Words Matter

An Integrative Review of Institutionalized Racism in Nursing Literature

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In health care, as in society, racism operates on multiple levels and contributes greatly to health and social inequities experienced by black Americans. In addressing racism, however, health care has primarily focused on interpersonal racism rather than institutionalized forms of racism that are deeply entrenched and contribute to racial inequities in health. In order to meaningfully address health inequities, health care must extend its focus beyond the interpersonal level. The purpose of this integrative literature review is to identify how and to what extent peer-reviewed nursing literature and professional nursing organizations have explicitly addressed *institutionalized* racism. A systematic search of relevant nursing literature published since 2008 yielded 29 journal articles that focused on black Americans' experience of institutionalized racism in health and health care; the articles explicitly named racism as institutionalized, institutional, systemic, systematic, or structural. This review summarizes author-identified implications of institutionalized racism for nursing education, research, and practice, and offers suggestions for use by the nursing profession to dismantle racist policies, practices, and structures. **Key words:** *health inequities*, *institutionalized racism*, *nursing*, *racial inequities*

THE upcoming release of Healthy People 2030 will be the fifth iteration of a national framework that outlines measurable goals and objectives for achieving health equity in American society.[1] Yet, despite nearly 4 decades of national attention, the goal of health equity remains elusive, as inequities in health based on race, socioeconomic status, and other demographic factors persist. For many health outcomes, racial inequity is in fact worsening. In 1950, for example, there was no significant difference in the rates of death from heart disease between black and white Americans. In 1980, however, a racial inequity in mortality from cardiovascular disease between blacks and whites appeared, and it has continued to widen.[2] Indeed, racial inequities persist for nearly all of the leading causes of death, including cancer, stroke, diabetes, kidney disease, hypertension, cirrhosis, and homicide,[3] resulting in higher age-specific mortality rates for black Americans than for white Americans.[4] These inequities are evident in the incidence, severity, and progression of chronic illness even when controlling for risk factors such

Statement of Significance

What is known, or assumed to be true, about this topic?

Black Americans experience persistent and pervasive inequities in health in the United States. Many Americans believed that the election of Barack Obama as the nation's first African American president provided uncontroverted proof that we had entered a postracial era. However, substantial evidence supports the argument that racism is alive and well in the United States, but manifests in subtler ways and is reinforced and sustained through historical and institutionalized racism.

What this article adds?

This review sheds light on the relative lack of attention that institutionalized racism has received from peer-reviewed nursing journals and from professional nursing organizations. Based on the findings of this review, we suggest that cultural competency training is insufficient for challenging implicit biases, white privilege, or historical power structures. We offer several suggestions for nursing science, practice, and education to help the nursing profession acknowledge, understand, and act to dismantle institutionalized racism.

as socioeconomic status; there is substantial evidence that racism and discrimination negatively impact health.[5-7] Clearly, racial inequities in many health outcomes warrant further attention.

Inequities faced by black Americans are particularly and uniquely entrenched in US society, given their historical roots in chattel slavery and the fact that every system in the United States, from education to health care, was originally designed by and for white Americans. It should thus come as no surprise that disproportionately worse outcomes exist for black Americans no matter

the system examined. While well-known forms of legalized discrimination such as Jim Crow laws are now illegal, the legacy of such institutional policies endures and serves to perpetuate racial inequities, as evidenced by ongoing residential segregation[6] and continued experiences of inequities related to other important social determinants of health. Education, for example, influences not only employment opportunities and the ability to earn a sufficient income, but also access to the health care system. Black Americans are less likely to graduate from high school and college than are non-Hispanic whites[8] and have higher unemployment rates.[9] But these inequities in education and employment do not explain the entirety of inequities in income and wealth; compared with the non-Hispanic white population, black Americans have lower income earnings at comparable levels of education and less wealth at every level of income. In 2013, the wealth of white households was 13 times the median wealth of black households.[10] Thus, the legacy of institutionalized racism continues to affect the health and well-being of black Americans in all facets of American society. Such racial differences exist and must be acknowledged.

WORDS MATTER

Whereas Healthy People draws attention to *health disparities*, this review uses the term *health inequities*, because it better describes *systematic*, *socially produced*, *unjust* differences in health that pervade American society.[11] There is an "inescapable ethical valence" to the term *inequities* as opposed to the more neutral term *disparities*[12]; in the discussion of health disparities, the prevailing emphasis on individuals can easily blame people for circumstances beyond their control.[13] In addition, although some scholars distinguish between "structural racism," as "the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems . . . that in turn reinforce discriminatory beliefs, values,

and distribution of resources," and "institutional racism," as racially discriminatory policies and practices,[14,15] in this review, *institutionalized racism* refers to both.

BACKGROUND

Race is a constructed social category that creates a mechanism whereby some groups are deemed superior to others and are given preferential access to societal goods and resources.[16] The reinforcement of this racial hierarchy has a long history of now debunked scientific theory and inquiry based on the assumption of race as an innate, fixed characteristic.[14,17] *Racism* is inherent in the construction of race as a social category. Racism encompasses a web of actions, beliefs, and economic, political, social, and cultural structures, all of which allocate privilege, resources, and power to benefit the dominant racial group—in the United States, people classified as white—at the expense of all others.[18] Many researchers now point to the growing body of evidence documenting racial discrimination in access to and the provision of health care services[5,19,20] and the important role that racism plays in perpetuating prejudicial attitudes and in generating and sustaining health inequities.[21,22] Thus, a growing chorus of stakeholders are calling researchers to discuss *racism* and health rather than race and health.[5,23]

In 2000, Camara Jones[24] developed a now classic framework for understanding racism on 3 intersecting and overlapping levels: institutionalized, interpersonal, and internalized. However, the conversation about racism in health care—particularly about institutionalized racism—is difficult and has been described as taboo in American nursing.[25] One of the most important factors contributing to the reluctance of the nursing profession to discuss racism is likely the profession's continuing emphasis on the individual patient, thereby fostering an environment in which racism is conceptualized as merely interpersonal.[26] This focus, however, precludes an understanding of racism at the institutional level. *Institutionalized racism* is the "differential access to the goods, services, and opportunities of society by race."[24(p1212)] It results from the interaction of macrolevel systems—social forces, institutions, ideologies, and processes—that interact with one another to generate and reinforce inequities.[27] Institutionalized racism manifests in many ways because of its normative and structural aspects: it is codified in our systems of law and in our customs of everyday living, such that there is no need to identify an individual's responsibility for racist behavior.[24] Thus, it has been argued[28] that a "new racism" plagues America, affecting all people, networks, and institutions. This new color-blind racism adheres to an ideology that rationalizes the status of minorities as the product of market dynamics and alleged cultural deficiencies[29] and ignores the "pervasiveness of material, economic, legal, and political stratification along racial lines in the United States that disadvantages people of color."[30(p93)]

Nurses, who represent the nation's largest share of the health care workforce and have a disciplinary knowledge base that incorporates a commitment to social justice, are well-positioned to reclaim their historical position as progressive reformers dedicated to addressing social injustice and improving health equity.[31] In an age of color-blind racism, it is urgently necessary to understand, acknowledge, and explicitly name institutionalized racism in order to address health inequities. As a first step, one must therefore determine the extent to which the nursing profession acknowledges and understands how racism functions at an institutional level by explicitly naming institutionalized racism in the scientific and professional literature that guides nursing science, education, and practice. The purpose of this integrative literature review, therefore, is to identify how and to what extent peer-reviewed nursing literature and professional nursing organizations have explicitly addressed institutionalized racism.

This study extends the recent work of Hardeman et al,[7] who systematically reviewed the top 50 highest-impact journals in each of

6 categories representing public health, including nursing, to determine whether public health researchers are naming institutionalized racism in the titles and abstracts of their peer-reviewed publications and to explore their discussions of it. Hardeman et al[7] found that the explicit naming of institutionalized racism in titles and abstracts was rare, and they called for future studies to review public health literature more deeply. The present review is a response to that call, in an attempt to understand the prevailing thought about and awareness of institutionalized racism within the nursing profession. This review includes literature published in peer-reviewed nursing journals, focusing specifically on the impact of institutionalized racism on black Americans, and capturing the nursing literature published after President Obama's presidential campaign and election, which to many Americans signaled proof that American society had entered a "post-racial" era, up to the present.[32]

METHODS

Relevant nursing journal publications were systematically identified and analyzed in accordance with the PRISMA statement for systematic reviews and meta-analyses.[33] In addition, professional organizations' Web sites were searched for position and policy statements. The following research questions guided this review:

1. What are the types of publications in peer-reviewed nursing journals that address institutionalized racism in the United States?
2. What terms are used to describe institutionalized racism in the United States (institutionalized vs institutional vs structural vs systemic vs systematic)?
3. Is institutionalized racism a core concept or secondary concept?
4. What sources of funding have supported scholarship published in nursing journals regarding institutionalized racism in the United States?
5. In what ways have major national nursing organizations addressed institutionalized racism (eg, publication of policy/position statements and specific calls to action)?
6. What implications are discussed for addressing institutionalized racism through nursing education, science, and practice?

Search strategy

Search strategies were designed in consultation with the health sciences librarian at our university. Using a combination of search terms and filters, PubMed, CINAHL, PsycInfo, ERIC, and JSTOR were searched for literature addressing racism published in peer-reviewed nursing journals (see Box 1). Google Scholar identified literature citing Hardeman et al's[7] systematic review of the public health

Box 1. Search Strategy

Database	Search Terms	Other Filters
JSTOR	Racism	English language; published in The American Journal of Nursing or Community Health Nursing[a]
PubMed	Racism	NLM Index: Nursing Journal
CINAHL	(TX racism AND TX nurs*) AND (African American OR black)	English language; geographic subset USA; nursing journal
PsycInfo	TX racism AND TX nurs*	
ERIC	TX racism AND TX nurs*	

Abbreviations: NLM, National Library of Medicine; TX, all text.
[a]These are the only 2 nursing journals indexed in JSTOR.

literature as well as Hardeman et al's[33] editorial in the *New England Journal of Medicine* on the role of health professionals in supporting black lives. The references in Hardeman et al's literature review were also hand searched for articles published in nursing journals.

To be included in this review, publications had to mention by name institutional, institutionalized, systemic, systematic, or structural racism in the text, title, or abstract; to be published in English in a peer-reviewed nursing journal after January 1, 2008; and to focus on institutionalized racism toward black Americans in the United States. Nursing journals were those indexed in the National Library of Medicine (NLM) as such. Publications in *The ABNF Journal*, the peer-reviewed journal of the Association of Black Nursing Faculty, were also included (the NLM does not currently index this as a nursing journal). The search thus included literature published in 182 peer-reviewed nursing journals. In addition to the databases, the Web sites of the American Nurses Association (ANA), the American Association of Colleges of Nursing, the International Council of Nurses, the Quad Council of Public Health Nurses, and the National League for Nursing were also reviewed to identify policy and position statements explicitly naming institutionalized racism (see Box 2). These organizations constituted a sample of influential nursing bodies representing nurses in practice and academia. Statements issued after January 1, 2008, that mentioned by name institutional, institutionalized, systemic, systematic, or structural racism were included. These journal publications and organizational statements thus represent the extent to which the nursing literature has addressed institutionalized racism since the beginning of the Obama presidency.

Screening process

The initial search returned 879 journal publications. The exclusion criteria were applied in 2 steps. After removal of duplicates and initial screening based on country, publication in a nursing journal, and focus on the experiences of black people, 205 remained. Next, the full text of each one was independently read and screened for the use of institutional, institutionalized, systemic, systematic, and/or structural racism by 1 of the 3 coauthors of this review. The coauthors met 7 times to discuss the review and screening and to resolve any uncertainty regarding inclusion; consensus was reached for each publication. After the full-text screen, application of exclusion criteria, and resolution of discrepancies, 29 articles or letters to the editor (henceforth, "articles") remained in the final sample for review (see the Figure).

Data extraction

The 3 authors divided up the 29 articles and entered the extracted data into a shared

Box 2. Nursing Organization Statements

| Nursing Organization	Policy/Position Statement
American Association of Colleges of Nursing	Diversity, Inclusion, and Equity in Academic Nursing (2017)
American Nurses Association	Code of Ethics for Nurses with Interpretive Statements (2015)
International Council of Nurses	Cultural and Linguistic Competence Position Statement (2013)
National League for Nursing	Public Policy Agenda (2017-2018)
Quad Council Coalition of Public Health Nursing Organizations	The Public Health Nurse's Role in Achieving Health Equity: Eliminating Inequalities in Health (2016)
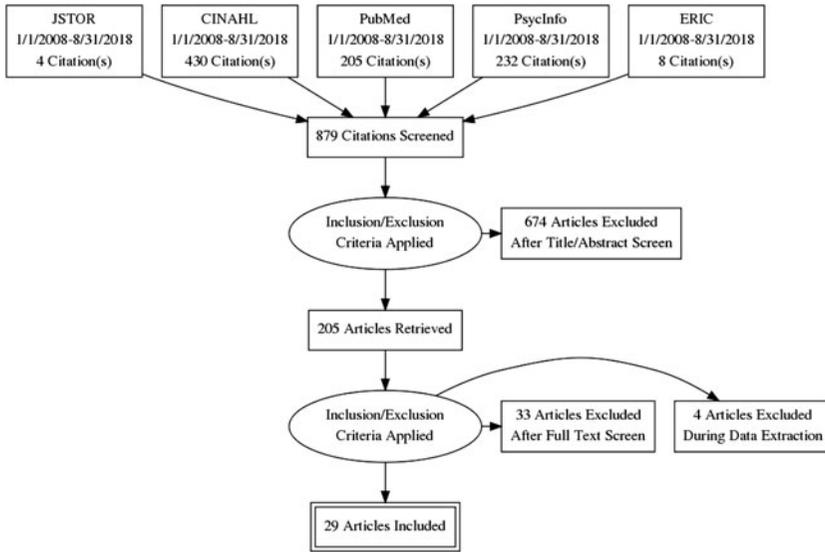
Figure. PRISMA diagram of literature search and screening process.

Google spreadsheet. The articles clustered into 6 general categories (original research, commentary/editorial, theoretical article, letter to the editor, literature review, or quality improvement). This information was entered, along with any funding sources for original research, terms used to reference or discuss institutionalized racism, and whether or not institutionalized racism was a core concept in each article. Institutionalized racism was judged to be of core importance based on whether or not removal of the term and related discussion would change the meaning and intent of the respective article.[7] Also entered were implications for nursing education, science, and practice as identified by the authors of each article. The nursing organization Web sites and position papers were also reviewed for mention of institutionalized, institutional, systemic, systematic, or structural racism.

RESULTS

The 29 articles included in this review were published in 15 journals, fewer than 10% of the nursing journals searched (see Table 1). These 15 journals represent a broad cross-section of nursing specialties, including cancer, mental health, and AIDS care. However, journals that targeted women's health and reproduction were the ones most likely to have published literature that explicitly named institutionalized racism. Twelve of the 29 articles presented commentary[35-47]; 5 presented original research[48-52]; 6 were theoretical[53-58]; 3 were quality improvement studies[40,41,59]; 2 were letters to the editor; and 1 was a literature review (see Table 2). Of the 5 articles with original research, 4 were qualitative studies and 1 was quantitative. Of the 12 commentaries, 2 were invited[37,39] comments on Thomas' original research[52] regarding institutionalized racism and the manifestations of such within the certification process for lactation consultants. None of the position or policy statements from nursing organizations that we reviewed addressed institutionalized racism (Box 2). Institutionalized racism was a core concept in 19 of the articles and a secondary concept in the remaining 10. Fifteen of the articles used the term *institutional racism*; 9, *institutionalized racism*; 6, *structural racism*; and 5, *systemic racism*; 11 of the articles used more than one of these terms.

Table 1. Nursing Journals Publishing Articles Naming Institutionalized Racism

Name of Journal	Commentary	Original Research	Theoretical Paper	Letter to the Editor	Literature Review	Quality Improvement
Advances in Nursing Science		1	1			
Cancer Nursing		1				
Creative Nursing						1
Issues in Mental Health Nursing	1					
Journal of the Association of Nurses in AIDS Care				1		
Journal of Human Lactation	3	1				
Journal of Midwifery & Women's Health	1		1		1	1
Journal of Perianesthesia Nursing	1					
Journal of Professional Nursing			2			
Journal of Transcultural Nursing	1	1	1	1		
Nursing Inquiry	1					
Nursing Outlook	1	1	1			
Policy, Politics, & Nursing Practice	1					
Public Health Nursing	1		1			
The ABNF Journal	1					

Table 2. Article Classifications, Terms Used, and Funding Sources

Author	Journal	Article Type	Core or Secondary Concept	Term used (Institutionalized, Systemic, etc)	Source of Funding
Alhusen et al[61]	*Journal of Midwifery & Women's Health*	LR	Secondary	Institutional	NINR-K23
Beard and Julion[48]	*Nursing Outlook*	OR	Secondary	Institutionalized	None
Bond[35]	*Journal of Midwifery & Women's Health*	CM	Core	Institutionalized	None
Brady[36]	*Journal of Perianesthesia Nursing*	CM	Secondary	Institutionalized	None
Van Otterloo[47]	*Policy, Politics & Nursing Practice*	CM	Core	Institutional	None
Broomfield-Massey and Noor[37]	*Journal of Human Lactation*	CM	core	Structural, institutional	None
Carmichael[64]	*Journal of Transcultural Nursing*	LE	Secondary	Institutional	None
Cooke et al[49]	*Advances in Nursing Science*	OR	Secondary	Institutional, structural	NIMH, NINR (P30 & T32), NICHD (P30), NIDA training grant (T32)
DeLilly[38]	*Issues in Mental Health Nursing*	CM	Secondary	Institutionalized	NINR T32
Doede[53]	*Public Health Nursing*	TA	Core	Institutionalized	None
Giles[39]	*Journal of Human Lactation*	CM	Core	Systemic, structural	None
Gordon[40]	*Journal of Midwifery & Women's Health*	QI	Core	Institutionalized	None
Gordon et al[41]	*Journal of Midwifery & Women's Health*	QI	Core	Institutionalized	None
Hall and Fields[54]	*Advances in Nursing Science*	TA	Core	Institutional, institutionalized	None
Hall and Fields[42]	*Nursing Outlook*	CM	Core	Institutional, structural	None
Holland[50]	*Journal of Transcultural Nursing*	OR	Secondary	Institutional, systemic	None
Hulme[55]	*Journal of Transcultural Nursing*	TA	Secondary	Institutional	None
Lancellotti[56]	*Journal of Professional Nursing*	TA	Core	Institutionalized, institutional	None

(continues)

Table 2. Article Classifications, Terms Used, and Funding Sources (*Continued*)

Author	Journal	Article Type	Core or Secondary Concept	Term used (Institutionalized, Systemic, etc)	Source of Funding
Ludwig-Beymer[43]	*Journal of Transcultural Nursing*	CM	Core	Institutional, systemic	None
Mkandawire-Valhmu et al[57]	*Nursing Outlook*	TA	Core	Institutional	None
Mojab[60]	*Journal of Human Lactation*	CM	Core	Institutional	None
Nelson[59]	*Creative Nursing*	QI	Core	Institutional, systemic	None
Ramaswamy and Kelly[44]	*Public Health Nursing*	CM	Core	Institutional	None
Reyes[63]	*Journal of the Association of Nurses in AIDS Care*	LE	Core	Institutionalized	None
Simmonds[45]	*The ABNF Journal*	CM	Secondary	Institutional	None
Somayaji and Cloyes[51]	*Cancer Nursing*	OR	Secondary	Institutionalized	None
Thomas[52]	*Journal of Human Lactation*	OR	Core	Systemic, structural	None
Thorne[46]	*Nursing Inquiry*	CM	Core	Structural	None
Waite and Nardi [58]	*Journal of Professional Nursing*	TA	Core	Systemic, institutionalized	None

Abbreviations: CM, commentary/editorial/book review; LE, letter to the editor; NICHD, National Institute of Child Health and Human Development; NIDA, National Institute of Drug Abuse; NIMH, National Institute of Mental Health; NINR, National Institute for Nursing Research; OR, original research; QI, quality improvement; TA, theoretical article.

Only 3 of the 29 articles indicated funding that supported their research; one of those 3 listed several funding sources. The funding sources included a K23 award through the National Institute for Nursing Research (NINR), T32 training awards through the NINR and through the National Institute of Drug Abuse, and a P30 grant through the National Institute of Child Health and Human Development.

AUTHOR-IDENTIFIED IMPLICATIONS

Implications for education and professional development

Of the 29 articles reviewed, 10 presented recommendations for education in academic settings and 7 presented recommendations for education or professional development within other settings (eg, health care agencies and professional organizations). Authors made both general and specific recommendations regarding development of faculty and trainers and the need for multiple levels of reflection on individual as well as on organizational levels. Authors also provided strategies for teaching about content related to institutionalized racism as well as relevant considerations for faculty and administrators.

Need for development

If faculty are to teach effectively, authors suggested a need for training and additional preparation.[46,50] Holland[50] argued that faculty must take personal responsibility to increase their theoretical knowledge about race and racism because, as Waite and Nardi[58] suggest, one cannot teach and practice what one does not know. Thorne[46] advocated for guidance on pedagogical practices that directly counteract racism and other forms of systemic discrimination because relying on empathy is insufficient, and conflict avoidance is often a professional expectation in nursing that serves as a barrier to difficult conversations. Others advocated for training on ways to teach that undo stereotypes,[48] as well as skill development in how to navigate the resultant difficult conversations, which require time and space to do well.[41] Hall and Fields[54] suggested that feedback is a critical component in faculty development because faculty may overestimate their effectiveness in observing and addressing overt and subtle bias in comparison with students' perceptions. They also suggested the need for faculty training to handle bias and address it proactively with policies and statements of nondiscrimination in syllabi.

Need for reflection

There was a consistent call for reflection on multiple levels to be effective in teaching about institutionalized racism in academic and other professional settings. Inward reflection on the part of administrators and academic leaders with respect to curriculum, institutional policies, and faculty recruitment and retention was encouraged.[48,54,58] Waite and Nardi[58(p7)] presented a list of several beginning strategies for nurse leaders to take to combat racial inequity; the list included the charge to "begin with your own self-reflective practice." Such practice begins with "becoming comfortable being uncomfortable"[60(p33)] so that we can learn to effectively listen, speak, and monitor our thoughts, feelings, and behaviors to understand and effectively respond to unconscious cognitive processes. In her review of Khiara Bridges' book *Reproducing Race,* Van Otterloo[47] reminded readers of the necessity of considering actions that are taken for granted as best practice without consideration of the specific needs of the woman being cared for, questioning assumptions based on the race of patients, and identifying acts of implicit and explicit racism in our practices.

Self-reflection by faculty and students to examine personal prejudices and biases was deemed critical to developing one's competence as a multicultural practitioner[54] and as a process for which students need the most guidance.[42] Suggested areas for this exploration include an individual's social location, ethnicity, class, gender, and ability.[54]

Self-reflection, however, is only a key *first* step; authors also recommended a careful, thorough examination of the historical contexts that inform biases.[40,42,46,58] Prior to a conversation on culture, Gordon et al[41] encourage a discussion on racism and privilege, which should include historical underpinnings as well as current manifestations.

Reflection should not only be inward and backward but outward as well. Hall and Fields[42] recommended critiquing cultural competency programs for inadvertent endorsement of stereotyping. They suggested examining whether these programs present only a celebration of cultural differences and neglect addressing the power inequities that exist between white people over blacks. They also recommended taking a closer look at nursing curricula to determine whether cultural content has been distilled down to a single course or class instead of woven throughout the curriculum, which others also suggested as a more effective strategy.[46,58] Thomas[52(p464)] recommended taking a closer look at the certification examination for lactation consultants, with acknowledgment of the potential impact of "stereotype threat" on testing outcomes for lactation consultants of color.

Need for strategies

Multiple authors agreed that the delivery of content to address racism must be considered carefully, and they offered specific strategies that have been useful as well as strategies that have been unhelpful. The most consistent educational implication was that cultural competency training is not enough. Hall and Fields[54] suggested that the persistence of racism despite inclusion of cultural competence in nursing curricula is due to a lack of explicitly antiracist material. Gordon and colleagues[41] recounted lessons learned from their experience of incorporating antiracism coursework into the cultural competency curriculum of their midwifery program. The addition of a course on power and privilege with antiracism content allowed the focus of the cultural competency course to shift from researching other cultures to introspection, which helped to create a deeper understanding of identity formation and recognition of implicit bias. Lancellotti[56] observed that while culture and diversity are discussed in nursing, racism is not, and that institutionalized racism within nursing must be acknowledged and discussed before transformation can take place. She reasoned that "Whiteness is so deeply embedded in our educational system that it may seem invisible,"[56(p180)] and this leads to the presentation of white, middle-class as normative and everything else as "other." She advocated use of Leininger's culture care theory to counter this narrative. Waite and Nardi[58] emphasized the need to unpack the influence of American colonialism on nursing education (as well as research and practice) and to include discussions of whiteness and privilege. Holland[50] suggested that revisions to curricula include clear terminology about race and racism and explicitly teach about power, privilege, and systemic manifestations of racism with the goal of moving students' perspectives about racism from the individual to the system.

Specific strategies offered included racial self-narratives and autoethnography to explore how students learned about race,[54] individuating and perspective taking,[52] and strategies that focus on relationship building and affective learning, utilizing pedagogies that emphasize "learning with" instead of "knowing about."[50(p96)] Studying microaggressions was also presented as a useful way to unravel structural racism and make connections between structural and interpersonal racism on an individual level.[54] Faculty responses that students found unhelpful included passively letting students control the dialogue, disengaging, dismissing the importance of the discussion, changing the topic, becoming emotional, and treating the person of color as the expert on the topic of race.[54] These authors went on to state that perceived negative actions by faculty were experienced as a continuation of the microaggression that may have started the conversation about racism in the

first place. This unintended negative outcome highlights not only the responsibility of the faculty/trainer, but also possible reasons why conversations about race may be avoided altogether. Beard and Julion[48] urged faculty to overcome the fear of saying the wrong or politically incorrect thing, being misunderstood, or being perceived as a racist. Hall and Fields[42] emphasized the importance of using such missteps as teachable moments: "It is not a shame to have unintentionally internalized subtle racist assumptions, but it is one's ethical and human responsibility to explore and question these assumptions so we do not operate from them in practice, policy, knowledge development, and education."[42(p168)]

Implications for nursing science

Of the 29 articles, 18 addressed implications for nursing research related to institutionalized racism and discrimination. Ultimately, implications for nursing science included remaining critical of the science itself, from the most abstract level to the most minute levels of measurement and analysis. Across articles, there was a sentiment that research itself is a tool that—depending on how it is designed, funded, and disseminated—can be used either to understand and challenge institutionalized racism in nursing spaces or to uphold the white Eurocentric status quo.

There were 2 general considerations for nursing science. First, Thorne[46] argued that critical analyses of politics, power, and structural determinants of health must be made more central to nursing's professional scholarship—a sentiment echoed by many authors in discussing nursing science. Lancellotti[56(p.181)] critiqued the term "nursing science" for its alliance with empiricism, which is grounded in a larger "white Eurocentric" philosophy that decides "what pursuits are worthy of investigating" and ultimately grants more prestige to objective, quantitative science as opposed to studies with a more critical lens. Studies guided by critical social theory, by comparison, are guided by "the belief that meaning and truth are contextualized by relationships, power, social structure, and history," with the goal of freeing oppressed individuals and populations from domination. Waite and Nardi[58] encouraged nurse scientists to recognize where there is an absence of perspectives in the development of nursing knowledge other than those of white Anglo-American culture, and to invite those with an antiracist lens into the design, implementation, and dissemination of scientific studies.

Theoretical/conceptual frameworks and study designs

Many authors discussed the need to ground research with culturally sensitive theoretical lenses and study designs that provide room for challenging current power structures that perpetuate institutionalized racism. Critical race theory,[39,42,56] community-based participatory research,[61] and ethnonursing[56] were discussed as emancipatory frameworks that would allow scientists to critically analyze power structures in partnership with research participants.

Other more traditional theories were examined for their potential contributions to the science as well, including Bronfenbrenner's ecological model[35] and Leininger's cultural care theory.[56] Hall and Fields[54] criticized the use of nursing theories in studies about racism, because nursing's person-health-environment conceptualization of health does not highlight race as an important concept related to personhood. They argued that nurses and nurse theorists, who are predominantly white, have not experienced race as a significant part of their identity and therefore do not see it as a significant concept. In contrast, people of color, who are largely underrepresented in nursing scholarship, experience race as a significant part of being a person.[54]

Measurement and analytic considerations

Authors discussed using a critical lens to understand the ways in which institutions might perpetuate inequities through

decisions about types of research that are supported and rewarded, about types of data that are collected (or remain uncollected), and about how critical concepts related to institutionalized racism and health disparities are measured and interpreted. For example, Thomas[52] discussed the need to critically evaluate how institutions collect and interpret data regarding candidate completion rates and whether these processes lead to institutional change or to blaming individuals.

Measurement of race influences nursing science related to institutionalized racism.[54,61] Power dynamics at play in designing research studies and selecting how and when to measure race—an issue initially raised by Drevdahl et al[62]—was revisited by Hall and Fields,[54] who reemphasized that the categories used to define and measure race are not natural or self-evident, but are instead influenced by hidden assumptions that require scientists to be transparent in describing how they measure race and their rationale for selecting their measures.[54] Without such consideration and transparency, researchers may end up harming the very populations they intend to help (eg, by reinforcing false beliefs that racial disparities can be attributed to biological differences). Thoughtfully and transparently defining and measuring racial categories helps to "determine the social effects of racism" and dispel incorrect assumptions about biological differences between races.[39] Alhusen and colleagues[61] encouraged scientists to distinguish race from nativity to better understand the contributions of each identity to health disparities.

At a more macrolevel, authors noted the influence of institutional policies and priorities on the scientific measurement of race and racism. Hall and Fields[54] recognized the power and influence that funding agencies have in determining how race is measured by specifying which race categories should be used in studies, thus producing incomplete racial demographic information. The implications of institutional policies and their influence on studies about racism were also discussed by Hulme,[55] who pointed out that although the National Institutes of Health

(NIH) requires inclusion of ethnic minorities and women in research, the same does not necessarily apply to industry and private foundations that fund a significant amount of research. Furthermore, using sickle cell disease (SCD) as an exemplar, Nelson[59] presented a compelling example of research funding inequity. Even though nearly 3 times as many Americans live with SCD than with cystic fibrosis (CF), in 2004, per capita support from the NIH and philanthropic organizations was $6 for SCD compared with $5074 for CF. Notably, the vast majority of Americans living with SCD are black and those with CF are white.

Ethical considerations

Ethical considerations concerning research conducted by academic health centers on institutionalized racism included the need to ensure that research is conducted in a way that does not allow science to progress at the expense of exploiting and mistreating communities of color, as has often occurred in the past.[45,55] Instead, nurse scientists must build sustainable relationships with communities and engage in frank discussions about race relationships.[51] Scientists must consider the best strategies to recruit people of color into studies in ethical ways that acknowledge historical experiences of racism at the hands of research institutions.[51,54,55] Within nursing education research, Holland[50] presented evidence of the negative impact of color-blind practices among faculty, students, and institutions that deny the presence of racism. Such practices resulted in reinforcing "Euro-American dominance" in nursing education programs and contributed to moral outrage and anger among students of color. Finally, one must also consider the ethical implications of using "standardized" measures that are normed against white participants to make comparisons across race/ethnicity, which risks "pathologizing" people of color.[54]

Gaps in need of more research

Identified gaps in nursing science included the need for more comprehensive measures

of racism beyond self-report and data about how institutions perpetuate or reduce practices that can be considered racist.[61] Hall and Fields[54] called for more research to help "close the gap between big racism in societal policies and health-related educational institutions and overt and subtle biases in interpersonal interactions [and] microaggressions."[54(p36)] Broomfield-Massey and Noor[37] discussed the need for more research on the impact of medicalization and situating certain specialty areas such as lactation consulting in academic settings with respect to candidates of color. Ultimately, more quantitative and qualitative data are needed regarding inequities in all areas of institutional functioning (eg, leadership, service design and provision, retention, and success of faculty of color), in policies and practices that perpetuate institutionalized racism and microaggressions, in teaching practices related to racism, and in areas of privilege and oppression within institutions.[37,50,57,60]

Implications for nursing practice

Of the 29 articles reviewed, 20 included implications for nursing practice. Their authors consistently recognized that effectively combating institutionalized racism in health care and advancing racial equity in health outcomes require actions on multiple fronts, and each study included implications for nursing practice at multiple levels. Thus, implications for nursing practice included interventions directed at individual patient care, communities or neighborhoods, organizations or institutions, and politics or policy. As with nursing science, there were 2 general approaches that authors took toward suggestions for nursing practice. Some authors offered broad, nonspecific suggestions intended to make readers reflect on how to most effectively implement the suggestions in their own practice, institution, or community. Others offered concrete, actionable interventions that could be pursued by nurses in diverse settings.

Individual patient level

Broad implications for practice at the individual patient level included using a life course perspective in which individual experiences are validated and acknowledged to foster trust and to disrupt systems in which patients delay or avoid health care. Alhusen and colleagues[61] argued that a life course perspective acknowledges cumulative risk and influence on health outcomes. Thus, for example, a black person's daily accumulation of microaggressions can result in chronically increased cortisol and subsequent hypertension and depression.[54] Considered more broadly, the individual patient encounter is the most accessible locus at which nurses can impact racial inequities; Hall and Fields[54] suggested approaching each patient narratively to preserve individuality and the life context, including racial identities and experiences.

More specific and concrete implications for nursing practice at the individual level included specific risk assessments and targeted interventions in particular populations. For example, Cooke and colleagues[49] suggested that elementary and preadolescent schoolchildren of color should be assessed for experiencing microaggressions within their school and social settings. Bond[35] suggested that midwives and other women's health care providers should develop programs to address stress, sexually transmitted infection risk, and interpersonal violence and to strengthen families to achieve healthier pregnancies in black women. Another specific suggestion for addressing the impact of institutionalized racism at the individual level included providing financial assistance to women of color to specifically boost their ability to apply for certification in lactation consulting.[39,52]

Organizational/institutional level

Implications for practice aimed at the organizational or institutional level centered on critically appraising organizational policies for their role in perpetuating institutionalized racism and modifying those policies as needed. Mojab challenged nurses working in every organization dedicated to eliminating inequities in the field of breastfeeding to "identify, dismantle, and re-create policies,

procedures, practices, customs, and structures in which institutional oppression is encoded."[60(p33)] She suggested that hospitals alter policies to attain the Baby-Friendly Hospital Initiative designation as a specific example of how to identify and rectify racist policies and practices within institutions. Gordon[40] called for development of explicit organizational goals, policies, and practices using a racial equity lens to avoid or minimize disparate impacts on communities of color. She detailed the development of a racial equity toolkit that midwifery organizations can use to facilitate the prioritization of racial equity across the organization. Other actionable suggestions for nurses included establishing policies that refuse to accommodate patients' requests for nurses based on race or ethnicity[36] and educating elementary school teachers, administrators, and staff about the impact of racial discrimination on child mental health.[49] Broader implications included establishing safe, nonpolarizing, constructive dialogue among nurses in practice to address challenges of nonhomogeneous workplaces and patient care.[51,64] Some of the authors challenged nurses to identify and remedy institutional practices that advantage certain groups at the expense of others[43,44] and to implement organization-wide racial equity initiatives.[37]

Neighborhood/community level

Implications for practice at the neighborhood or community level were rare, discussed in only 3 articles. Doede[53] challenged public health nurses to form partnerships with other public health stakeholders to reduce racial inequities in employment. Somayaji and Cloyes[51] identified several factors contributing to mistrust of the research process and of the health care system among black Americans with cancer; these authors urged academic and health care institutions to establish trusting, sustaining relationships with black communities by building community-based programs in partnership with the community. More broadly, Ramaswamy and Kelly[44]

encouraged public health nurses to educate others in public forums and via the media about institutionalized racism and its effects on health.

Political or policy level

Implications for nursing practice targeting political systems or policy change centered broadly on advocacy and engagement with legislators to enact public health policies to increase access to social determinants of health such as education and employment. DeLilly,[38] who suggested a human rights approach to address health inequities, highlighted the need to advocate for governmental regulation to prevent racial discrimination in employment opportunities and access to health care. Doede[53] provided the most concrete suggestions for nurses to intervene at the policy level to reduce inequities in employment by urging nurses to advocate for a higher minimum wage, stronger worker protections under the Occupational Safety and Health Administration, paid leave for lower income workers, and comprehensive worker benefit packages that include health insurance and retirement.

DISCUSSION

Fewer than 10% of nursing journals published articles that explicitly named institutionalized racism. In these few articles, several authors identified important considerations for nurse researchers and suggested diverse strategies for nursing practice and education that can be used to combat institutionalized racism in the United States. Two caveats, however, should be kept in mind during the following discussion. First, the initial search for this review returned several articles that discussed institutionalized racism but did not name it as such (nor did they name structural, systemic, systematic, or institutional racism), so they were excluded. This exclusion underscores the importance of *explicitly* naming institutionalized racism,

because "that which is not named remains unacknowledged."[56(p180)] Without naming institutionalized racism, one risks reducing "issues of race to a battle for the hearts and minds of individual racists," because the language used to describe racism determines the methods with which one fights it.[65] Second, institutionalized racism was a core concept in only 19 of the 29 included articles. The fact that institutionalized racism was a secondary concept in 34% of the final sample is likely to have contributed to what may be an over-reliance on individual-level solutions for tackling an entrenched, systematic issue. These caveats notwithstanding, this small body of literature still offers important insights to guide the nursing profession as it seeks to engage in the difficult work of dismantling racist systems, structures, and policies.

Meaningfully and effectively tackling institutionalized racism will require a systematic rethinking and reordering of many of the structures within which nurses currently practice, teach, and conduct research. A critical step whose time has come may be a thoughtful reexamination to nursing's alliance with empiricism, beginning with the recognition that randomized clinical trials and the pursuit of objective "truth" can be incomplete when one is attempting to understand human experiences rooted in power structures and imbalances. Many areas of concern to nurse researchers—including institutionalized racism—do not lend themselves to an objectivist approach, and nursing should take seriously the call of feminist and critical race theorists to examine assumptions of nursing research. Giles[39] succinctly described the utility of critical race theory in acknowledging the combined effects of allegedly race-neutral systems, and until and unless researchers recognize their own assumptions and hidden biases, nursing science will continue to risk perpetuating inequities instead of meaningfully addressing them.

The heavy emphasis on nurses' self-reflection, examination of assumptions, and perspective-taking underscores the impor-

tance of nursing education and professional development. Many programs and health care institutions offer training in diversity and cultural humility, but the findings of this review reveal that such training is not sufficient for challenging assumptions and implicit biases.[41,42,54,58,59,63] Instead, this review underscores the importance of rethinking diversity training as a time for consciousness-raising by educating nurses about historical systems of oppression while also examining white privilege and implicit biases. Yet such endeavors must be undertaken slowly, thoughtfully, and carefully to avoid creating situations in which people become upset, angered, and frustrated. Personal narratives, perspective-taking, and teaching strategies that focus on relationship building and affective learning are useful methods to address the charged topic of racism. It is crucial for nursing students at every level to be exposed to the concepts of institutionalized racism and encouraged to reflect on their own thoughts and beliefs, as well as on nursing's professional responsibility and social mandate to dismantle unjust systems to truly address health inequities and provide the best care for patients and populations. However, several articles in this review found that nursing faculty were ill-prepared to effectively introduce these concepts within the classroom.[40,50] Nursing faculty must therefore have adequate time, preparation, and support to incorporate issues of institutionalized racism and implicit bias into their teaching, which underscores the need for education of the entire faculty (including leadership) to appreciate the connections between issues of racism, power, privilege, and health outcomes. The results of this review suggest that this cannot be accomplished through brief, 1-time efforts such as daylong workshops. Instead, the institutional culture must shift to embrace ongoing opportunities for faculty to engage in dialogue and reflection about institutionalized racism and implicit bias themselves, so that it can be effectively shared with students in a way that respects the diversity of students'

experiences and thoughtfully challenges students to examine their own positionality.

Understanding institutionalized racism is insufficient; nurses must also know how to act to dismantle racist systems. Advocacy is a tool with which nurses are intimately familiar; advocacy on behalf of hospitalized patients and their families is a core nursing intervention.[66] However, any meaningful effort on behalf of the profession to address and dismantle institutionalized racism will require nurses to become familiar and comfortable with advocacy at a higher systems level. This call is not new. There has been a persistent expectation, albeit one rarely heeded, that nurses will engage in advocacy beyond the individual level.[67] Educating and empowering nurses to engage in advocacy at the policy level is contingent upon creating space within nursing curricula and designing professional development opportunities for nurses at all levels of practice and education to learn and engage in policy advocacy.

Nursing has a well-developed infrastructure in the form of professional organizations that can support policy advocacy. However, this review found a lack of attention to institutionalized racism on the part of specific influential nursing organizations in the United States. To be sure, it is entirely possible that other professional nursing bodies have issued clearly articulated calls to action or position papers about this topic. However, the lack of easily located position statements on the Web sites of the 5 organizations searched indicates that nurses in many areas of practice, research, and education lack guidance as to how to effectively challenge institutionalized racism within their own spheres of influence. In August 2018, the Society for Adolescent Health and Medicine (SAHM)—an interdisciplinary professional organization of physicians, nurses, social workers, and psychologists, among others—issued a position paper providing clear recommendations for organizations dedicated to improving the well-being of youth. The authors outlined the harmful effects of racism in its myriad forms and challenged SAHM's membership to recommit to its foundational principles of justice, equity, and respect for humanity. This position statement could serve as a guide for nursing professional organizations, as they consider how to guide the nursing discipline to address institutionalized racism. In particular, in early 2018, the ANA put forth a request for public comment about nurses' role in addressing discrimination in its various forms, including racial discrimination. Members of our own faculty, including authors of this article, provided comments that encouraged the ANA to incorporate more about institutionalized racism. The ANA could use SAHM's unequivocal call to action, in addition to such suggestions, to inform the eventual release of a position statement.

A few limitations to this review bear mentioning. As with any literature review, the search strategy may not have uncovered all articles that should have been included. Although the selection of search terms was comprehensive and a health sciences librarian assisted in determining the search strategy, articles may have been missed because they were included in nursing journals that are not indexed as nursing journals. For example, the peer-reviewed journal of the Association of Black Nursing Faculty was not indexed as a nursing journal. Because this journal was likely to include rich dialogue about institutionalized racism and its impact on black people, it was included in the review. But other non-nursing-indexed journals might also be likely to have rich dialogue about institutionalized racism as well. The indexing of journals itself may provide commentary about how systems include and exclude different perspectives. It is also possible that nurses may have published articles about institutionalized racism in nonnursing journals that have more of an interdisciplinary and/or public health focus, thus hindering this review's ability to capture all nurse voices on the issue of institutionalized racism. Such an endeavor was outside the scope of this review, which focused on forums that exclusively represent nurses and nurses' voices. Future reviews could provide insight

into how many nurses position similar work in nonnursing journals (which itself forces one to ask why those authors might have decided against disseminating such work in nursing journals). Finally, the review was limited to studies focusing primarily on the experiences of black Americans, owing to the distinct experiences that reflect the historical legacy of chattel slavery, Jim Crow, and many other examples of codified discrimination. Certainly, black Americans are not the only individuals in the United States who have experienced health-harming racial discrimination. Although an analysis of institutionalized racism experienced by all racialized groups is beyond the scope of this review, it is likely that the present findings could be applicable to institutionalized discrimination experienced by other marginalized groups fighting against systems of oppression.

CONCLUSION

Although not representative of the entire body of nursing literature, this review nev-

ertheless furthers the understanding of how and to what extent nursing literature has addressed institutionalized racism since the historic election of the nation's first black president in 2008. Relative to the number of peer-reviewed nursing journals and the amount of scholarship published by those journals, institutionalized racism was explicitly named by a very small percentage. This relative silence on the topic could be interpreted as the complacency that gives racism its power[65] because institutionalized racism is perpetuated by those who fail to challenge it.[43(p2)] Being a nurse does not confer immunity against racism in America. The profession must move the current conversation about cultural competency both inward and backward: inward to explore prejudices and unconscious biases, and backward to explore the historical events and contexts that have shaped and continue to shape current biases. These continuous introspective and retrospective views will inform nursing education, science, and practice and ultimately meaningfully impact racial inequities in health.

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