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EDITORIAL

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"Dismantling structural racism: Nursing must not be caught on the wrong side of history"

> "There are decades where nothing happens; and there are weeks when decades happen." —
>
> attributed to Vladimir Ilyich Lenin

This is a watershed moment in history that could change everything. How could we consider writing about leadership programmes, workforce, educational levels, clinical hours, or the like, at a time like this? We are almost half-way through the 2020 'International Year of the Nurse and Midwife' (IYNM) and already what might once have been the solid ground of an IYNM editorial is now shifting sands under our feet.

Nurses from diverse backgrounds, countries, and structural positions, but with a shared global concern, have come together here to call for an immediate challenging and dismantling of the views, behaviours, and organizational structures that have supported, perpetuated, and enabled the racism, injustices, and inequities that still pervade much of nursing and health care. Such racism has often made services and organizations unwelcoming and unsafe places for Black Asian and Minority Ethnic/Black, Indigenous, People of Color (BAME/BIPOC) nurses.

As we write, the streets of the USA and cities across the world are filled with people demanding an end to structural and systemic racism in every aspect of our world. The destructive and oppressive racism behind the killings of George Floyd and many others in the USA, the murder of Stephen Lawrence, and others in the UK, the numerous preventable Aboriginal deaths in custody in Australia, plus many other examples of neglectful health care, have exposed racism and xenophobia as serious public health issues (Karan & Katz, 2020), on a par with the COVID-19 pandemic. Public Health England (2020) recently published the report: "COVID-19: review of disparities in risk and outcomes". This descriptive review, based on surveillance data, confirms that existing health inequalities are replicated by the impact of COVID-19 and even increased in some cases. It also confirms that the risk of dying, for those diagnosed with COVID-19, is higher in BAME/BIPOC groups than White ethnic groups due to structural and systematic social inequalities in health.

Racial inequity and prejudice are widespread and systemic in health services (Kline, 2014) and nursing and midwifery (Brathwaite, 2018; Puzan, 2003; Wren Serbin & Donnelly, 2016) and this transcribes directly onto the lives of BAME/BIPOC nurses, linking to both psychological trauma and physical health impacts. At a time when skin colour and cultural identity places BAME/BIPOC health workers at risk of increased health inequalities and discrimination, the profession cannot be complacent or silent, for as Karan & Katz (2020, p.2) remind us: "Staying silent now is saying something" and that 'something' is incompatible with nursing's values.

It is important to draw attention to ethnicity and cultural identity because they link directly to structural racism, the persistence of White privilege, unconscious bias, and the ongoing imposition of dominant culture. White privilege is consistently misrepresented as accusing all White people of being "bad individuals" (Schroeder & Diangelo, 2010, p.244) or of dismissing that they have 'worked hard for what they have', or not recognizing when they 'came from humble origins'. It has nothing to do with these factors. Discussing 'White privilege' unpacks what Puzan calls, "the unnoticed advantages that are camouflaged within the whiteness of nursing" (Puzan, 2003, p.194). Perhaps it is this very 'unnoticed' dimension that can make discussions of racism and structural disadvantage so difficult for many White people. Somehow, even mentioning White people and BAME/BIPOC people violates the more comforting narrative that nursing is 'colour blind' and does not notice colour, culture, or any other differences because 'nurses treat everyone the same'. This "color blind perspective" (Barbee, 1993, p.351) has rendered any meaningful discussion of racism in Euro-American nursing, "taboo" (Barbee, 1993, p.346) for decades.

In simple terms, everyday racism plays a significant part in healthcare delivery and provision. Nursing and midwifery dare not allow themselves the luxury of imagining that racism, whether institutional or interpersonal, is someone else's problem, or that such assumptions will *not* reveal themselves in clinical settings. Racialized dynamics are frequently re-enacted in health care. In IYNM, COVID-19 has exposed a crisis in care and taught us much about structural racism, xenophobia, institutionalized injustice, and their targets. Nurses need to be alert to the injustices and inbuilt inequities amplified by the COVID-19 pandemic and their disproportionate impacts on those societally marginalized and disadvantaged groups, such as the poor, older adults, and minority communities and also be prepared to challenge them.

Being a registered nurse or midwife in 2020 must mean being aware of social injustices and the systemic racism that exist in much of nursing, health, and social care and having a personal and professional responsibility to challenge and help end them. It means having an open and caring approach towards those we serve. It means being emotionally intelligent and critically reflective to understand how our own attitudes and prejudices might have an impact on how we care and, consequently, being prepared to change. This will be a lifelong journey

Editorial note: Editorials are opinion pieces. This piece has not been subject to peer review and the opinions expressed are those of the authors.

in anti-racism, where we might all stumble or fall at some points, but being a nurse must mean that we keep challenging and questioning ourselves and the systems and structures that govern people's lives.

For decades, White leadership of our services and organizations, who often 'create the culture' and determine working and care environments, have struggled to recognize that institutionalized racism even exists, despite frequent alerts from BAME/BIPOC nurses and a massive body of research and literature demonstrating the everyday, corrosive presence of racism in both health services and higher education, see e.g., Kline (2014). As Brathwaite notes, "the reality of racism is more than an agenda issue", it is a "reality of everyday working life" (Brathwaite, 2018, p.257). The daily existence of many BAME/BIPOC clinical nurses and academics is "a litany of micro-aggressions on tolerable days and too many macro-aggressions on harder days" (Edwards, 2020). Meanwhile, the gap between the occasional performative allyship of 'racism is unacceptable' other executive 'position statements' and the everyday "racial hostility" (Mapedzahama et al., 2011, p. 161) experienced by BAME/BIPOC nurses and faculty remains as wide as ever. When hospital CEOs and university Vice Chancellors send communications to staff to say #BlackLivesMatter, we need to reflect on why these lives did not matter enough earlier and why concerns were not translated into effective, actionable policies.

Racism is about much more than 'peoples' feelings'. Entrenched racism damages BAME/BIPOC student attainment and faculty/clinical advancement in ways that have been recognized for decades (Stevenson et al., 2019). Yet still, in 2019, this same report can find that: "A recurring theme in stakeholder responses was that racism and discrimination was not discussed in HE (Higher Education), not discussed at the necessary levels and therefore not addressed" (original emphasis) (Stevenson et al., 2019, p.33). This is not institutional forgetfulness. Addressing racism has simply *not* been sufficiently important. This is the gauntlet thrown down to nursing and midwifery in this IYNM.

Nursing cannot wait another generation to eradicate racism from our practice, Nursing Schools, and health services. There is no need for more 'inquiries' or commissions. The time for 'further research' or 'working through issues' has long passed; no more 'diversity trophies', 'pledges', 'awareness-raising workshops', or happy placards are needed (De Souza, 2018). The time for procrastination politics is over. Only tangible, demonstrable changes, with measurable and meaningful positive impacts for BAME/BIPOC peoples, will end the persistence of racism's social and structural injustices. The abiding legacy of 2020's IYNM could be the beginning of the erasure of racism and the other pernicious discriminations based on culture, religion, sexual orientation, class, and more that prevent communities from flourishing. This would enable *all* nurses to realize their full potential in tackling the major health issues that our world faces, from chronic illness, supporting an aging population, preparing the next generation of fierce nurses, ending poverty, through to creating sustainable climate change.

Do not underestimate the challenges we all face. Many of the conversations and reflections that we must have will not be 'comfortable', or should they be. White faculty and nurses especially are going to have to change how they think and behave and White fragility (Jowsey, 2019, p.5) will be a significant obstacle as: "deep-seated white-centred structural influence on cultural safety, equality and equity cannot be understated, nor can it easily be undone" (Jowsey, 2019, p.5). It will not be sufficient only to be personally or passively 'not racist'. As Angela Davis said, "In a racist society, it is not enough to be non-racist, we must be anti racist." (Kendi, 2017, p.378). Nursing cannot expect BAME/BIPOC nurses to 'solve this problem'. It is not their role or responsibility to create this change. Having one BAME/BIPOC person as head of a hospital or university "Diversity Committee'' is not even close to 'tackling racism and inequality'. The disability movement many years ago took up the mantra of 'Nothing about us, without us'. If we started at even *this* point we could make dramatic progress.

Imagine Schools and services understanding how and why power and ascendency operate to ensure that BAME/BIPOC staff and students are always 'minorities'. Imagine them examining staff demographics and committing to ending, *now*, the perpetual under-representation and involvement of BAME/BIPOC colleagues. Imagine BAME/BIPOC nurses not only being 'given jobs' in Schools and health services but also being revered for their expertise and experiences and being seen as full and valuable partners on publications, research grants, promotion committees, Executive Groups, and more because that is and was already their rightful place. Imagine health services and universities welcoming and valuing BAME/BIPOC nurses for more than their benefit to 'diversity optics and status quos' (Edwards, 2020). Imagine powerful White people who may never have been told to 'Be quiet and listen' in their entire lives, realizing that fora and meetings are not their personal podiums and that BAME/BIPOC faculty and students have important perspectives and views that need to be heard.

The time for talk alone is over. We can do no better than urge Kline's action plan for what must happen "after the speeches" (Kline, 2020) and Olonisakin's "markers" of:

- Positionality,
- Intersectionality,
- Fair representation,
- Diversified pedagogical practices, and.

Systematic de-hierarchizing of identities in assessing progress on tackling inequality.

that will differentiate the universities (and, we would argue, health services) of the future from those who choose to "remain mired in exclusionary logic" (Olonisakin, 2020). What kind of School, University, or Health Service do you want *yours* to be and for whom?

Clear statements of support for anti-racism or #BlackLivesMatter, calls for historical truth-telling and acceptance and wide-ranging changes, have been made by Nursing and Healthcare organizations and services worldwide, but we await committed and enduring action. Every School of Nursing, nursing union, professional organization, Chief Nurse, Council of Deans, Nursing Academy, Leadership

Group, and Health Services executive has a responsibility to produce an action plan and timeline showing their role in how these changes will be brought about. Nursing needs to see how these will be developed in partnership with BAME/BIPOC colleagues who have both a large footprint in the health system and the capacity to lead and sustain needed change, both within and beyond our profession.

The world stands at a juncture of justice and Nursing must not be caught on the wrong side of history. The Berlin Wall was breached on the night of 9 November 1989, and the entire barrier and the ideologies that erected and sustained it were demolished and gone by December 1990. If that supposedly insurmountable barrier can be torn down in a year, then nursing and midwifery can, just as quickly and urgently, dismantle the obstacles, blocks, and ideologies that sustain and maintain the racism and discrimination that cause such disadvantage. Imagine if this were IYNM's lasting legacy for nursing, midwifery, health care, and society. Instead of another year of cake and congratulations, 2020 would forever be etched in nursing's history as the year that nursing finally tackled institutionalized racism.

CONFLICT OF INTEREST

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