Title: Reflections on whiteness: racialised identities in nursing.

Abstract:

In this article, I discuss structural domination of whiteness as it intersects with the potential of individual critique and reflexivity. I reflect on my positioning as a white nurse researcher while researching international nurse migration. I draw on two large qualitative studies and one small focus group study to discuss my reactions as a white researcher to evidence of institutional racism in the British health services and my growing awareness of how racism is reproduced in the British nursing profession.

Introduction

There is a rich, global literature on racism in nursing (Baxter, 1988; Condliffe, 2001; Kushnick, 1988; Likupe & Archibong, 2013). There is also a long history of activism against racism (Blanchett Garneau et al., 2018; GrumblingAppendix, 2016; Thorne, 2020). Individual nurses (McKay, 2020), nursing organisations (Kinnair, 2020) and nurse academics have spoken out in support of *#BlackLivesMatter* and advocate anti-racism action (Blanchett Garneau et al., 2018). There is evidence of strategies to tackle institutional racism and unconscious bias in nursing (Dangerfield et al., 2020; Foster, 2020; Iheduru-Anderson et al., 2021). As well as a powerful critique of nursing to address the historical legacy of colonialism and racism in nursing and nurse education (Brathwaite, 2018; Stake-Doucet, 2020; Thorne, 2020).

While racism has been shown to be prevalent in nursing and health care settings globally (Allan et al., 2004; Allan et al, 2009; Allan, 2016; Blanchett Garneau et al., 2018; Brathwaite, 2018; Hall & Fields, 2012, 2013; Kline, 2014, Olusanya, 2021; Smith et al., 2008; 2015; Thurman et al., 2019), Iheduru-Anderson et al. (2021) argue there is little acknowledgement of institutional racist practices in nursing and little awareness of now nursing is complicit in institutionally racist health services. This is not surprising given that nursing has always been a mirror of society, constrained by its social, political and economic context. Nursing is as constrained by society's beliefs and structures around race, ethnicity, gender and social class stereotypes as any other profession or public institution (Snee & Goswami, 2020; Traynor, 2013). Consequently, there is denial in nursing that racism is systemic and institutional (Drevdahl et al., 2006). Where there is acknowledgement of racism, it tends to centre around individual acts of racism or individual racist nurses rather than any awareness of different levels of racism (Flanigan & Christiansen, 2021). The literature shows that there is a need to understand how racism is reproduced across different health care settings; and the struggle against racism and discrimination in nursing and health care services is ongoing (Iheduru Anderson et al., 2021; Thorne, 2020; Van Herk et al., 2011).

In this article, I contribute to this critique of nursing's position vis-à-vis racism and anti-racism by discussing the structural domination of whiteness as it intersects with the

potential of individual critique and reflexivity. I draw on Blanchett Garneau et al.'s paper on nursing pedagogies which sustain (among other racist practices) racialising processes to reflect on my positioning as a white nurse researcher who has researched overseas nurse migration for a number of years, 2003-2021.

Rather than use the all-inclusive terms Black and White, following Brathwaite (2018) I use the term Black, Asian and minority ethnic (BAME) to refer to nurses of non-European heritage and white to refer to nurses of European heritage[1].

Background: my understanding of racism

My understanding of racism was initially informed as an undergraduate of Sociology and later in life through my experience as a nurse researcher. As a white researcher of international nurse migration, I have come to understand that racism, structurally and institutionally systemic in British society and, therefore, nursing, manifests itself directly and indirectly (Larsen et al., 2005; Smith et al., 2008). Intentionally and unintentionally may be a clearer way of describing these interpersonal racist acts (Health Equity Style Guide for the COVID-19 Response: Principles and Preferred Terms for Non-Stigmatizing, Bias-Free Language" of the Centers for Disease Control and Prevention (CDC), 2020). It is a system of discrimination, oppression and white privilege (DiAngelo, 2018; Iheduru Anderson et al., 2021) which is painfully obvious to people of colour in everyday acts of micro-aggressions and systemic injustices (Akala, 2019) but goes unrecognised by white people who benefit from their white, racialised identities and positioning (DiAngelo, 2018; Olusoga, 2016). It is not, as I previously believed, solely down to an individual's actions, beliefs or attitudes although these underpin and therefore interact with institutional policies and practices (Akala, 2019; Olusoga, 2016); this individual-level understanding of racism is common in nursing (Drevdahl et al., 2006; van Herk et al., 2011) although there are some emerging studies which challenge this (Mitchell et al., 2017). Racism is built into social structures and as a

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[1] As I am writing from a British position, I have used the British (albeit, itself contested) practice for referring to BAME when speaking or writing about people of colour (Brathwaite, 2018). BIPOC (Black, Indigenous, and people of colour)may be more familiar to a North American audience. I am also mindful of the international audience who may have different views. All acronyms when referring to people's colour, race and ethnicity are reductive, inaccurate, unrepresentative of smaller groups; they imply a hierarchy between groups and eliminate differences between and within groups. Acknowledging this, as I'm not addressing specific racial or ethnic categories, I believe BAME follows the spirit of Flanagin and Christiansen's advice in their 2021 paper, Updated Guidance on the Reporting of Race and Ethnicity in Medical and Science Journals.

result, is often invisible to white people (Akala, 2019) as whiteness itself is historically invisible (DiAngelo, 2018; Olusoga, 2016). While studies into whiteness in the United Kingdom (UK) exist, Phoenix (1996), Clarke and Garner (2010), Garner (2009), Nayak, 2003, being good examples, it is an under-researched area (Nayak, 2007). Garner (2009) argues that whiteness as a category is underexplored both in academic literature and in popular discourse in the UK. Garner argues that the potential for whiteness studies to be attacked by populist right-wing groups in the context of Europe's (and the UK's) history of the Holocaust may explain this. He argues that:

> The danger of lending credence to identity politics based on white racial reflexivity haunts the British fieldwork. (2009, p.2).

Discussion of whiteness in nursing literature is again more prevalent in American, Australian and Canadian literature than in British literature; see for example, Allen, 2006, Puzan, 2003.

Whiteness, white privilege and white supremacy

What is whiteness? It is generally taken to denote an absence of specificity, or an invisible non-raced identity (Nayak, 2003; Garner, 2007). However as Garner (2009) suggests, increasingly whiteness is visible both by white communities and individuals themselves (perhaps even more so in the context of the migration debates in the UK during the 2010s) and by BAME groups. He also cites fear of whiteness as a political tool to disempower BAME communities. Garner argues that:

> Whiteness may emerge therefore as either marked (visible) or unmarked (invisible), depending on the location of the person doing the looking. (2009, p.3).

American studies (for example, Lamont, 2000) suggest that whiteness is socially constructed through what are perceived to be widely accepted, 'normal' or 'commonsense' norms and values. In constructing and performing whiteness, 'Other' is also constructed as the antithesis of whiteness (Garner, 2009). The key consequence of whiteness is white privilege.

DiAngelo (2018) argues that racism rests on white privilege (systemic and structural advantages over people of colour) and white supremacy (the belief that white people are superior to people of colour) which blinds white people to their own colour, rendering them unaware of their whiteness and the privilege this gives them. Or as Blanchett Garneau et al.

(2018) describe, this is a process where the *harms of culturalist assumptions* go unrecognised and unchallenged by the white perpetrator (DiAngelo, 2018). Whiteness is therefore about power arising solely from an individual's skin colour and the privilege that this gives them in society, including access to resources at interpersonal and structural levels, which has a generational advantage. Clarke and Garber (2010, p.15) describe these advantages as

> 'legacies of inter-generational relative advantage. However low they are in a given socio-economic order, white people benefit from being white, and not necessarily intentionally.'

To this I would add that social class privileges peculiar to British nursing (Snee & Goswami, 2020) may intersect with whiteness to construct white privilege. Social class may be a reflection of white privilege in the British context. As Snee and Goswami (2020) argue, there remain class advantages for those from professional backgrounds in British nursing; the impact of social class endures to privilege female nurses particularly strongly in career progression. They argue that nursing has a 'glass ceiling' for those nurses not from professional backgrounds. At this stage, their analysis does not include race or ethnicity as the data they draw do not have these categories. I realise in retrospect that I have benefitted from white privilege as a nurse, nurse teacher and researcher. As DiAngelo (2018) argues, acknowledging my whiteness is a small, recurring step to addressing my personal responsibility for anti-racism.

The 'good/bad binary' and white fragility

DiAngelo (2018)'s description of the good/bad binary in white people's understanding of who is a racist and the ensuing white fragility have been important to my emerging understanding of racism, racism in nursing and white privilege. DiAngelo (2018, p.71) uses the phrase '*He's not racist. He is a really nice guy'* to describe the good/bad binary which is how white people imagine racists. In nursing, I think we might say, '*she's not a racist, she's a really good nurse'.* We imagine a racist to be someone who commits 'simple, isolated and extreme acts of prejudice' (2018, p.71); we believe that only bad people can be racists. DiAngelo calls the good/bad binary '*the most successful adaptation of racism in recent history'* (2018, p.71). This belief prevents white people acknowledging their colour and their white privilege in structural and institutional forms of racism. It prevented me from

acknowledging my own whiteness and my own racism. My mental image of a racist was formed by class and family beliefs which were expressed as I was growing up, by media reports of violence by skinheads towards Asian immigrants in the 1970s and later in the 1990s, of the police stopping and searching young Black men in London.

White fragility, which prevented me from speaking about my own racism, was the consequence of the good/bad binary belief. By failing to acknowledge my own whiteness and white privilege, by believing only bad people are racists, I denied racism existed in its fullest extent, that is, in everyday acts of oppression as well as in systemic white privilege. White fragility means that if I am exposed as a racist, either by my acts or my own realisation, I may deny it and argue that I am the one being treated unfairly. This is behind the response, '*all lives matter*' to *#BlackLivesMatter* (Stollznow, 2021). DiAngelo (2018, 107) argues that this response comes from a position where the white person fails to see themselves in racial terms, refuses to engage further with discussions of racism and in their own minds, becomes the victim of racism. This position of white fragility is powerfully socialised in white culture (Clarke & Garner, 2010).

Racialising processes in nursing

The language of racism is difficult for white people as it requires us to make whiteness visible and thus, our complicity in racism (DiAngelo, 2018). To avoid this discomfort, DiAngelo argues that we use other labels (social class, nationality) to avoid naming racism. I believe that the discursive repertoires of race (Frankenberg, 1994) in nursing make this even more difficult for white nurses to acknowledge the whiteness of nursing and challenge systemic racism. Clarke and Garner (2010) use 'discursive repertoires' to describe the ways in which society uses discourse to structure racism. These are where there is evasion of direct references to 'race' with discourses involving culture, nation, class and gender. These discourses may be overt or covert. DiAngelo (2018) cites covert codes for racism which emerge in American social exchanges, such as parents' talk about neighbourhoods. A nursing example from my experience was when I was told as a student and later as a clinical teacher by nurses looking after young patients with sickle cell disease, that 'those' patients do not require analgesia because 'they don't experience pain like we do' and that 'they put a lot of the pain on'. Blanchett Garneau et al. (2018) argue that existing nursing pedagogies powerfully reproduce racism; these pedagogies are entrenched, unseen and

unacknowledged (Hall & Fields, 2012; van Herk et al., 2011). Pedagogies in nurse education encompass approaches to learning which include informal, incidental and formal learning which is socially constructed through interactions and relationships between lecturers and students, students' peer relationship and between students and staff in clinical teams in health care organisations (Allan & Smith, 2010). Pedagogies shape and constrain how students are socialised during their educational programmes, including their clinical placements; they shape the curriculum, the hidden curriculum, the spaces and sites of learning (Evans et al., 2009). Nursing pedagogies reproduce racism to construct a homogeneity in nursing where whiteness is dominant, unseen and invisible and BAME nurses are seen as other (Puzan, 2003). This renders talking about racism difficult if not impossible (Holland, 2015). Iheduru-Anderson et al. (2020) argue that a culture of silence around, and a collective denial of, racism, act as racialising processes in nursing both in current nurse education and practice and in historical accounts (Stake-Doucet, 2020). BAME nurses struggle to fit in (Smith et al., 2008) because difference is excluded and whiteness continues unacknowledged and unseen.

I illustrate whiteness as a racialising process in nursing by drawing on two large qualitative studies and one small focus group study to discuss my reactions as a white researcher to evidence of institutional racism in the British health services. I discuss my growing awareness as a researcher of how racism is reproduced in the British nursing profession.

The studies

I draw on three studies into international nurse migration: study A in 2003-2005 (Allan et al., 2004), study B in 2006-2008 (Smith et al., 2008) and study C (Allan & Westwood, 2016). See Table 1 for details.

Table 1: study details

	Study title	Study aim	Sample, setting	Method	Research team	Findings:
Study A	We Need Respect	Exploring overseas trained nurses' experiences	n=67 IRNs RCN members.	Focus group study	1 white British female, 1 EU male	Institutional racism Discrimination,

2003 - 2005		of migration & Integration in the UK	3 sites England		researchers	direct/indirect Racist discourses of migration
Study B 2006 - 2008	Valuing all the talents of a diverse healthcare workforce	Understanding equal opportunities for overseas trained health care professionals in the UK	n=90 IRNs, mentors, managers in 4 NHS and 1 private hospital setting. Ghanaian case study.	Qualitative biographical interview study	Research team: 1 black British male, 3 white British female, 1 white EU male	Institutional racism Discrimination, direct/indirect Experiences of promotion F4P complaints
Study C 2014 - 2015	Barriers to NMC registration for overseas trained nurses working in the UK	Understanding barriers to registration with the NMC in the UK for overseas trained nurses	n=11 Philippine ONs working as HCAs in NHS hospital trusts in London	Focus group study	2 white British Female researchers	Barriers included language acquisition, IELTs testing, cost of IELTs which was borne by ONs, frustration and anger of ONs at perceived benefit of ONs working as HCAs for NHS.

Drawing on findings from studies A and B, I wrote two articles *The Rhetoric of caring* (Allan, 2007) and *Overseas nurses' bullying and racism: a case of racist bullying?* (Allan et al., 2009). At the time of studies A and B, the most significant learning for me was my recognition of institutional racism and awareness (from the rich qualitative data) of how racism was reproduced in nursing and the British National Health Service (NHS). The first two papers (Allan, 2007; Allan et al., 2009) report research findings but I can see now that they also address my early sense of my positioning as a researcher. This positioning is overtly

discussed in an article reporting the research process in study C *White British researchers and internationally educated research participants: insights from reflective practices on issues of language and culture in nursing contexts* (Allan & Westwood, 2015)*.* In this paper my colleague and I unpick some of the challenges we encountered as white researchers in interviews with BAME internationally educated nurses (IENs) (see Table 1). We begin to understand that our positioning as white, feminist researchers locates us in a more powerful position than the research participants. I suspect that neither of us were really conscious of our white racialised identities at this time in the sense Diangelo (2018) argues; our reflections were informed by our feminist stance rather than our white racialised identity. It seems to me now that our white fragility blinded us to the effects of racism and our participants' experiences of that racism. I can also see that my fragility was shaped by my belief in the 'good/bad' binary model that DiAngelo describes and has been throughout the period I have researched IENs' experiences of migration to and integration in the UK (including my time spent supervising doctoral students' work in this area).

I refer to these papers to explore the relationship between the structural domination of whiteness as it intersects with my critique and reflexivity on my positioning as a white researcher investigating the experiences of BAME IENs. I reflect on my positioning as a white nurse researcher while researching overseas nurse migration. In doing so, I discuss my reactions as a white researcher to evidence of institutional racism in the British health services and my growing awareness of how racism is reproduced in the British nursing profession.

My positioning as a white researcher

My positioning in studies A and B was that of a white researcher who had no awareness of her own white racialised identity. That did not mean I was untouched by the racism described to me; rather I saw no connection between me and that racism. I felt shock on interviewing the IENs in both studies; shock at what I describe in my field diary as the '*Dickensian conditions IENs are expected to tolerate*'. Their experiences included:

> *Pearl arrives one Winter late afternoon at [xxx] station from Heathrow. She rings the care home, and is told to take a taxi to the care home which was in [deep*

countryside][2]. *She arrives; it's raining, cold and dark. She's shown to a bedroom and told she will start work the next day. She's asked for her passport which is kept for many weeks. She finds the bed sheets are dirty – someone's slept in them before her. Next morning, she's woken to go on shift. When she asks where she will sleep that night, where the promised 'accommodation' is, she's told 'you sleep in the care home'.*

I understood these shocking experiences as othering, the direct and indirect ways they were treated as marginal members of society with fewer access to rights than everybody else (Powell & Menendian, 2016).

> 'Othering is a set of dynamics, processes, and structures that engender marginality and persistent inequality across any of the full range of human differences based on group identities' (Powell & Menendian, 2016, p.16).

In the example above from study B, Pearl is denied her contractual rights to accommodation, rights to property (her passport), right to rest (working after a long flight from South Africa), right to respectful treatment at work. IENs in both studies A and B routinely described having their passports confiscated either, as in Pearl's case, when they arrived at a care home for several days, or when disciplinary action was taken against them.

I felt shame as it slowly dawned on me that as a nurse, I had some collective, professional responsibility for racism. I read the histories of nurse migration to the UK and the personal histories of BAME nurses (Baxter, 1988) and realised I had never considered BAME nurses' experiences before. My existence as a white nurse had not problematised social experiences and conditions different to mine. At this time, despite my shock, anger and shame, I had yet to develop an awareness of whiteness as a racialised identity, yet alone an understanding of white privilege. I found the racism I heard about in the IENs' accounts disturbing but I did not yet recognise my own part in the white supremacy which underpinned the systemic racism I was told about (Clarke & Garner, 2010).

I think my failure to recognise my whiteness was shaped partly by the dynamics of the research process. IENs made great efforts to get to the interviews; one participant travelled

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[2] I have changed some words from my original notes to protect Pearl (which is a pseudonym).

for five hours to attend a face-to-face interview. When I asked her why, she said she needed her voice to be heard as her treatment in the UK had been so upsetting. In the study A, IENs brought refreshments to share, took photographs of each other in the group and exchanged contact details. Five IENs participated in both studies and many in study B had heard of study A and gave that as their rationale for participating; they wanted their voices to be heard. The interviews with the IENs were at times intimate 'Helen let me tell you....' strikingly direct. I was invited to homes, to meals to meet friends. Although I recognised myself as having different experiences as a nurse and as a woman, I thought of myself as 'telling their story' and didn't question our respective positions in the research. I did not question their willingness to voice experiences of racism in mixed ethnic focus groups run by white researchers (study A) or in interviews in study B. I was not a *white ally* (Kendi, 2020) as I now understand it as I did not reflect on any of these feelings or search the literature to understand them. I thought it unproblematic that I voiced their experiences. I wonder now how far colonial and racist biases underpinned my relationship with these participants, that is, how far was my 'altruistic' motivation to tell their story shaped by my situated white privilege and supremacy? Instead, I turned to writing to disseminate the findings.

In *The Rhetoric of caring* I wrote about how nursing and nurses claim to care while we reproduce institutional racism in the NHS. I argued that there is a long professional history of racism, bullying, horizontal violence and hierarchies set in an institutionally racist organisation into which this more recent treatment of newer migrants fits. I was angry at British nursing's and nurses' ethnocentrism. In the second paper, (Allan et al., 2009), we wrote about the minutiae of racism using IENs' experiences of bullying and racism on the adaptation course they are required to complete before registering with the Nursing & Midwifery Council (NMC). We show how IENs were othered and marginalised; they were seen as 'slow' and not good learners by their mentors who failed to have any consideration of different cultural approaches to learning. We argued that this framing of IENs as culturally different was racist. An example is the common complaint against IENs that their communication skills were inadequate:

> They're saying that the IEN is not understanding [but] the [IEN] is not assertive
> enough to say 'I'm sorry, I don't understand what you've said'....but it's more
> dangerous than keep coming and saying you didn't understand the

> *meaning….because at the end, there's stigma that they say of [IENs] 'She can't speak English'.*

Racist attitudes among British 'host' nurses were frequently described by IENs who described unease at social communication in ward teams and not fitting in:

> *My manager said I haven't greeted another sister [ward manager] there….She just comes in and put her bag down and go to tea as if I'm not existing. I don't know what to do, so I don't say anything.*

Their nursing methods were seen as different and less valid than British nursing; there were higher numbers of referrals in participating trusts to the NMC Fitness for Practice (F4P) committee. IENs described feeling spied on by the ward team as their clinical practice was scrutinised:

> *You are spied on, in the morning they [HCAs] go to the managers and tell lies about I've been doing….this lady not having had a wash according to the carers.*

We were told by mentors and managers in these trusts that IENs' practice was less safe than British trained nurses and had nothing to do with how IENs were perceived or treated during their adaptation course. When we interviewed members of the NMC, they failed to see that the overrepresentation of BAME IENs had anything to do with racism. We concluded that as learners on the adaptation course, IENs were bullied and racially discriminated towards by mentors and managers within a racist system. It was not until 2016 with reports by West and Nayar (2016) and West et al., (2017), that the NMC was forced to re-examine whether such high referral rates of BAME staff to F4P was related to racism and take these allegations of systemic institutional racism seriously. In other papers from studies A and B (Henry, 2007; Larsen et al., 2005; Larsen, 2007) we argued that framing difference in practice as cultural difference masked institutional racism in the NHS and was a convenient way to avoid everyday micro-aggressions as well as systemic racist structures.

During study C, once again I was shocked at the extent of continuing racism in NHS. IENs were employed by large well-known NHS hospital trusts as healthcare assistants (HCAs) rather than as registered nurses because they repeatedly failed to pass language tests. The

IENs considered that their employers who could rely on them while working as HCAs to work effectively as registered nurses and felt taken advantage of.

> Then my manager asked me 'Do you mind to take whether a student or the banking staff do they do it properly and then I have taken and I found that the student nurse she was doing you know incorrectly.

They also felt that there was no support to learn English and what was available was expensive on an HCA salary. Finally, they believed that the language tests themselves were too difficult to pass with no social interactions with English speakers and they could not see why the components of the test were essential for nurses to pass.

> The only problem with that is if they give you a scenario that you don't have really idea [sic], like I have experienced about nuclear [power] and I don't know, I just can't say something. It's um I have no idea so I lost it.

> Just lessen the score. … not make it too tough for us, who are already here for 5 years, working in healthcare setting, I think we have given enough experience that we are able, capable to communicate well.

In effect, they felt exploited by a racist system. IENs working as HCAs were then refused APEL for their prior study abroad by the university I worked on an access course for IENs working as HCAs was designed and funded to allow them join the second year BSc nursing programme. It did at least offer a way out of the language cul-de-sac and was paid for by their employers.

I was shocked that discrimination was still as powerfully described by these IENs in 2016 as it was in the two earlier studies. In study B this exploitation had been powerfully described by a trades union representative we interviewed:

> [IENs] are recruited under this ethical policy but it's not ethical and it means these people are treated badly….they are exploited and at risk. I think some of these nurses disappear….they are exploited, in debt and powerless and have no choice.

My positioning in study C shifted as I and my colleague recognised our whiteness in the focus group study. We discussed this shift in *White British researchers and internationally educated research participants: insights from reflective practices on issues of language and*

culture in nursing contexts (Allan & Westwood, 2015)*. In this paper we unpicked some of the challenges we encountered which arose from our positioning as white researchers interviewing overseas nurses from different, non-white backgrounds using a psychodynamic perspective. Through an analysis of our respective standpoints as feminists and our feared biases in relation to social stereotyping and prejudice, we concluded that we represented, held and paralleled systemic patterns of discrimination in our roles as researchers vis-à-vis our BAME IEN research participants. We argued that:

> *Our reflexive process has shown us how reflexivity enhances data analysis and enriches emerging theoretical understandings of both the research process and the topic under investigation.*

This was the beginning of my understanding of whiteness and white racialised identities in nursing and nursing research. I began to explore and 'see' my whiteness as McIntosh (1988) describes:

> *As a white person I realised I had been taught about racism as something that puts others at a disadvantage, but I hadn't been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage. I think whites are carefully taught not to recognise white privilege, as males are taught not to recognise male privilege. So I have begun to ask in an untutored way what it is like to have white privilege. (*McIntosh, 1988, p.1)

Discussion

Racists accentuate differences between groups that do not exist and ignore differences (inequalities, bias, discrimination) that do (Kendi, 2020). After completing three studies into IEN migration and integration in the UK, my research findings had shown me that British nurses, managers, mentors had effectively accentuated differences between IENs and British registered nurses and ignored inequalities and discrimination against them. Our data showed that IENs were constructed as other, marginalised and, through practices like NMC F4P referrals or trusts' failure to promote IENs, attempts were made to exclude them from the profession. The NMC had little awareness of its part in these practices and seemed reluctant to examine their own referral processes. The findings from the three studies showed me how racism works and to whose benefit; I could no longer explain IENs'

experiences of racism as caused by individual acts of racism; I also had begun to recognise my own whiteness and role in British nursing's institutionally racist system. Recognising my white identity, led me to answer Kendi's (2020) question: am I a Racist? Kendi suggests that to answer this question, white people have to recognise that they are beneficiaries of and contributors to racism. As a white person, that meant acknowledging my whiteness and my white racialised identity.

A starting point to understanding my racialised white identity is to understand that whiteness is not an invisible non-raced identity (Clarke & Garner, 2010). As Clarke and Garner (2010) argue, the failure to recognise whiteness is due to society's need *not* to recognise white identities in order to maintain white privilege and supremacy . This unmarked white privilege based on beliefs about white supremacy constructs our socialisation as whites and forms our racialised white identities. Hartigan (2005, p.1) suggests this is because:

> *Whiteness asserts the obvious and overlooked fact that [white people[3]] are racially interested and motivated. Whiteness both names and critiques hegemonic beliefs and practices that designate white people as normal and racially 'unmarked'*

As Clarke & Garner (2010) argue, a recurrent topic in [British ethnographic] studies is the heterogeneity and elasticity of the category 'white' in its members' affiliations with black and Asian cultures, where the terms 'black' and 'white' become ideal-types. This constructs whiteness as a set of contingent hierarchies where:

> *Whiteness can revolve around forms of cultural capital that translate into racialised privilege, which in turn concretises into a system comprised of a set of contested and contingent racialised hierarchies 2010, (p.35)*

However, as Morgan (2020) argues, recognising whiteness is not an intellectual act. It is also an emotional one as I found; after all, it took me nigh on 20 years to do so, 2003 -2021. DiAngelo (2018) describes this position as one of white fragility, where the white person struggles to see themselves in racial terms. And importantly, to see the relationship between white privilege, white supremacy and racism. I overcame well-established, protective

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[3] Adapted from Hartigan. I have substituted white people rather using whites as a noun following Flanagin and Goswami, 2020.

defence mechanisms to acknowledging my racism and whiteness (Allan & Westwood, 2015); it was difficult. I can now see I was working in a 'good/bad' binary position (DiAngelo, 2018) which rested upon my poor understanding of racism, white privilege and white supremacy. I thought 'I don't attack people like racists do, I don't have racist feelings towards BAME people, I research ENNs' experiences of racism and write about them. I can't be racist'. While I did not think of racism as simple, isolated and extreme acts of prejudice, I did not understand fully what systemic racism was or how it felt to people from BAME backgrounds. The shock I've described from studies A and B was part of my journey to understanding that racism rests upon systemic white privilege. As DiAngelo (2018) describes, as is common among white people, I could not acknowledge my own racism because to do so would be deeply unsettling and would raise difficult questions: what do I do about racism now I understand systemic white privilege? At the point I recognised this in study C, I was able, as Kendi (2020) suggests, to explore the structures of racism and the interplay between systemic and individual racism.

Conclusions

The ethnic homogeneity of nursing no longer holds true yet the hegemony of whiteness in nursing continues to be an unspoken phenomenon that exists in silent dominance (Puzan, 2003; Schroeder & DiAngelo, 2010). The culture of silence in nursing means that BAME nurse are silenced by the nursing leadership and organisational culture that diminishes their experiences by denial, the reluctance to associate experiences to racism, and lack of support (Iheduru-Anderson, et al., 2020).

My belief that racism was an individual act blinded me to systemic, structural and institutional racism. This belief was reinforced by racialising processes in nursing throughout my 40 year career. As a nurse, nurse teacher and more recently, nurse researcher, I was racialised into racist practices throughout my career. I played a part in racialising students. In this article, I have focused on whiteness as a racialised identity to examine one particular form of discrimination in nursing. My positioning was also shaped by gender and social class which I have acknowledged above. It seems to me, looking back, that there were very few men and very few students or registered nurses of colour in the 1970s in the London teaching hospitals. As Snee and Goswami (2020) have found using data from the Great

Britain Class Survey (2011-2013), social class acts as a barrier to promotion or many in nursing. Further work is needed to explore how colour, whiteness, gender and social class intersect to reinforce privilege within nursing.

As I have found, it is painful and difficult to reflect on my whiteness, the privilege whiteness entitles me to and the ways in which I have been not only part of a racist system but unintentionally racist myself. Hall & Fields (2013,171) call on "nurses to avoid shame, denial, defensiveness, and colo[u]rblindness and fearlessly and energetically engage one another in continuing race and racial dialogue". They assert that by engaging in this uncomfortable introspection, white nurses would be unfettered by racial fears, race denial, and blindness to white privilege. I fear that the pain and difficulty of these actions may be underplayed. Nurses need support to cope with uncomfortable introspection.

I have followed Blanchett-Garneau et al. (2018) who argue that I am not responsible for my white privilege – I was born into a social position. However I am responsible for recognising that privilege and addressing it in some way. They call this recognition and acceptance of responsibility 'critical consciousness'. My reading of DiAngelo's argument around white fragility is similar. She cites Marty (1999) to make the point:

> *As in other Western nations, white children born in the United States face the moral predicament of living in a white supremacist society. Raised to experience their racially based advantages as fair and normal, white children receive little of any instruction regarding the predicament they face, let alone any guidance on how to resolve it. … they experience or learn about racial tension without understanding Euro-Americans' historical responsibility for it and knowing virtually nothing about their contemporary roles in perpetuating it. (Marty, 1999)*

Reflecting back on my research career, it is ironic that I spent a significant amount of time as a researcher investigating racism in the NHS against IENs while ignoring my own positioning as a white researcher and my own white privilege. I interpret my failure to understand my own position in a white supremacist society as a defence against the pain of recognising my own racism, or white fragility. I suggest that as a profession, at least in the UK, nurses have some way to go to do this collectively; to really understand the dynamics of racism in practice, education and research.

References

Akala (2019). *Natives Race and Class in the Ruins of Empire.* Hodder & Stoughton

Allan, H. T., Larsen, J., Bryan, K. & Smith, P. (2004). The social reproduction of institutional racism: internationally recruited nurses' experiences of the British Health Services. *Diversity in Health and Social Care*, *1*(2), 117-126.

Allan, H. (2007). The rhetoric of caring and the recruitment of overseas nurses: the social production of a care gap. *Journal of Clinical Nursing*, *16,* 2204-2212. https://doi.org/10.1111/j.1365-2702.2007.02095204

Allan, H. T. , Cowie, H. & Smith, P. (2009). Overseas nurses' experiences of discrimination: a case of racist bullying? *Journal of Nursing Management*, *17,* 898–906. https://doi: 10.1177/0969733010368747

Allan, H.T. & Smith, P. (2010). Are pedagogies used in nurse education research evident in practice? *Nurse Education Today*, *30,* 476–479. https://doi.org/10.1016/j.nedt.2009.10.011

Allan, H. T. & Westwood, S. (2015). White British researchers and internationally educated research participants: insights from reflective practices on issues of language and culture in nursing contexts. *Journal of Research in Nursing*, *20,* 640-652. https://doi.org/10.1177/1744987115618236

Allan, H. T., & Westwood, S. (2016). Perceived barriers to UK nurse registration among non-european nurses. *Nursing Standard*. *30*, 45-51. https://doi: 10.7748/ns.30.37.45.s41

Allan, Helen T. (2017). Editorial: Ethnocentrism and racism in nursing: reflections on the Brexit vote. *Journal of Clinical Nursing*, *1*, e0150160. https://doi.org/10.1111/jocn.13627

Baxter, C. (1988) *Black nurse : an endangered species. A case for equal opportunities in nursing*. National Extension College Trust

Allen, D. (2006). Whiteness and difference in nursing. *Nursing Philosophy*, *7*, 65-78. https://doi:10.1111/j.1466-769X.2006.00255.x

Blanchett Garneau, A., Browne, A. J., & Varcoe, C. (2018). Drawing on antiracist approaches toward a critical anti-discriminatory pedagogy for nursing. *Nursing Inquiry*, *5*, e12211 https://doi-org.ezproxy.mdx.ac.uk/10.1111/nin.12211

Brathwaite, B. (2018). Black, Asian and minority ethnic nurses: colonialism, power and racism. *British Journal of Nursing*, *27*, 254-258. https://doi: 10.12968/bjon.2018.27.5.254

Clarke, S., & Garner, S. (2010). *White identities, a critical sociological approach*. Pluto Press

Condliffe, B. (2001). Racism in nursing: a critical realist approach. *Nursing Times*, *97*,(2), 40. https://www.nursingtimes.net/roles/nurse-managers/racism-in-nursing-a-critical-realist-approach-09-08-2001/

Dangerfield, A., Ferrante, J., Jennings, K., & Moorley, C. (2020). Practical action: the way forward to eliminating racially biased treatment of BAME nurses. *Nursing in Critical Care*, *25*, 376-378. https://doi: 10.1111.nicc.12568i

DiAngelo, R. (2018). *White Fragility.* Penguin Random House

Drevdahl, D., Philips, D. A., & Taylor, J. Y. (2006). Uncontested categories: The use of race and ethnicity variables in nursing research. *Nursing Inquiry*, *13*, 52–63. https:doi: 10.1111/j.1440-1800.2006.00305.x

Foster, S. (2020). BAME staff and microaggressions. *British Journal of Nursing*, *29*, 797. https:www.magonlinelibrary.com by 158.094.254.101

Frankenberg, R. (1994). *White women, race matters*. University of Wisconsin Press

Garner, Steve. (2007). Whiteness: an introduction London: Routledge

Garner, S. (2009) Empirical research into white racialized identities in Britain. *Sociology Compass,* 3(5) pp. 789–802.

Grumbling Appendix (2016). *Radical Nurses Archive. A Record of British nurse activism in the 1980s*. https://radicalnursesarchive.wordpress.com/

Hall, J. M., & Fields, B. (2012). Continuing the conversation in nursing on race and racism. *Nursing Outlook*, *61*, 164–173. https://doi. org/10.1016/j.outlo ok.2012.11.006

Hall, J. M., & Fields, B. (2013). Continuing the conversation in nursing on race and racism. *Nursing Outlook*, *61,* 164–173. doi. org/10.1016/j.outlo ok.2012.11.006

Hartigan, J. (2005). *Odd tribes: towards a cultural analysis of white people*. Duke University Press

Health Equity Style Guide for the COVID-19 Response: principles and preferred terms for non-*stigmatizing, bias-free language*. Centers for Disease Control and Prevention; 2020. https://eur02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjamanetwork.com%2Fjournals%2Fjama%2Ffullarticle%2F2783090&data=04%7C01%7CH.Allan%40mdx.ac.uk%7C5fbaddbb304d4b9d3b1908d975fd8bc1%7C38e37b88a3a148cf9f056537427fed24%7C0%7C0%7C637670554106284251%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=rztmZkUqK70kdmuuuhbF6mhdGaMtHXQCY%2FxrJqYsCSQ%3D&reserved=0

Iheduru-Anderson, K., Shingles, R. R., Akanegbu, C. (2021). Discourse of race and racism in nursing: an integrative review of literature. *Public Health Nursing*. *38*, 115-130. https:doi-org.ezproxy.mdx.ac.uk/10.1111/phn.12828

Kendi, I. (March 2020). *Anti-racist vs. not racist*. [Video] Youtube
https://www.youtube.com/watch?v=KCxbl5QgFZw

Kinnair, D. (2020.) *Beyond Covid-19, we need action and investment to address systemic inequality in our health and care systems.* Royal College of Nursing (June 9, 2020).
https://www.rcn.org.uk/news-and-events-blogs/tackling-inequalities-in-the-health-system-090620

Kline, R. (2014). The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and potential impact on patient care in London and England. Middlesex University Research Depository
www.mdx.ac.uk/__data/assets/pdf_file/0012/59799/The-snowy-white-peaks-of-the-NHS.pdf.pdf (Unpublished)

Kline, R. (2015). *Beyond the snowy white peaks of the NHS? Better Health Briefing 39A Race Equality Foundation.* Briefing Paper August 2015.
https://raceequalityfoundation.org.uk/wp-content/uploads/2018/02/Health-Briefing-39-_Final.pdf

Kushnick, L. (1988). Racism, the national health service, and the health of black people. *International Journal of Health Services, 18*, 457-470. https: doi: 10.2190/LEUW-X7VW-Q2KD-UML9

Lamont, M. (2000). *The dignity of working Men Cambridge*, Harvard University Press.

Larsen, J., Allan, H. T., Bryan, K. & Smith, P. (2005). Overseas' nurses motives for working in the UK: global perspectives or local prejudice. *Work,* Employment and Society. *19*(3), 49-368

Larsen, J. (2007). Embodiment of discrimination and overseas nurses' career progression. *Journal of Clinical Nursing 16*, 12, 2187-2195

Likupe, G. & Archibong, U.E. (2013). Black African nurses' experiences of equality, racism, and discrimination in the National Health Service. *Journal of Psychological and Organizational Culture 3*, 227–4. https://doi:.org/10.1002/jpoc.21071

McKay, J. (2020). Nurses protest in support of Black Lives Matter.
https://nursingnotes.co.uk/news/workforce/nurses-protest-support-black-lives-matter/

Marty, D. (1999). White anti-racist rhetoric as apologia: Wendell Berry's the Hidden Wound. In, Nayakama, T., & Martin, J. (eds) (1999). *Whiteness: the Communication of Social Identity*, Sage. p. 51-64

Mitchell, A., Koch, T., & Allan, H. T. (2017). 'It's a t*ouch of sugar'*: Guyanese women's beliefs about diabetes' *Action Research Journal*, *18,* 433-447.
https:doi.org/10.1177/1476750317721303

Morgan, H. (2020). *Decolonising Psychotherapy, 2020. British Psychotherapy Foundation.* [Video] Youtube https://www.youtube.com/watch?v=dn7dHacXZ90

Nayak, A. (2003) Ivory Lives: economic restructuring and the making of whiteness in a post - industrial youth community. *European Journal of Cultural Studies, 6*(3):305-25

Nayak, A. (2007). Critical whiteness studies. *Sociology Compass, 1*(2): 737-755.

Olusanya, B. O. (2021). Systemic racism in global health: a personal reflection. *Lancet*, E1051-1052. https:doi: 10.1016/S2214-109X(21)00147-9.051

Olusoga, D. (2016). *Black and British: a Forgotten History*. MacMillan

Phoenix, A. (1996). ''I'm white – so what? The construction of whiteness for young Londoners'. In Weis, L., Fine, M., Powell Pruitt, L. & Burns, A. (eds). *Off white: readings on power, privilege, and resistance*. Routledge Pp. 187-197

Powell, J., & Menendian, S. (2016). The problem of othering: towards inclusiveness and belonging. Othering and belonging: expanding the circle of human concern, *2,* 14-39. https://otheringandbelonging.org/the-problem-of-othering/

Puzan, E. (2003). The unbearable whiteness of being (in nursing). *Nursing Inquiry*, *10*, 193-200 https: doi:10.1046/j.1440-1800.2003.00180.x

Smith, P. A., Allan, H. T., Larsen, J. A., Henry, L. & MacKintosh, M. M. (2008). *Valuing and recognising the talents of a diverse healthcare workforce.* http://www.rcn.org.uk/__data/assets/pdf_file/0008/78713/003078.pdf

Snee, H., & Goswami, H. (2020). Who cares? Social mobility and the 'class ceiling' in nursing. *Sociological Research Online*. https:doi:10.1177/1360780420971657

Stake-Doucet, N. (2020). Beyond Florence. The racist lady with the lamp. *Nursing Clio,* November 5th 2020. https://nursingclio.org/2020/11/05/the-racist-lady-with-the-lamp/

Stollznow, K. (2021). Why is it offensive to say 'all lives matter'? *The Conversation.* https://theconversation.com/why-is-it-so-offensive-to-say-all-lives-matter-153188

Thorne, S. (2020). Pandemic racism and the nursing response. *Nursing Inquiry*, *27,* e12371. https:doi.10.1111.nin.12371

Thurman, W., Johnson, K. E. & Sumpter, D. F. (2019). Words Matter: An Integrative Review of Institutionalized Racism in Nursing Literature. Advances in Nursing Science, *42*, 89-108 https:doi: 10.1097/ANS.0000000000000265

Traynor, M. (2013). *Nursing in Context: policy, politics, profession*. Palgrave MacMillan.

Van Herk, K. A., Smith, D., & Andrew, C. (2011). Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry*, *18*, 29–39. https:doi.org/10.1111/j.1440-1800.2011.00539.x

West, E, & Nayar, S. (2016). *A Review of the Literature on the Experiences of Black, Minority and Internationally Recruited Nurses and Midwives in the UK Healthcare system. Unpublished report to the NMC.* https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/literature-review.pdf

West, E., Nayar, S, Taskila, T. (2017). *The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process*. https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/bme-nurses--midwives-ftp-research-report.pdf