The Nurses Role in Addressing Discrimination: Protecting and Promoting Inclusive Strategies in Practice Settings, Policy, and Advocacy (DRAFT for Public Comment)

Purpose:

Discrimination in any form is harmful to society as a whole and against the values and ethical code of the nursing profession. The purpose of this position statement is to reiterate the significance of a nondiscriminatory stance and provide guidance in creating inclusive strategies for nursing care of individuals and populations from all backgrounds.

Statement of ANA Position:

The American Nurses Association (ANA) recognizes progress in national efforts to decrease discrimination associated with race and socioeconomic status through improving access to health care and quality of health care for all. However, concerted efforts must continue in order to eliminate discrimination in all of its forms. The ANA recognizes that inclusion begins at the level of the individual nurse. All nurses must recognize attitudes and practices which contribute to discrimination and actively seek opportunities to promote inclusion of all people in the provision of quality health care while eradicating disparities. The ANA supports policy initiatives which are directed toward abolishing all forms of discrimination.

History/previous position statements:

Previous ANA position statements support the elimination of discrimination in all of its forms. The position statement on *Discrimination and Racism in Health Care* (ANA, 1998) calls for equality and justice at individual and population levels. The consequences for ignoring discriminatory behaviors and acts include an ever increasing gap in health

care disparities and negation of our professional values. The ANA position statement on *The Nurse's Role in Ethics and Human Rights* (ANA, 2016) provides additional documentation in support of eliminating discrimination based upon the ethical obligations of nurses as outlined in the Code of Ethics for Nurses with Interpretive Statements. Numerous recommendations are outlined in the position statement with implications for individual nurses, the nursing profession, nursing education, nursing research, and health care organizations. This current position statement continues to uphold previous and current position statements by promoting nondiscrimination.

Supportive material:

Discrimination exists when a person is treated unfavorably or unjustly according to a particular characteristic such as race, age, gender or religion. There are many other characteristics for which discrimination can occur. For example, discrimination can occur on the basis pregnancy, political affiliation, military status, etc.; the list goes on and may change over time as we now recognize that genetic testing can be used as a basis for discrimination. Attitudes and beliefs about personalcharacteristics in the forms of bias, prejudice, and stereotyping may influence behavior, but the actual act of discrimination also known as *intentional* or *blatant discrimination,* occurs when an individual or group acts upon those attitudes and beliefs (Black, Johnson & VanHoose, 2015; Gee & Ro, 2009). This form of discrimination may be manifested as microagressions in the form of a *microassault. Implicit* or *unintentional discrimination* can be as detrimental as intentional discrimination although it resides outside of the perpetrator's awareness (Bertrand, Chugh & Mullainathan, 2005). Manifestations of this type of macroaggression are unconscious behaviors considered to be rude or demeaning to the individual or group

which are classified as *microinsults*, while *microinvalidations* disavow the experiences or beliefs of a group (Holley, Tavassoli & Stromwall, 2016; Sue, 2010).

Perceived discrimination. When an individual believes that they have experienced discrimination based on personal characteristics such as race, they may exhibit poorer physical and psychological health (Sutin, Stephan &Terracciano, 2015). The link between perceived discrimination, racism, and health including mental health, chronic health conditions, and personality development has been a focus for greater understanding of health disparities among ethnic groups. The effects of perceived discrimination can affect the outcomes of health care as those reporting this type of discrimination believe that are not receiving optimal care, may delay treatment, have difficulty adhering to treatment plans, and may experience internalized racism creating ongoing stressors which further affects health status (Blendon et al., 2007; Carlisle, 2015; Williams, 2012). While some researchers have suggested that health disparities are due to socioeconomic status (SES), other researchers have found that disparities continue even when socioeconomic factors are taken into account. That is, regardless of (SES), African-Americans continue to be at greater risk for hypertension as well as other metabolic disease (Monk, 2015).

Health disparities. The delivery of healthcare has long been associated with discrimination, either perceived on the part of the patient or actual or inadvertent on the part of the provider or institution (Reynolds, 2004). Hastert (2016) reported that the discrimination and resulting inequalities in health outcomes were not related to income, but to demographics, specifically race and ethnicity. However, Brooks, et al. (2017) and Link, et al. (2017) did demonstrate both a race/ethnic and socioeconomic impact on

health and health outcomes. The grouping of these health outcomes is commonly referred to as health disparities (Lee, Ayers & Kronenfeld, 2009). Steed, et al. (2017) called for additional data collection and research regarding mental health and gender minorities, the LGBT population while McGuire and Miranda (2008) called for the elimination of disparities in all aspects of mental health care.

Discrimination has several definitions in the Merriam-Webster Dictionary, among them is "the practice of unfairly treating a person or group of people differently from other people or groups of people". Stuber, Meyer and Link (2008) suggested that stigma be included with prejudice as perceived causes of discrimination and therefore poor health outcomes. Pascoe and Richman's (2009) meta-analysis described the negative impact of a patient's perceptions of discrimination regarding healthcare delivery on their actual health outcomes. Lee, Ayers and Kronenfeld (2009) described how perceptions of discrimination led to a delay in seeking healthcare, resulting in poor health outcomes. Burgess, et al. (2008) described an immense web of factors, including actual variations of illness among demographic groups, access to healthcare and healthcare funding policies as reasons for health disparities.

ANA takes the position that it does not matter if an individual's demographic is expected to have a higher incident of illness. All patients should be screened equally for all health risk factors, including but not limited to elevated blood pressure, elevated blood glucose, HIV, decreases in visual and hearing capacity, proper body mass index, all applicable cancer screenings, mental health screenings and all preventive health services such as vaccinations.

Finally, ANA takes the position that discrimination has no place in healthcare. All patients are equal and should be treated impartiality and with civility. Civility is an active behavior that embodies mutual respect, promotes communication, and fosters collaboration among nurses and patients and the healthcare team (Lower, 2012). ANA takes the positon that treating the illness or injury is important and the demographic or socioeconomic status should not influence the level of care provided. ANA takes the positon that organization policy that inadvertently supports discrimination is in error. It does not matter if it is an organization policy that discriminates or a policy in support of individual employees who discriminate, it is wrong and needs to be stopped.

Recommendations:

The ANA recommends implementation of the following activities:

- Nurses must engage in a period of self-reflection regarding their personal and professional values regarding civility, mutual respect and inclusiveness and resolve any potential conflicts in ways that ensure patient safety and promote the best interests of the patient (ANA, 2015).
- Nurses should seek out and support nursing practice environments that embrace inclusiveness strategies and promote civility and mutual respect regarding patients, coworkers and members of the community.
- Nurses advocate for policies that are inclusive and promote civility and human rights for all health care workers, patients and others within the organization and community.
- Nurses encourage all health care agencies to adopt and aggressively maintain policies, procedures and practices that embrace inclusiveness, promote civility, mutual respect, contain methods for reporting violations and require interventions to avoid recurrence.
- Nurses work both within the profession and with other health care professionals to create diverse, inclusive communities that promote, protect, and sustain high quality, effective, efficient, safe healthcare practices (ANA, 2010).
- Nurses in all environments and at all levels embrace the concepts of justice and caring, diversity and inclusiveness as well as civility and mutual respect as guiding principles within the provision of health care.
- Nurse researchers support and conduct research that is inclusive in nature, including diverse populations and their health care needs.

- Nurse managers, supervisors and administrators assess policies to insure support of inclusiveness, civility and mutual respect, acknowledging that the lack of such policies may result in environments that fail to sustain high quality; effective, efficient and safe healthcare practices (ANA, 2010).
- Nurse educators promote a diverse workforce by developing education practices to attract and retain students from all backgrounds. Increasing the number of diverse nurses in the workforce will begin to reflect the diversity of the overall US population (Graham, Phillips, Newman & Atz, 2016).
- Nurses embrace a patient-centered approach responsive to the individual cultural needs and concerns of their patients and families (Cuevas, O'Brien & Saha, 2017).

Summary:

Discrimination continues to affect the health of populations. Discriminatory practices that are either intentional or unintentional must be addressed by individual nurses and the profession as a whole. Given the impact of unintentional discrimination based upon attitudes and stereotyping, all nurses must examine their biases and prejudices for indications of discriminatory actions. Health disparities continue to exist and are influenced by health policies, individual discriminatory actions, institutional racism, marginalization, and perceived discrimination by the affected population. The nursing profession is responsible for promoting an environment of inclusiveness where all receive safe, quality care, intolerant of any discriminatory practice.

References:

American Nurses Association. (1998). *Discrimination and racism in health care*. Retrieved from http://nursingworld.org/positionstatements.aspx

American Nurses Association. (2010). *Nursing's social policy statement: The essence of the profession* (10th Ed.). Silver Spring, MD: nursesbooks.org.

American Nurses Association. (2015). *Code of Ethics for Nurses with Interpretive Statements*. Silver Spring, MD: nursebooks.org

American Nurses Association. (2016). *The nurse's role in ethics and human rights: Protecting and promoting individual worth, dignity, and human rights in practice settings*. Retrieved from http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Resources/Ethics-Position-Statements/NursesRole-EthicsHumanRights-PositionStatement.pdf

Bertrand, R., Chugh, D. & Mullainathan, S. (2005). Implicit discrimination, *The American Economic Review, 95*(2), 94-98.

Black, L.L., Johnson, R. & VanHoose, L. (2015). The relationship between perceived racism/discrimination and health among black American women: A review of the literature from 2003-2013. *Journal of Racial and Ethnic Disparities, 2*, 11-20. doi: 10.1007/s40615-014-0043-1

Blendon, R.J., Buhr, T., Cassidy, E.F., Perez, D.J., Hunt, K.A., Fleschfresser, C.,…Herrmann, M.J. (2007). Disparities in health: Perspectives of a multi-ethnic, multi-racial America, *Health Affairs, 26*(5), 1437-1447. doi: 10.1377/hlthaff.26.5.1437

Brooks, C. J., Gortmaker, S. L., Long, M. W., Cradock, A. L., & Kenney, E. L. (2017). Racial/ethnic and socioeconomic disparities in hydration status among us adults and the role of tap water and other beverage intake. *American Journal of Public Health, 107*, 1387-1394. dOI: 10.2105/AJPH.2017.303923

Carlisle, S.K. (2015). Perceived discrimination and chronic health in adults from nine ethnic subgroups in the USA, *Ethnicity & Health, 20*(3), 309-326. doi: 10.1080/13557858.2014.921891

Cuevas, A.G., O'Brien, K. & Saha, S. (2017). What is the key to culturally competent care: Reducing bias or cultural tailoring?, *Psychology & Health, 32*(4), 493-507. doi: 10.1080/08870446.2017.1284221

Gee, G.C. & Ro, A. (2009). Racism and discrimination. In C. Trinh-Shevrin, N.S. Islam & M.J. Rey (Eds.), *Asian American communities and health: Context, research, policy, and action.* San Francisco, CA: Jossey-Bass.

Graham, C.L., Phillips, S.M., Newman, S.D. & Atz, T.W. (2016). Baccalaureate minority nursing students perceived barriers and facilitators to clinical education practices: An integrative review, *Nursing Education Perspectives, 37*(3), 130- 137. doi: 10.1097/01.NEP.0000000000000003

Hastert, T. A. (2017). All dollars are not created equal: Health disparities persist even among the highest income Americans. *Preventive Medicine, 96*, 154-155. http://dx.doi.org/10.1016/j.ypmed.2016.10.008

Holley, L.C., Tavassoli, K.Y. & Stromwall, L.K. (2016). Mental illness discrimination in mental health treatment programs: Intersections of race, ethnicity, and sexual orientation. *Community Mental Health, (52)*, 311-322. doi: 10.1007/s10597-016

Lee, C., Ayers, S. L., & Kronenfeld, J. J. (2009). The association between perceived provider discrimination, health care utilization, and health status in racial and ethnic minorities. *Ethnicity & disease, 19*(3), 330.

Link, B. G., Susser, E. S., Factor-Litvak, P., March, D., Kezios, K. L., Lovasi, G. S., ... & Johnson, E. (2017). Disparities in self-rated health across generations and through the life course. *Social Science & Medicine, 174*, 17-25. doi: 10.1016/j.socscimed.2016.11.035 9990-9

Lower, J. (2012). Civility starts with you. *American Nurse Today, 7*(5). Retrieved from https://www.americannursetoday.com/civility-starts-with-you/

McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs, 27*(2), 393-403. doi: 10.1377/hlthaff.27.2.393

Monk, E.P. (2015). The cost of color: Skin color, discrimination, and health among African-Americans. *American Journal of Sociology, 121*(2), 396-444.

Reynolds, P. P. (2004). Professional and hospital discrimination and the US Court of Appeals Fourth Circuit 1956–1967. *American Journal of Public Health, 94*(5),

Streed, C. G., McCarthy, E. P., & Haas, J. S. (2017). Association Between Gender Minority Status and Self-Reported Physical and Mental Health in the United States. *JAMA Internal Medicine.177*(8):1210-1212. doi:10.1001/jamainternmed.2017.1460 710-720.

Sue, D.W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.

Sutin, A., Stephan, Y. & Terracciano, A. (2016). Perceived discrimination and personality development in adulthood. *Developmental Psychology, 52*(1), 155-163. doi: 10.1037/dev000069

Williams D.R. (2012). Miles to go before we sleep: Racial inequities in health, *Journal of Health and Social behavior, 53*(3), 279-295. doi: 10.1177/0022146512455804