

# **Massachusetts Nurses Association Position Statement on Anti-Racism**

## **I. Introduction**

The mission of the Massachusetts Nurses Association, MNA, the Association for registered nurses and healthcare professionals, is to preserve the identity, integrity, and continuity of professional nursing and healthcare in the Commonwealth of Massachusetts. As members of a pluralistic society we are committed to upholding the highest standards of care while protecting and preserving the principles of equality, equity, and justice for our members and the communities that we serve (MNA bylaws).

The Massachusetts Nurses Association is dedicated to creating and maintaining environments of work and care which are supportive of equitable opportunities for advancement and employment, as well as optimum patient outcomes, regardless of age, color, creed, disability, gender, nationality, race, ethnicity, religion and/or sexual orientation. (MNA policy on affirmative action)

The MNA is committed to lending our voice and actions to working in concert with all groups and individuals committed to and working for the dismantling of structures and policies that enable and support continued disparities in health outcomes. Disparities created by systems and structures that also present barriers to the professional growth and advancement of our members of color who continue to be systematically excluded and who experience barriers hindering their opportunities for professional advancement (Hines, 1989; Sidhu, 2008).

As a professional association and union comprising nurses and healing professionals dedicated to the humanistic provision of socially essential care and the alleviation of suffering, we recognize institutional racism and the systematic oppression of poor, vulnerable communities and communities of color as both a crisis in public health and a pervasive obstacle to achieving the goals of our work in both our professional practice and in the labor movement

(Causadias, 2019; Hahn, Truman, & Williams, 2018; Sidhu, 2008; Hines, 1989; Kaufman, 2018).

As nurses and healthcare professionals, we name racism as a determinant of health (Hahn, Truman, & Williams, 2018; Office of the Attorney General, 2020). We bear first-hand witness to the consequences of systemic racism and the inevitable policies which result in predictable, observable health disparities as well as the social, economic, institutional, physical, and psychological violence perpetrated against people of color, working-class people, and all members of society who are socially devalued and systemically assaulted (Institute of Medicine, 2002; Causadias, 2019; Hahn, Truman, & Williams, 2018).

The Massachusetts Nurses Association takes seriously our charge to be vocal advocates for the health and safety of the vulnerable members of our communities. We resolve to explicitly and publicly affirm our intention to stand as an Association committed to anti-racist principles and policies. We further commit ourselves thorough our practices, policies, and programs to continue to educate ourselves and our members about racism, and to work in concert with groups committed to the cause of social equity and racial justice for all people regardless of race or ethnicity.

## **II. Rationale/Scope of the Issue**

As nurses and healthcare providers committed to the health and wellbeing of the individuals and communities we serve, we name racism as a dehumanizing force which undermines our professional charge and highest commitment as providers to improve functioning, alleviate suffering, and provide wholeness and integrity of being (Wright-Thomas, 2020).

The global novel corona virus (Sars-CoV-2/COVID-19) pandemic has laid bare chronic health disparities which continue to plague our system of health care

(Yancy, 2020; The Joint Commission, n.d.; Office of the Attorney General, 2020). As the pandemic evolved in the U.S. it revealed that African American, Black, Latino(a), and Native American communities were more likely to contract the COVID-19 virus, and were also more likely to die from complications resulting from the virus (Yancy, 2020; The Joint Commission, n.d.; Office of the Attorney General, 2020). These health disparities, while shocking in the moment, are unfortunately not new. Research has consistently shown that minorities/people of color, indigenous people and individuals in vulnerable communities have greater difficulty accessing needed health care services, are more likely to be uninsured, and are overrepresented in publicly-funded health systems (Institute of Medicine, 2002; The Joint Commission, n.d.; Causadias, 2019; AHRQ, 2018; Office of the Attorney General, 2020). Research also confirms that health disparities in quality of care and outcomes appear to persist even after researchers control for education, income, access to insurance, and access to care (Institute of Medicine, 2002; The Joint Commission, n.d.; Heath, 2020).

In the midst of dealing with the health and economic trauma resulting from the effects of the pandemic members of African American and Black communities are again bearing the collective cultural trauma of perceived and documented systemic racism, crystalized in this moment in the names and bodies of Ahmaud Arbery, Breonna Taylor, George Floyd, Tamir Rice, Botham Jean, and Eric Garner to name but a few (Switch, 2020; Gooden, 2018). These names and lives are among the growing number that have come to embody the unfortunate reality of racial injustice for black and brown communities who are twice as likely to be killed at the hands of police than whites (Switch, 2020; Tate, 2020).

The murder of George Floyd became a catalyst for civic activism with calls for racial justice and an end to systemic racism. These calls for justice echoed and amplified the calls for social justice in the face of the racial health and economic disparities highlighted by the global pandemic. These twin

catastrophes combined to expose the deeply rooted, systematized, and institutionalized structures and policies that over generations have, by intent or consequence, disenfranchised and disempowered marginalized minorities and vulnerable communities while creating privilege and sustaining bases of economic, social, and political power for individuals racially categorized as white (Gooden, 2018; Hahn, Truman, & Williams, 2018; Kendi, 2019; Diangelo, 2020).

As an association of nurses and healthcare providers, we acknowledge and denounce the ongoing impact that systemic racism has played in creating barriers of entry to practice and career advancement for nurses, physicians, and other health professionals of color among our membership, as well as outside of our membership (Hines, 1989; Gooden, 2018).

As an association we understand the importance of situating the vestiges of racism we witness today in the context of our nation's history. We recognize that the racist policies, practices, and beliefs present at the birth of our nation were embedded in our country's institutions and psyche after the official end of slavery through the implementation of Jim Crow segregationist laws which restricted access to education, housing, bases of power, and jobs ('Our Nation Is Moving Toward Two Societies, One Black, One White—Separate and Unequal': Excerpts from the Kerner Report, n.d.; Gooden, 2018). These racist laws explicitly curtailed the economic, professional, social, and political advancement of Black people (Hines, 1989; Diangelo, 2020; Kendi, 2019; Causadias, 2019; Gooden, 2018).

Destructive racist policies embodied in Jim Crow segregationist laws continue to permeate every aspect of American life through statutes, laws, and policies governing our nation (Kendi, 2019; Diangelo, 2020). They have through explicit and implicit means framed the norms, beliefs, and practices that have guided policy and influenced policy makers throughout the continued growth and evolution of our country, including at the inception of our healthcare system

and the development of its practitioners and “leaders” (Gordon, 2020; Sidhu, 2008; Diangelo, 2020; Hahn, Truman, & Williams, 2018; Hines, 1989).

We see manifested today, the legacy and consequence of racist ideas and beliefs planted and nurtured at the birthing of the nursing profession. At its conception, white “Nurse Leaders” fought for and claimed legitimacy and recognition for the nursing profession and those deemed acceptable to be considered registered nurses, mainly white women (Hines, 1989). At that time the belief in the unworthiness of Black women/people of color to practice or be recognized as legitimate practitioners was entrenched in emerging institutions of learning and codified through laws, policies, and practices, barring Black nurses and other nurses of color from accessing schools of nursing or sitting for state boards of registration examinations, excluding them from claiming legitimacy as registered nurses (Hines, 1989). The malicious seeds of racism were nurtured as then emerging “Nurse Leaders”, gathered their newly created ranks of registered nurses into professional associations. This newly recognized force of registered nurses banded together to exert their collective will, demanding recognition for the Nursing profession and their members, while explicitly barring Black nurses and nurses of color from joining their professional associations (Hines, 1989). These racist norms, policies, and practices were fostered and codified in the form of pay disparities as white “Nurse Leaders” through their professional associations lobbied for better pay for nurses and the nursing profession, while justifying significantly lower pay for Black nurses, deemed as being inferior to their white counterparts (Hines, 1989).

The legacy of racism codified in Jim Crow segregation resulted in segregated schools, associations, hospitals, and where integration was required in the hospital, segregated floors. Segregationist practices, relegated Black nurses and nurses of color to second class status while creating generations of “Nurse Leaders” and educators nurtured and groomed in the belief of the Black nurse as inferior, not possessing “the capacity to fill positions that entailed very heavy

responsibility and that discipline could not be maintained without “firm and competent white direction”” (Hines, 1989, p. 99). Today we see the legacy of the seeds of racism bearing fruit as evidenced in the lived and shared experiences of our own members of color, many of whom report continue restrictions in access to leadership opportunities such as charge and exclusion from positions on specialty, high skill units, such as Intensive Care Units, Emergency Department or as Educators.

As an association committed to the health and wellbeing of the individuals and communities we serve and the advancement of workers of all races, we acknowledge the affects that systemic racism has inflicted on the social, economic, and professional development, and advancement of our own members of color, our patients, and the communities we serve. We name racism as a violation of human rights and acknowledge our responsibility as a labor union and professional association to work for and to actively promote the cause of health and social equity, and racial justice for all people.

### **III. Recommendations:**

- Review MNA affirmative action policy and plan for update as appropriate: <https://www.massnurses.org/nursing-resources/position-statements/affirmative-action;>
- Review all organizational policies regularly with the goal of actively working to ensure working toward the achievement of anti-racist goals/racial equity;
- Affirm through organizational policies MNA commitment to anti-racism and social justice;
- Develop resources for ongoing education members and staff;
- Develop action plan for creating safe spaces for hosting productive conversations and dialogue related to anti-racism, racism, and bias;

- Review training of union leadership, (administration, staff and bargaining unit leadership) with a focus on anti-racism/racial equity;
- Create an electronic library of resources or links to resources to assist members and staff on racism, bias and anti-racism;
- Develop training for organizational staff related to anti-racism, bias, and effective standards/mechanisms for intervening on behalf of members;
- Discuss/explore characteristics of anti-racist nursing practice, with a focus on patient safety and team dynamics;
- Discuss/explore accountability practices related to members' rights to seek justice if experiencing racism in their workplace, their bargaining unit, or within any other MNA organizational body including, but not limited to, developing model contract language;
- Affirm support for member-led initiatives to address racism, social injustice and disparities in the community;
- Affirm intentions to engage with community and associations engaged in anti-racist work;
- Create an electronic system for members to file/report concerns related to incidents of racism or prejudice with the goal of being able to measure the need for education and track improvement over time;
- Create an assessment tool to survey the membership regarding attitudes related to racism and bias the goal of which would be to evaluate the need for education and the type of education needed.

#### **IV. Statement of Rights Section**

The Statement of Rights in relation to the nurse might more appropriately be a "Statement of Rights and Responsibilities". Specific rights for example, are likely to include things like the following:

- The right to seek union intervention and assistance if experiencing racism or prejudice from a fellow union member or employer;

- The right to a workplace with a clear, active policy plan for eliminating racial inequity;
- The right to receive culturally competent care from healthcare providers with professional knowledge of racial inequities in healthcare outcomes and who actively strive to prevent racial and social inequities.

## V. Definition of Terms

- **Race** - A social construct imposed on individuals or groups that artificially classifies/divides people into grouping based on physical attributes, particularly skin color. These groupings generally reflect cultural interventions -beliefs and attitudes - rather than biological or genetic distinctions (Yasuko & Smedley, 2020)
- **Racism/racial discrimination** – The subordination and marginalization of members of low social power groups (in the U.S. Native Americans, Latino(as), Black and Asian), by members of the socially dominant group (Whites), manifested by the behaviors or attitudes that create distinctions that exclude, restrict or create preference based on race, color, descent or national or ethnic origin. May include overt or covert behavior (Multicultural Council of Saskatchewan, 2016)
- **Systemic Racism** – The reproduction and embedding of socially created values, beliefs, and practices that privilege a dominant group’s culture, beliefs, and norms as preferable/superior to the subordinate group; having the effect of hindering or invalidating the accomplishment, recognition, enjoyment, or exercise on equal footing, of human rights and fundamental freedoms of the subordinate group; resulting in systemic oppression and



suppression of a racial group's social, and political, and economic advantage over another (Merriam Webster Dictionary online, n.d.; Wijeyshinghe & Griffin, 1997)

- **Anti-Racist** – working proactivity against racism and systemic racism (Kendi, 2019)
- **Racist** --“One who is supporting a racist policy through their actions or inaction or expressing a racist idea” (Kendi, 2019, p. 13)
- **Antiracist**-- “One who is supporting an antiracist policy through their actions or expressing an antiracist idea” (Kendi, 2019, p. 13)
- **Racist/Antiracist policy** --: “A racist policy is any measure that produces or sustains racial inequity between racial groups. An antiracist policy is any measure that that produces or sustains racial equity between racial groups” (Kendi, 2019, p. 18)
- **Racial inequity:** “Racial inequity is when two or more racial groups are not standing on approximately equal footing” (Kendi, 2019, p. 18)
- **Disparity** – Inequity
- **Social Determinants of Health** -- Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.” In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also

affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins. (healthypeople 2020 <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>)

- **Person of Color** – Individuals in non-white racial groups
- **Human Rights** – Life, liberty, and the pursuit of happiness (add ref U.S. Constitution)
- **Privilege** – The concrete benefits of access to resources, social rewards and power to shape the culture norms and values of society. White privilege is the benefit individuals in white racial groups receive, consciously or unconsciously by virtue of their skin color – (add reference (Wijeysinghe & Griffin, 1997)
- **Racial Microaggression** – A comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group (such as a racial minority)

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