient-centered care or merely isolated in one course or section of a course, not to be mentioned again. Determine if an analysis about American colonialism is included in nursing theory and cultural diversity courses that examine "whiteness" as well as "other" cultures; further, is it then included in other courses to provide a framework for assessment and patient care. Examine curriculum for the inclusion of nurses of color (e.g., Mary Mahoney, Mary Seacole, Susan King Taylor, Betty Smith Williams and others) as co-founders of modern nursing practice. Measure the amount of time and focus on antiracist pedagogy that appears in the curriculum and whether it is threaded throughout or isolated into one course, or section, or learning activity.

Table 1 provides a summary of these beginning strategies to address decolonization and racism in your organization and/or classroom, organized as problem areas that need to be addressed, for ease of use by nursing leaders in diverse practice roles today.

Decolonization in the context of nursing is a direct, active process of confronting, exposing, and changing instances of marginalization of nurses or patients of color and of identifying and challenging racist status perspectives and practices in nursing and other healthcare organizations, to end the perpetuation of racism in nursing organizations, healthcare delivery, and in nursing education. It is a continual process, rather than an outcome. Given that the process of colonization has developed synergistically between the colonized and the colonizers, decolonization and the strategies it embodies must incorporate this combined history. Ultimately, leaders must uphold and activate paradigms of ethnic and cultural knowledge on a broader platform to uncover the treasure of diverse languages, worldviews, teachings, and experiences (McGibbon et al., 2014). It is critical for nurse leaders to focus their attention on each of these areas given that those who have been colonized have been systematically excluded from nursing history, from contemporary academic institutions, and from Eurocentric knowledge development systems. Amnesia about American colonization and its ongoing impact

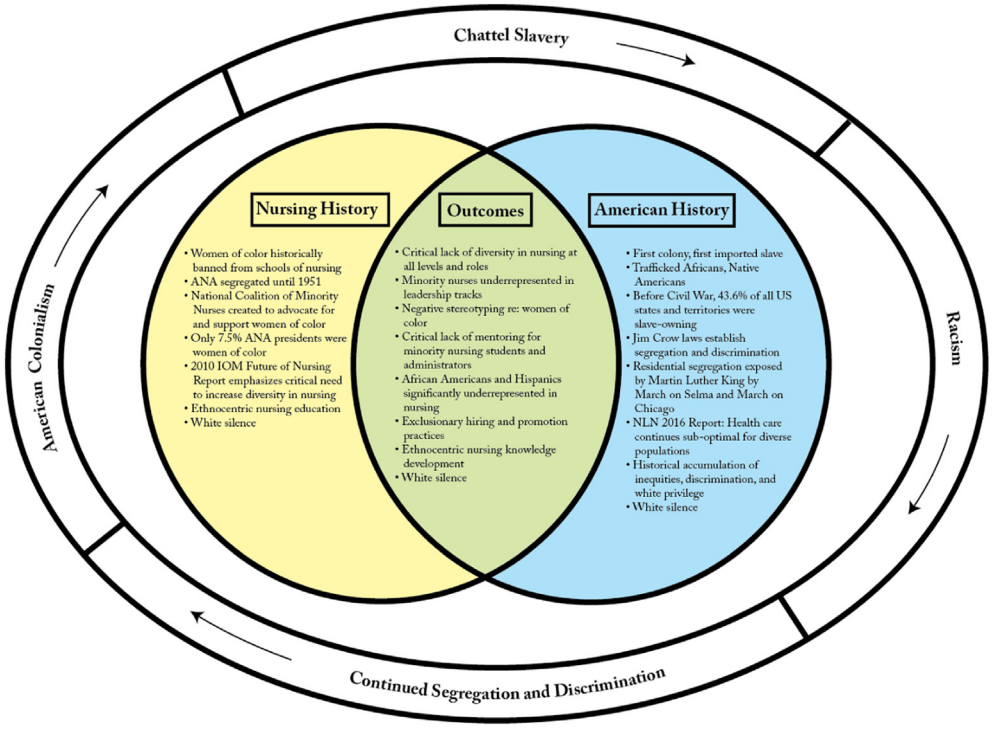

Fig. 1. Outcomes of racism and persistent colonialism on American nursing.

within the nursing profession undergirds many practices that continue to create and preserve poor health status among those who must be our partners in pursuit of optimum health care and health outcomes for all persons (McGibbon et al., 2014).

As such, a commitment to decolonization in the nursing profession possesses vast potential for all of our intellectual and practice endeavors. Quite importantly, decolonizing strategies in the nursing profession would become more pronounced if nurse leaders enforced our profession's alliance with social justice and human rights endeavors. Today, these are not often at the vanguard of, for example, talking points, policies, mission statements, curricular documents, or professional practice guidelines in any significant way, despite some of the nursing profession's justice-based historic roots (McGibbon et al., 2014). Furthermore, a coherent and explicit emphasis on the structural determinants of health could enlighten and facilitate the process of decolonizing nursing knowledge development, education, and practice (McGibbon et al., 2014).

Implications for nursing leadership

The role of race in nursing education and practice, as well as healthcare delivery, is a key marker for and co-variant of health disparities (Giger, 2011) This is particularly pertinent as the US population continues to grow more diverse in race, religion, gender practices, and immigration status (American Association of Colleges of Nursing, 2015; United States Census Quick Facts, 2016). As a recent study of race and poverty in Chicago concluded, lifespan can be determined by one's zip code, which also predicts economic status, race, and health status (Vickroy, 2016). This is one of many studies which has identified the role that racism plays in the persistence of social and economic inequities and in health disparities in the US. Understanding and combating racism and its influence in healthcare and in nursing leadership comes at a time when Healthy People 2020 now includes racism in the roots and risks associated with the Determinants of Health. Racism is defined as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage…health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" (United States, Department of Health and Human Services, 2008, ¶ 6).

The nursing shortage is real, and so is the shortage of nurse leaders in all aspects of health care, including at the policy table, in systems management, and providing culturally tailored primary healthcare. The nursing profession is charged to effectively combat the new plagues of the modern world, including: health inequities, new and emerging infections and pandemics, child labor, human trafficking, terrorism, community violence, poverty, ignorance, and the plight of the girlchild. The nursing profession's stakeholders are increasingly diverse in race, SES, religion, and values, representing a multi-ethnic, multi-racial, multilingual, and sociotechnical worldview, with needs and expectations that can only be understood and recognized by nurse leaders with different perspectives. Nurses must practice unencumbered, to the full extent of our education, preparation, and experiences. Nurses of white European heritage must take their blinders off, examine the track to leadership in their own organizations for nurses of color, and commit to the changes necessary to end the covert and overt racism of American colonialism in nursing, which prevents full use of the talents and perspectives available for leadership roles throughout nursing.

Although nursing professionals are proud of their legacy of advocacy for human rights, nursing leadership lags far behind its own agenda to develop a diverse nursing workforce that mirrors its patient populations, with full access to opportunities for education and advancement. Only when that goal is reached, can the nursing profession offer necessary perspectives other than those from white Eurocentric voices that inform nursing education, healthcare policy and action, and population health advocacy. Towards that end, nurse leaders in education, professional organizations (e.g., the ANA, *American Organization of Nurse Executives*, **American Association of Colleges of Nursing**, and *National League for Nursing*), and health care and nursing care practice settings must address white silence directly and confront complicity in the persistence and power of institutional racism in the nursing profession. Nurse leaders must acknowledge white silence and challenge it in all its guises,

Table 1
Beginning strategies for nurse leader accomplices to decolonize the nursing profession.

Problem area	Stakeholders	Examples of actions
Inclusion/exclusion	Nurses in all areas of practice and levels of education	- Regularly examine the leadership track and knowledge development machine at your place of business: how does it include and accommodate diverse membership? How is the contribution of nurses from ethnic minority backgrounds invited, included, acknowledged, and valued? - Ensure sustained mentorship of nurses of color - Assure the voices of nurses of color are included in practice, leadership, research, and operations decision making
Hiring and promotion practices	Nursing administrators, NCOs, deans and directors	- Examine your organization's hiring and promotion practices - Examine the venues, sources, and practices that marketing is using: is it targeted to a Eurocentric population? Will it reach those in healthcare with different understandings, requirements, and viewpoints? - Partner with marketing to include input from diverse populations into marketing decisions
Nursing knowledge development	All professional nursing organizations	- Ensure inclusion of diverse viewpoints and forms of evidence in addition to clinical research when gathering evidence to support change
	Nurse educators	- Ensure that the policy writing group, task force, or research team includes members from diverse heritages who can bring different perspectives and understandings and histories to the table - Examine what research questions or critical inquiry processes are used to formulate policies and proposals; what populations or interests stand to benefit, and what populations are left out?
White silence	Nurses in all areas of practice and levels of education	- If you see or witness racism in any form, speak up - Participate in anti-racist or diversity or social justice meetings, groups, or task forces - If you are of white European heritage, read the literature on anti-colonialism in nursing to learn how to be an ally – an accomplice – a co-conspirator in effecting positive change in your organization - If you are a nurse of African, Asian, Indigenous or Hispanic heritage, learn about anti-colonialism paradigms and anti-oppressive pedagogies; partner with others to find and use your voice when perceiving acts of racial injustice or institutional colonialism - Advocate for intentional diversity training in how to engage in meaningful dialogues about race with coworkers, students, employees, stakeholders
Ethnocentric Nursing Education Curriculum	Educators AACN, CCNE, NLN, ACEN nursing education and accreditation organizations	- Recognize that to end American colonialism in nursing education, there is need for widespread change in nursing curriculum - Begin with your own self-reflective practice - Assure the incorporation of antiracist theories, models and/or conceptual frameworks into nursing foundation courses - Teach students to broaden their perspective to understand the different worldviews of the diverse nursing workforce and their patients - Hold workshops and conferences on antiracist curricular practices and anti-oppressive pedagogy for faculty - Teach the skills necessary to challenge discriminatory behaviors

including the private as well as the public. For instance, the American Association of Colleges of Nursing have acknowledged the need for "adequate representation" of diverse groups in the nursing profession and lists its actions to date towards that end (e.g., offering technical assistance to workforce diversity initiatives, collaborating on position papers and other initiatives, sitting on panels, and advocating for more federal funding to enhance diversity (American Association of Colleges of Nursing, 2015, ¶1)). However, as the National Black Nurses Association (2014) stated in 1971, the presence and influence of nurse leaders from minority groups in nursing leadership positions at the organizational and national level continues as small, often invisible, and largely missing.

Conclusion

The nursing profession has developed and progressed within the context of American colonialism offering a basis for the colonizing of intellectual growth in our profession. Likewise, racism and white privilege perform a vital role in sustaining colonialism within our profession. Racism does not just add to risk for health disparities in our patients and loss of opportunities for ourselves, racism exacerbates these risks exponentially. It is imperative that both student and practicing nurses understand how their membership in the larger healthcare profession is shaped through the social, political, and historical contexts rooted in American colonialism. Becoming aware of and responding to how American colonialism creates and sustains health inequities is a fundamental step to creating a change in nursing practice, professional development, and education, as well as creating a new narrative for how we can optimize the health of all people. Decolonizing the nursing profession takes a willingness to recognize racism and its associated elements of white supremacy, white privilege, and whiteness as a personal worldview. American colonialism in our culture has had a major influence in our nursing profession, an influence that has produced oppression in education, practice, and leadership today. It is time for nurses in positions of leadership to take the next step in decolonizing the nursing profession. Become accomplices and take action to identify, examine logistically, and then destroy structural racism wherever it is expressed or experienced. This paper offers professional nurse leaders another opportunity to reflect on human rights history and to move beyond reflection to active steps that decolonize our profession and effectively overcome the persistent challenges to recognize and directly address racism in our profession.

References

African American Registry (2013). National Association of Colored Graduate Nurses Founded. Retrieved from http://aaregistry.org/historic_events/view/national-association-colored-graduate-nurses-founded.
American Association of Colleges of Nursing (2015). Fact sheet: Enhancing diversity in the nursing workforce. Retrieved from https://www.ic4n.org/wp-content/uploads/2012/02/AACN-Diversity.pdf.
ANA (2017a). ANA history. Retrieved from http://www.nursingworld.org/history.
ANA (2017b). ANA past presidents. Retrieved from http://nursingworld.org/FunctionalMenuCategories/AboutANA/Leadership-Governance/ANA-Past-Presidents.
Angelou, M. (2014). As quoted in The Root. Retrieved from http://www.theroot.com/maya-angelou-s-words-that-spoke-to-all-our-lives-1790875890.
Baptiste, M. (2015). Workplace discrimination: An additional stressor for internationally educated nurses. *Online Journal of Issues in Nursing*, *20*(3), 1.
Barbee, E. L. (1993). Racism in US nursing. *Medical Anthropology Quarterly*, *7*(4), 346–362.
Beavis, A., Hojjati, A., Kassam, A., Choudhury, D., Fraser, M., Masching, R., & Nixon, S. (2015). What all students in healthcare training programs should learn to increase health equity: Perspectives on postcolonialism and the health of aboriginal peoples in Canada. *BMC Medical Education*, *15*, 155–165. https://doi.org/10.1186/s12909-015-0442-y.
Bery, S. (2014). Multiculturalism, teaching slavery, and white supremacy. *Equity & Excellence in Education: University of Massachusetts School of Education Journal*, *47*(3), 334–352. https://doi.org/10.1080/10665684.2014.933072.

Coffman, K., Putman, B., Adkisson, A., Kriner, B., & Monaghan, C. (2016). Waiting for the expert to arrive: Using a community of practice to develop the scholarly identity of doctoral students. *International Journal of Teaching and Learning in Higher Education*, *28*(1), 30–37.

Daily Mail Reporter (2011, May 13). Florence nightingale asks for ladies "of the right calibre" to train as nurses in letter unearthed after 130 years. Retrieved from http://www.dailymail.co.uk/health/article-1386381/Florence-Nightingale-asks-ladies-right-calibre-train-nurses-letter-unearthed-130-years.html.

Dale, N. G. (2014). Decolonizing the empathic settler mind: An autoethnographic inquiry. (Dissertations & Theses. Paper 154. Retrieved from) http://aura.antioch.edu/etds/154.

DiAngelo, R. (2011). White fragility. *International Journal of Critical Pedagogy*, *3*(3), 54–70.

Fanon, F. (1963). *The wretched of the Earth.* New York, NY: Grove Press.

Giger, J. (2011). Defining health disparities from three viewpoints: Reducing inequities in healthcare. In P. S. Cowen, & S. Moorhead (Eds.), *Current issues in nursing* (pp. 370–376) (8th ed.). St. Louis MO: Mosby Elsevier.

Go, J. (2004). "Racism" and colonialism: Meanings of difference and ruling practices in America's Pacific empire. *Qualitative Sociology*, *27*(1), 35–58.

Hall, J., & Fields, B. (2013). Continuing the conversation in nursing on race and racism. *Nursing Outlook*, *61*(3), 164–173. https://doi.org/10.1016/j.outlook.2012.11.006.

Hardeman, R., Medina, E., & Kozhimanni, K. (2016). Structural racism and supporting black lives-the role of health professionals. *New England Journal of Medicine*, *375*, 2113–2115.

Harrell, C. J. P., Burford, T. I., Cage, B. N., Nelson, T. M., Shearon, S., Thompson, A., & Green, S. (2011). Multiple pathways linking racism to health outcomes. *Du Bois Review: Social Science Research on Race*, *8*(1), 143–157. https://doi.org/10.1017/S1742058X11000178.

Henderson, J. (2000). The context of the state of nature. Reclaiming indigenous voice and vision. Retrieved from https://eric.ed.gov/?id=ED456011.

History Channel (2017). Emancipation proclamation. Retrieved from http://www.history.com/topics/american-civil-war/emancipation-proclamation.

Hoyt, C. (2012). The pedagogy of the meaning of racism: Reconciling a discordant discourse. *Journal of the National Association of Social Workers*, *57*(3), 225–234.

Indigenous Action (2014). Accomplices not allies. Retrieved from http://www.indigenousaction.org/wp-content/uploads/accomplices-not-allies-print-friendly.pdf.

Jackson, M. (2009). Neo-colonialism, same old racism: A critical analysis of the United States' shift toward colorblindness as a tool for the protection of the American colonial empire and white supremacy. *Berkeley Journal of African-American Law & Policy*, *11*(1), 156–192.

Joseph, A. (2015). Beyond intersectionalities of identity or interlocking analyses of difference: Confluence and the problematic of "anti"-oppression. *Intersectionalities: A Global Journal of 2015 Social Work Analysis, Research, Polity, and Practice*, *4*(1), 15–39.

Matias, C., Viesca, K., Garrison-Wade, D., Tandon, M., & Galindo, R. (2014). What is critical whiteness doing in OUR nice field like critical race theory? *Applying CRT and CWS to understand the white imaginations of white teacher candidates* Retrieved from https://doi.org/10.1080/10665684.2014.933692.

McGibbon, E., Mulaudzi, F., Didham, P., Bartond, S., & Sochan, A. (2014). Toward decolonizing nursing: The colonization of nursing and strategies for increasing the counter-narrative. *Nursing Inquiry*, *21*(3), 179–191.

Minority Nurse Staff (2013, March 30a). Looking for black nurse leaders: A call to action. *Minority Nurse*, *100* Retrieved from http://minoritynurse.com/looking-for-black-nurses-leaders-a-call-to-action/.

Minority Nurse Staff (2013, March 30b). Making history: Black Nightingales. Retrieved from http://minoritynurse.com/making-history-black-nightingales/.

National Black Nurses Association (2014). History. Retrieved from http://www.nbna.org/history.

National Coalition of Ethnic Minority Nurse Associations (2017). Retrieved from http://ncemna.org/.

National League for Nursing (2016). Achieving diversity and meaningful inclusion in nursing education. Retrieved from http://www.nln.org/docs/default-source/about/vision-statement-achieving-diversity.pdf?sfvrsn=2.

Northrup, H. (1950). The ANA and the negro nurse. *American Journal of Nursing*, *50*(4), 207–208.

Patel, L. (2015). Desiring diversity and backlash: White property rights in higher education. *The Urban Review*, *47*(4), 657–675. https://doi.org/10.1007/s11256-015-0328-7.

Pollitt, P., & McCready, Esther (2016). RN: Nursing advocate for civil rights. *Online Journal of Issues in Nursing*, *21*(2). https://doi.org/10.3912/OJIN.Vol21No02PPT01 Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-21-2016/No2-May-2016/Articles-Previous-Topics/Esther-McCready-RN-Nursing-Advocate-for-Civil-Rights.html.

Puzan, E. (2003). The unbearable whiteness of being (in nursing). *Nursing Inquiry*, *10*(3), 193–200. https://doi.org/10.1046/j.1440-1800.2003.00180.x.

Rabaka, R. (2007). The souls of white folk: W.E.B. Du Bois's critique of white supremacy and contributions to critical white studies. *Journal of African American Studies*, *11*(1), 1–15. https://doi.org/10.1007/s12111-007-9011-8.

Rajaram, S., & Beckworth, S. (2014). Cultural competence: New conceptual insights into its limits and potential for addressing health disparities. *Journal of Health Disparities Research and Practice*, *7*(5), 82–89.

Reuters (2007). Chronology: Who banned slavery when. Retrieved from http://www.reuters.com/article/uk-slavery-idUSL1561464920070322.

Rooddehghan, Z., ParsaYekta, Z., & Nasrabadi, A. N. (2015). Nurses, the oppressed oppressors: A qualitative study. *Global Journal of Health Science*, *7*(5), 239–245. https://doi.org/10.5539/gjhs.v7n5p239.

Scammell, J., & Olumide, G. (2011). Racism and the mentor-student relationship: Nurse education through a white lens. *Nurse Education Today*, *32*, 545–550. https://doi.org/10.1016/j.nedt.2011.06.012.

Schmeidling, N. (2000). Minority nurses in leadership positions: A call for action. *Nursing Outlook*, *48*, 120–127. https://doi.org/10.1067/mno.2000.100490.

Schroeder, C., & DiAngelo, R. (2010). Addressing whiteness in nursing education. *Advances in Nursing Science*, *33*(3), 244–255 Retrieved from http://nursing.uc.edu/content/dam/nursing/docs/CATER/Addressing_Whiteness_in_Nursing_Education__The.7.pdf.

Sinclair, R., & Albert, J. (2008). Social work and the anti-oppressive stance: Does the emperor really have new clothes? *Critical Social Work*, *9*(1) Retrieved from http://www1.uwindsor.ca/criticalsocialwork/social-work-and-the-anti-oppressive-stance-does-the-emperor-really-have-new-clothes.

Thésée, G., & Carr, P. (2012). The 2011 international year for people of African descent (IYPAD): The paradox of colonized invisibility within the promise of mainstream visibility. *Decolonization: Indigeneity, Education & Society*, *1*(1), 158–180.

Trueman, S., Mills, J., & Usher, K. (2011). Racism in contemporary Australian nursing. *Aboriginal & Islander Health Worker Journal*, *35*(5), 19–22 Retrieved from http://researchonline.jcu.edu.au/19638/4/19638_Trueman_et_al_2011_author_manu.pdf.

United States Census (2016). Quick facts. Retrieved from https://www.census.gov/quickfacts/table/PST045216/00.

United States Department of Health and Human Services (2008). The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations January 6. (Retrieved from) http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf.

United States Human Rights Network (2010 August). *The United States of America: Summary submission to the UN universal periodic review.* United States of America: Universal Periodic Review Joint Reports, 8.

Van Herk, K. A., Smith, D., & Andrew, C. (2011). Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry*, *18*(10), 29–39.

Vickroy, D. (2016, Nov. 26). Study examines role of race, poverty in health. Retrieved from http://edition.pagesuite.com/tribune/article_popover.aspx?guid=e222505c-7dcc-4daa-8097-e741620b3427.

Viruell-Fuentes, E., Miranda, P., & Abdulrahi, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine*, *75*, 2099–2106.

Williams, O., Pieterse, A., Loach, C., Bolden, M., Ball, J., & Awadalla, S. (2010). Beyond health disparities: Examining power disparities and industrial complexes from the views of Frantz Fanon (part 1). *Journal of Pan African Studies*, *3*(8), 179–193 Retrieved from http://www.biomedsearch.com/article/Beyond-health-disparities-examining-power/306596727.html.

Wright, S. (2006). I know why I am here: RCN general secretary Beverly Malone has no doubts about why she is a nurse. *Nursing Standard*, *20*(32), 1–2.