
Abstract

The remnants of colonialism manifesting as structural violence, racism, and oppression continue to plague our society as evidenced by the persistence of health inequities, particularly for minority populations in the United States.
As a profession bound by moral and ethical mandates, nursing must resist and deconstruct oppression in all its forms. Nurses, informed by critical race theory, intersectionality, and historical trauma, can become formidable allies with marginalized populations in the fight for social justice and health equity.

IN JANUARY 2017, the American Nurses Association (ANA) issued a formal statement on ethics and human rights.1 This statement was unequivocal in its call for nurses to uphold human rights and social justice, with a particular emphasis on vulnerable populations. The ANA used the term "formidable" in

describing the synergy of ethics, human rights, and nursing, a strong word that emphasizes the seriousness with which this major body that governs the profession of nursing in the United States takes these issues. This is relevant because nurses comprise the largest segment of health care providers who are guided by strict ethical guidelines, placing patients and their unique needs at the center of care.2

The Institute of Medicine defines patient-centered care as care which is "respectful of, and responsive to, individual patient preferences, needs and
values"3(p6) and ensures that "patient values guide all clinical decisions."3(p6) When nursing duties and loyalties conflict with societal power structures and nurses blindly adhere to policies rooted in structural racism, patients are no longer the center of care. This can result in the dehumanization and marginalization of patients, adversely affecting health outcomes.4

As feminist nurse scholars, the authors of this theoretical article call upon our nursing colleagues to become formidable allies in the current era of a reinvigorated white supremacist ideology. Similar to scholars in the disciplines of social work and education who are seeking to deconstruct the white patriarchal hegemony of their respective disciplines, we urge nurses to move from "benevolent supporters" to "risk takers."5(p43) Becoming formidable allies requires nurses to recognize and acknowledge the role that historical trauma plays in reproducing inequities that manifest as poor health outcomes for specific populations. In this article, we, therefore, discuss how historical trauma has, and continues to, adversely affect health outcomes for specific populations in the United States. Rooted in feminist epistemologies, in addition to a historical trauma framework, we also draw on critical race theory and intersectionality to explore nursing's mandate to engage in social justice. We discuss nursing's traditional role of advocacy and provide examples of how patients are easily marginalized when fidelity and obligation are centered on institutional hierarchies.4

We highlight 3 resistance movements: the Black Lives Matter (BLM) movement, Development, Relief, and Education for Alien Minors (DREAMers) Act, and the protest of the Dakota Access Pipeline (DAPL). In our analyses, we look at the history that gave rise to the ascension of these movements. Lastly, we describe the role that nurses might play as formidable allies in supporting such movements given our obligation to enhance the safety, well-being, and ultimately, the health equity of individuals and communities existing on the margins of US society.

Statements of Significance

What is known or assumed to be true about this topic:

* We know that health inequities persist in the United States particularity between the dominant white society and populations experiencing marginalization.
We also know that these inequities are rooted in colonial discourses and institutionalized racism.

* We know that nursing has an ethical and moral mandate to confront and dismantle oppression in all of its forms.

What this article adds:

* This article offers nurses new epistemologies informed by intersectionality, critical race theory, and historical trauma, from which to practice to be more fully engaged with marginalized populations in our collective liberation.

* This article provides examples of resistance movements and the ways in which nurses may become allies with marginalized populations, as they fight back against oppression.

POSITIONALITY

A principle central to feminist scholarship is the acknowledgment that there is not one, but many truths, informed by our individual experiences and worldviews.6 As nurse scholars, we incorporated multiple perspectives in the call to action to decolonize the academy, specifically in nursing scholarship as well as nursing practice and health policy. The ways in which the authors self-identify reflect inclusivity and our intention to privilege traditionally marginalized voices. The authors of this article represent multiple races and ethnicities (white, black, Native American, multiracial, and Latina). Our perspectives are also informed by our social locations representing privilege (race, class, education level, cis-gender, and heterosexual) and marginalization (women of color, queer, and immigrant) in an attempt to articulate a more holistic and inclusive view.

ROLE OF SOCIAL JUSTICE IN PROVIDING NURSING CARE

In the ANA statement on ethics and human rights, there is an emphasis on nursing's obligation and commitment to social justice and the profession's responsibility to integrate principles of justice into nursing and health
policy.1 The debate surrounding the exact meaning of social justice in the context of nursing care is beyond the scope of this article, but the authors of this article adhere to the principles of social justice espoused in the nursing
manifesto.7 At the heart of the philosophy in the nursing manifesto is the ideas that human beings are inherently worthy of dignity and respect. Social justice requires solidarity in the dismantling of any structure that denies basic human rights to anyone by way of their socially ascribed identity.7 Second-generation human rights as articulated in the International Covent on Economic, Social and Cultural Rights call for access to education, health care, and a basic standard of living for all human beings.8 For these rights to be realized by all people, it will require those in positions of influence to leverage their power within institutions designed to maintain social and political hierarchies.8 Current efforts to dismantle the Affordable Care Act, for example, have a direct bearing on second-generation human rights, as it will affect access to affordable and quality health care.

Social justice is far from being realized, as evidenced by the persistence of health inequities, particularly for minority populations. Health inequities are defined as health differences that are socially produced, "systemic in their distribution across the population, and unfair."9(p1661)

People belonging to marginalized groups in the United States disproportionately experience health problems such as cardiovascular disease, obesity, diabetes, and inflammatory and autoimmune disorders.10 These conditions are correlated with the chronic activation of stress hormones experienced by racial minorities facing daily assaults to their humanity and their dignity.8 For example, a recent study showed an increase in anxiety levels, depression, eating and sleeping disorders, and poor school performance among children who fear separation from their parents that would result from deportation.11 These health inequities result from far more than physical manifestations of chronic stress.

A landmark report in 2008 correlated health inequities with social and economic determinants of health.7 For example, approximately 200 million children worldwide are unable to reach their full potential due to adverse events experienced early in life including poverty.7

ADVOCACY

International codes of conduct, standards of practice, and nursing curricula include advocacy as a key component to nursing care, the definitions of which are context specific.12 Advocacy frameworks that are based on principles of social justice adhere to the notion that advocacy is a moral imperative.13 In this context, advocacy requires that nurses are emphatic in their efforts to address health inequities on behalf of marginalized patients. This implies the recognition that patient rights are human rights and not only legal rights, and that these rights must be protected.13

Nursing is largely understood as practicing within the sphere of personal, one-on-one relationships and therefore nurses are privy to the daily injustices experienced by their patients. Because of this proximity, nurses may assume the role of an advocate. At times, however, this may also lead to nurses assuming a position of authority, which can exacerbate existing power differentials and perpetuate an ideology that patients are inherently lacking in agency.13 Without further examination, this role can perpetuate paternalistic practices in health care, whereby the nurse assumes to know what is in the best interest of their
patients.13 These assumptions are often based on stereotypes embedded in western models of health care.14 A western-oriented, individualistic focus limits our ability to get to the root causes of inequities, resulting in solutions that are short-sighted and ineffective in making meaningful systems-level changes.13,14 Nurses are in a position to expand the role of advocate beyond the individual level to propose and champion policies that create the conditions in which human rights can be realized for everyone. Nevertheless, as mentioned earlier, in order for nurses to do so, they first need to recognize and acknowledge the historical realities of the populations that they serve and how these realities impact health outcomes in contemporary society.

HISTORICAL TRAUMA

Marginalized populations historically subjected to persistent oppressions are vulnerable to experiencing what has been termed "historical trauma." Mental health expert and Native scholar, Dr Brave Heart has been credited with the development of the critical framework of historical trauma to describe the generational impact of the trauma of colonial policies experienced specifically by Indigenous populations.15 Dr Brave Heart specifically describes historical trauma as a "constellation of characteristics associated with massive cumulative group trauma across generations."16(p245) Historical trauma is an interdisciplinary framework that builds upon psychosocial, political/economic, and social/ecological systems frameworks.17

The framework of historical trauma has been used by scholars to explain the impact of colonization, historical oppression, psychological trauma, and cultural suppression of Native American, Aboriginal or First Nation, and Indigenous communities. Historical trauma speaks to the unresolved trauma from the devastating effects of colonialism including genocide, loss of land, loss of culture, loss of language, loss of kinship systems, and forcible removal from family and communities.16 This context of postcolonial suffering and cumulative loss has helped to shed light on many of the present-day health disparities seen in Native and Indigenous communities today.16

Sotero 17 argues that a historical trauma framework is necessary for understanding how and why certain populations have a higher disease burden than others. Four distinct assumptions underpin historical trauma: (1) mass trauma; (2) trauma continuing over an extended period; (3) traumatic events reverberating throughout the population to create a universal experience of trauma; and (4) the consequence of the trauma experience derailing the population from a natural, projected course.17

The framework of historical trauma has since evolved over the last few decades to include vulnerable populations, minority groups, and communities other than Native Americans to explain the relationship between present-day health disparities, oppression, and traumatic historical events as well as ongoing structural violence.18

CRITICAL RACE THEORY AND INTERSECTIONALITY

Critical race theory and intersectionality provide a powerful underpinning that moves away from the individual-level toward structural-level factors. Critical race theory and intersectionality derive from different disciplines (legal studies and black feminist thought), but when applied to health inequities, similarly acknowledge, name, and seek to dismantle oppressive structures in health care.

Critical race theory starts with the premise that racism is not an aberration, but rather, is embedded in everyday policies, structures, and institutions of American life.19,21 Bonilla-Silva 20 used the term "racialized" in describing these systems, which emerged alongside the concept of race and which operate to maintain hierarchical social structures. The result is unequal distribution of resources and power that benefit the oppressing group, also referred to as structural racism.20 These power structures stem from white supremacy built on a scientifically debunked notion that a "white race" is genetically superior to nonwhite groups.21 Public institutions, including health care institutions, are not exempt from these privileging and dominating structures and ideologies.
Structural racism permeates throughout public and private sectors creating a matrix of inequities that become deeply embedded in all aspects of everyday
life.10 For example, discriminatory housing laws and segregation create neighborhoods in which people of color disproportionately live in substandard housing, are exposed to environmental toxins, and have limited opportunities for economic advancement.10 The divestments in these communities make it difficult to attract primary care providers and specialists. As a result, community members have limited access to quality health care facilities, higher clinician to patient ratios, and a greater likelihood of experiencing racially biased
care.10 Yet, medical researchers and health care practitioners have explicitly and implicitly attributed disparate health outcomes of people of color to biological and intellectual inferiority.22

Intersectional analysis extends this critical stance, as it elucidates the ways in which social, economic, and political machinations manipulate determinants of health to perpetuate systems of oppression and domination.23 Intersectional thought is historically rooted in resistance movements by women of color against violence and oppression in the late 19th and early 20th centuries. Crenshaw 24 and Collins 25 contributed early academic scholarship by explaining the tenets of intersectionality, which emphasize focusing on the complex nature of oppression for low-income women of color. Intersectionality theory emphasizes that the root causes of marginalization cannot be traced to one specific social location (race, class, or gender), but rather must include an overall analysis of how power functions to create a matrix of intersecting oppressive processes impacting people occupying multiple marginalized social locations.23 Multiple categories of difference (eg, gender, race, and social class) are both created and sustained by structures of domination. These categories of difference create categories of "other" that

inform societal norms and standards in our everyday social processes.23 Intersectionality emphasizes that this matrix of power differentials constrain opportunities for marginalized people, while privileging dominant groups, resulting in a status quo of oppression that is embedded in everyday institutions.23

Throughout history, marginalized populations in the United States (and worldwide) have engaged in various forms of resistance to demand reconciliation and restitution for the gross inequities imposed upon them by the ideologies of white supremacy and other systems of domination that have shaped our society.26 The adverse health outcomes and generations of trauma that they have (and continue to) experienced impact their livelihoods and at times threaten their very existence. In the next section, we discuss key resistance movements of our time that help center our understanding of current health inequities and provide counter-narratives to the dominant tropes ascribed to various communities.

THE BLM MOVEMENT

The BLM movement is a recent example of a resistance movement whose goal is to call attention to and interrupt what is considered institutional and state-sponsored violence against black individuals and black communities. A global network with over 40 chapters, BLM is a social movement focusing on the experiences of black lives in the United States, and dismantling systems that perpetuate the devaluing of black and brown communities and people of color in the United States.27

The BLM movement was brought to life by Alicia Garza, Patrisse Cullors, and Opal Tometi-3 radical black women organizers. BLM was created in response to the acquittal of George Zimmerman, a self-appointed neighborhood watch captain, in Sanford, Florida, who shot and killed Trayvon Martin in February 2013. Trayvon was an unarmed African American teenager walking to his father's house (in a middle-class gated community), holding Skittles and an iced tea. The day after the verdict was announced, acquitting Mr Zimmerman, Garza posted the following on Facebook, which she later described as "an impassioned online message, 'essentially a love note to black people.'"27(p453) The post read, "Black people, I love you. I love us. Our lives matter."27(p453) Shortly thereafter, Tometi, Garza, and Cullors launched the BLM movement using social media. Similar to Trayvon Martin, Michael Brown, an unarmed African American teenager, was shot and killed by a police officer in Ferguson, Missouri, in August 2014. The case sparked national attention and within weeks of Brown's death BLM gained national recognition, as it mobilized the organization of peaceful resistance, connecting more than 500 people from over 18 major cities across the United States.27

DREAMers

The Deferred Action for Childhood Arrivals (DACA) program was established in 2012 as a mechanism for undocumented young adults, brought to the United States as minors, to receive temporary work authorizations, 2 years of deportation reprieve and the possibility of renewal.28 This group is known as DREAMers, as they also form part of the immigrant population eligible to benefit from the federal DREAMers Act,29 the DREAMers come from around the world with the majority born in Latin America. According to Lopez and Krogstad,30 most DACA recipients are from Mexico (548 000), followed by El Salvador (25 900), Guatemala (17 700), Honduras (16 100), Peru (7420), South Korea (7310), Brazil (5780), Ecuador (5460), Colombia (5020), and Argentina (3970). Even though DACA recipients are eligible for legal employment, they continue to face limited access to health care,

including ineligibility for expanded Medicaid coverage and insurance through the State Health Insurance Exchanges without federal
subsidies.29

Castaneda and Melo 31 note that even households eligible for social services avoid enrolling in public health programs out of fear of imprisonment and deportation. This state of fear has caused immigrant parents to isolate their children from support systems such as health care, as some institutions that were previously considered sanctuaries, have become targets of Immigration and Customs Enforcement (ICE) agents.29 For example, Boggs 32 reported that ICE agents attempted to arrest individuals, merely suspected of being undocumented, at the entrance of their children's school in New Jersey. Other cases involved a woman who was detained by ICE agents while seeking domestic abuse protection at a Texas courthouse 33 and the case of a group of Latino men arrested by ICE agents after leaving a church warming center in Virginia.34

THE DAKOTA ACCESS PIPELINE

The 1800-mile, $3.78-billion DAPL carries crude oil beneath 4 states and 2 major rivers near the Standing Rock Indian reservation in North Dakota. Beginning in April 2016, the Standing Rock Sioux and their supporters (also known as the Camp of Sacred Stones) gathered in protest near the pipeline construction site, sparking the creation of the grassroots #NoDAPL movement. Standing Rock Sioux tribal members, other Native Americans, and non-Natives deemed themselves water protectors, and established the Sacred Stone Camp near the pipeline construction site to peacefully protest the construction of the DAPL.35

The #NoDAPL movement has been at the center of controversial years-long legal disputes about risks to water safety, colonialism, the eminent domain of the Native American land under the 1868 Fort Laramie Treaty, and placing corporate profits over lives. At the height of the movement, there were reports of protestors being pepper sprayed, shot with rubber bullets, attacked by dogs, being denied food, water, and medical supplies, threatened by lawsuits, and drenched with cold water during freezing winter temperatures.36

The US government has a significant history of placing financial and business interests over Native American rights. Through a continued colonial legal framework, there was minimal inclusion of the tribe during the historical survey, permits were rushed, and plans and notification were not provided until the end of the process when approval for the pipeline was nearly finalized.37 The Standing Rock Sioux tribe decided to take action after they were made aware of further violations of their land treaty and water rights. After many months of protests, exhaustive efforts by the Standing Rock Sioux, and more than 750 arrests of protestors, the battle of the DAPL ended.36 Eventually, the camps were shut down and the protesters left. Over 520 000 barrels of crude oil now flow daily through the pipeline, beneath crucial sources of fresh water and through Native sacred lands.36

These movements are an indication that populations under constant threat of having their human rights denied are vying to have their voices heard from the margins to which they have been relegated. What the nursing profession can learn from these movements are strategies to harness our collective voices. As the largest body of health care professionals,2 using nursing organizations is one platform for leveraging our collective power to serve as agents of change in an effort to improve health outcomes particularly among the most marginalized in our society. We speak to the role of the nursing profession in this regard, next.

RESPONSE OF THE NURSING PROFESSION

While the ANA has made statements calling for an end to the separation of immigrant children from their families at the border, for example, on many other issues, professional nurses and their governing bodies have for the most part remained silent. History has shown that our silence has dire consequences. For example, in 1976, the Government Accounting Office released the results of an investigation into "incidental" tubal ligations or hysterectomies that had been performed during other routine procedures on Native American women, and without the consent of the patient, or with consent under coercion.37 Records verified that the Indian Health Service (IHS) in 4 southwestern states had performed 3406 sterilizations between 1973 and 1976.37 During this same period, there was an increase in abortions at IHS clinics. IHS health care professionals, including nurses, used coercive tactics to obtain consent by threatening to withdraw future health care provisions or threatening to take custody of the children of the Native American women involved.37

The silence and collusion with violence during colonization, the Tuskegee Syphilis study, and during the Nazi regime are all warnings as to how "suffering has been and is being perpetrated by us [nurses], and that we continue to promote suffering when we remain silent about the political realities that cause it."38(p255) One of the ramifications of the Tuskegee Syphilis study specifically, and a clear example of how historical trauma reverberates across generations, is the hesitancy of people of color to participate in research. This has important implications, as proposed health interventions may then not be culturally tailored to effectively meet the unique needs of specific populations when the experiences of those populations are not taken into consideration through research in the development of the said interventions. By advocating for populations that have experienced marginalization and by participating in the various movements that seek to redress experiences of oppression, nurses can help mitigate the distrust that has resulted from these historical events between minority populations and health care professionals. One way that nurses can specifically play a role in ensuring that the experiences of underserved populations are captured in research and inform effective interventions is by becoming involved in the National Institutes of Health initiative, All of Us, which focuses on precision medicine that values diversity, recognizes the importance of acknowledging individual differences in developing knowledge about various diseases, and thereafter, seeks to ensure the development of effective treatment.39 Our ultimate goal as nurses should be to center the voices of the most marginalized to ensure that their voices also inform health care practice and policy.

Combining the advocate and ally roles indeed requires nurses to amplify the voices of the communities suffering from systemic injustices. This is in recognition that the lived experiences of marginalization peoples are critical to dismantling oppressive systems and in creating effective and sustainable solutions. Authentic partnerships are those in which historically silenced voices are privileged such that communities are able to promote and advocate for their own needs. Anything short of this model of partnership threatens the human rights of communities on the margins and undermines the efforts of nurses.8 Nursing advocacy and allyship becomes possible through the active participation in professional and civil organizations as well as to run for political office at the local, state, or national level.

NURSES AS ALLIES

There are a number of examples of nurses, individually and collectively, working as allies with marginalized communities. One example of nurse allyship and activism is the National Nurses United

(NNU) organization that stood in solidarity with the #noDAPL water protectors.40 The NNU is a national professional nursing association and network of volunteer RNs who advocate for safe, accessible, and quality health care for all as a human right. The NNU was vehemently opposed to the treatment of the #NoDAPL protestors, Standing Rock Sioux tribal members, First Nations members, and environmental activists by the police and security guards at the DAPL construction site.40 In 2016, the NNU publicly condemned physical attacks and brutal force by police and armed guards, stating that these attacks were "reminiscent of assaults on peaceful protestors during the Civil Rights movement."40 In response, the NNU deployed nurse volunteers to assist with first-aid needs for those assaulted with pepper spray, physical attacks, dog bites, and other resulting health concerns.40

Another example of current nurse activism is the organization Rebellious Nursing Philly, a subgroup of a national Rebellious Nursing movement that began with a conference in 2013. Subsequent to this, Rebellious Nursing Philly began a local chapter and worked on various activism projects, one of which involved work with #BlackLivesMatter movement.41 The group penned a statement on BLM and submitted a letter to the editor of the New England Journal of Medicine (unpublished) in response to articles about the BLM movement.41

Another example of nurse-as-ally includes the efforts of many American nurses and nursing organizations championing immigration justice. Among them is nurse Martha Williams of Weslaco, Texas, who created an area of reciprocity between the United States and Mexico, consisting of a network of free clinics along the
border.42

Finally, in Arkansas, a nursing student and DACA recipient joined the state's Nursing Student Association and successfully advocated for new legislation to allow DACA recipients to take the National Council Licensure Exam (NCLEX).43 The representatives of the ANA Membership Assembly recently addressed this issue, recommending that all the states allow the DREAMers to take the licensure examination (NCLEX) without facing barriers, as a supportive measure to diversify the US nursing workforce and ease the nursing shortage.44

MOVING FORWARD

As we reflect on our current political climate in the United States as well as in other western countries, we weigh the risks of remaining silent and the inadvertent impact of the pivotal movements underway. We are moved to call upon nurses to take action and become allies. Informed by the frameworks of historical trauma, intersectionality and critical race theory, we recognize our responsibility to dismantle racism in all its forms-interpersonal, implicit, and structural. Nurses in the United States must recognize that our profession has been developed and continues to operate within the context of colonialism and structural racism. The nursing profession is thus a microcosm of these larger configurations of power.38,45 By identifying ourselves as professional nurses and allies, we recognize that racism and colonialism are major drivers of health inequities in the United States.45,46 We must therefore take direct and immediate action on a personal, community, and professional levels, especially because we work within an inherently racist health care system.8 For white nurses who comprise the majority of the nursing workforce (81%),47 this involves a serious and ongoing personal commitment to self-reflect and study the concepts and literature concerning white racial literacy.48 Certain key concepts are critical for white nurses to understand as a part of this personal commitment.

One such concept is white fragility,48 defined as the behaviors and defensive reactions that white people make when challenged about white supremacy. This defensiveness is a function of white supremacy perpetuating white privilege.
White nurse allies must engage with the work of black feminist and critical race scholars to incorporate concepts such as intersectionality and colorblindness into nursing curriculum, practice, and policy. This will serve to improve our understanding of the ways in which white supremacy influences our thinking and actions as we work alongside marginalized communities for justice and liberation.
For minority nurses, utilizing the tenets of intersectionality will facilitate reflection on the power they yield by way of their education and profession while not dismissing their experiences with marginalization based on their social location as a minority.23

Drawing on our understanding of our professional role as advocate and our history as allies, nurses well positioned to engage in an epistemological shift to focus on becoming allies because as professionals, we have a deep understanding about how to recognize disempowerment or loss of agency.
Undergraduate nursing education is one avenue through which critical race scholarship can intervene to bring issues of race, power, and privilege to the fore. Research has shown that nurse educators recognize the importance of addressing structural inequities, specifically racism, but feel unprepared to do so.49 Collins 50 notes that when any homogenous group dictates whose knowledge is considered valid, other ways of knowing-black feminist thought for example-are further marginalized. If taught in the absence of a critical pedagogy, the taken-for-granted assumptions are accepted without question and a white, European worldview becomes the implicit norm to which all other worldviews are compared and delegitimized.51 Subaltern epistemologies provide a retort to this Eurocentric stance, and instead contend that knowledge can also be based upon the lived experience, allowing for multiple ways of knowing.50

The nurse as ally amplifies the voice of those on the margins in our clinical work, scholarship, and research. In other words, we emphasize the importance of centering in the margins.19,23 This should not be undertaken from a place of sympathy, but out of our ethical mandate and social responsibility for justice.1,52 Systems of oppression operate because the individuals operating within these systems do nothing to disrupt the status quo and in so doing collude with racism and injustice. As Young states, "individuals bear responsibility for structural injustice because they contribute by their actions to the processes that produce unjust outcomes."52(p105)

DISCUSSION

While current cultural, political, and economic ideologies make it incredibly challenging for nurses to practice in accordance with our moral and ethical mandates, we believe our knowledge, informed by critical race, intersectionality, and a deep understanding of historical trauma make us formidable in the fight for health equity. At the heart of our ethical identity is loyalty to our values, the lengths we are willing to go in order to uphold those values and a critical evaluation of historical complicities and of contemporary events that impact the nursing profession.3

Knowledge is inextricably linked with power 53 and, contrary to popular belief, nursing is not a profession void of power.7 In fact, nurses have the capacity to both exercise and resist power, making nursing care inherently a political
activity.54 Acknowledging historical injustices is critical to understanding how they continue to reverberate in contemporary society. Armed with this knowledge, nursing, as a key profession in health care, has the necessary foundation on which to exercise power in order to improve health outcomes and

changes in health policy. By engaging with these movements, as nurses, we become more knowledgeable and more aware of the realities faced by millions of our citizens existing on the margins of US society. More importantly, by privileging the voices of those who have lived experience of racism in the United States, nursing is utilizing epistemologies that have remained on the periphery of nursing education, practice, and policy.

Nursing history is rich with activism and action, built upon the scholarship and praxis of emancipatory nursing.55 An overview of historical and contemporary nurses dedicated to social justice and activism can be found at https://nursemanifest.com/nursing-activism-project.
This website also provides resources for current activism and a catalogue of articles related to nursing activism. These resources need to be disseminated widely and incorporated into undergraduate and graduate nursing educational curricula, as they provide specific action steps to align nurses with our core professional, ethical, and human rights declarations.

In conclusion, we reiterate the sentiments in the nursing manifesto: "We believe that it is possible to find connection in the midst of alienation, to find inspiration in the midst of cynicism, to find nourishment and meaning in the midst of spiritual impoverishment, to find hope in the midst of despair, to find wholeness in the midst of fragmentation, to find peace in the midst of violence, to find enrichment in the midst of economic idolatry, and to find sovereignty in the midst of constraints."7(p79)

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