Racism in Contemporary Australian Nursing

The white eye is always outside the frame……but seeing and positioning everything within it. (Hall, 1981)

I refer to the article, "A Little Story About Racism in Nursing" by Robyn Coulthard in the January edition of this Journal (Volume 43,1). If the subject matter were not so serious it would be an amusing and illustrative anecdote to retell student nurses. It confirms that racism within nursing continues to exist and does not rely on being either, conscious or deliberate rather racism comes in various forms. Prejudice certainly still exists within nursing in Australia and with a couple of notable exceptions by Indigenous academics such as Edwards and Sherwood (2006) has been a, 'sleeper' issue, which the profession has largely ignored or denied exists. Racism is a taboo and ineffable topic.

A review of the literature demonstrates that defining racism appears to be a very difficult task. In the systematic review of empirical research on self reported racism and health by Paradies`s (2006), only 28 out of the 138 studies contained a definition of racism. Despite the aforementioned, Paradies defines racism as a form of, "…..oppression/privilege which does exist in a dialectical relationship…… a societal system in which people are divided into races, where power is unevenly distributed or produced based on their racial classifications" (2006, p.144). Yet another definition of racism describes it as involving harmful and/or offensive acts and omissions that are based on the perceived racialised characteristics of a person, and that are committed against that person just because he/she is a member, or perceived to be a member, of a certain ethic group. (Corlett, 2003)

Racism in nursing and health care

The scenario described in the article is an obvious example of 'inappropriate care', but can also be classified as an example of 'racialised care'. In this instance the racism was not expressed overtly or blatantly and exemplifies how racism expressed, through attitudes and behaviours, can manifest in many guises, such as antipathy, avoidance, ignoring, disengagement, rejection, disgust, contempt, scorn, ridicule, and indifference (Essed, 1991; Goldberg, 1993; Hollinsworth, 2006; Johnstone & Kanitsaki, 2008b; Moody-Adams, 2007).

Whatever the characterization, either as an example of 'inappropriate care', 'culturally insensitive' or 'culturally unsafe' care, this is not really the issue of concern exemplified by this commentary. Rather the issue is that the words and language employed by the nurses are axiomatically reflective of the nurses' perceptions of race, ethnicity and cultural characteristics of Indigenous peoples. Whilst the nurses in question probably did not have a clear intent to be racist they nevertheless did commit an act of racism. Johnstone and Kanitsaki, (2008a) have described, "the specific phenomenon of language prejudice and discrimination as a

form of cultural racism that was discovered serendipitously in the context of a broader study exploring cultural safety and cultural competency in an Australian healthcare context" (p.20). In this instance the nurses' language reinforced enduring ideas of Aboriginal people as being 'different' from white Australians, which necessarily implies a stigmatization of an Indigenous identity. Goffman (1963) notes that stigma refers to, "bodily signs designed to expose something unusual and bad about the moral status of the signifier" (p.11).

As Allen (2006) states, "difference entails classification and classification involves power," (p.66) hence when the nurses sought to describe something (a 'typical' Aboriginal child) they engaged in a three stage process which requires, (1) establishing boundaries ('what' is being described); (2) attributing qualities (what is it 'like'); and (3) attribution requiring the application of preexisting criteria (Gee, 1999). The process is critical to representing 'different' groups of people (Kincheloe. 1998). (i.e. Indigenous vs non-Indigenous; black vs white). When classifications are made and racialised around skin colour there can be, either impliedly or expressly, a clear inference that the difference is in accordance with a biological hierarchy. This Darwinian belief concerning skin colour, being a defining sign of fixed biological differences, is still prevalent despite contemporary scientific thinking, not only discrediting but also debunking this.

Nursing Care

When a person perceives that they have been treated unfairly or demeaned in some way on the basis of their race, it is often referred to as interpersonal racism. The operating word is, 'perceived' namely, a subjective perception felt by the recipient. Hence, there is no intention or *mala fides* required pursuant to this definition. Further breaking down the aforementioned definition it can be separated into, overt or covert racism. Henry (2004) states that overt racism is unintentional, meaning the perpetrator is not even aware of. If these particular nurses were questioned I am certain they would say with conviction, that as part of their practice, they are motivated by a commitment to caring and are unbiased in treating all who seek their assistance. Yet at the same time their language gives them away in perpetrating prevailing social stereotypes. By "[A]ltering their behaviour, vocabulary, and intonation in very specific ways in response to their audience, nurses enacted ethnic difference." (Saethre, 2009, p.781). Accordingly, the nurses in this instance were glaringly, committing overt, interpersonal racism.

The profession of nursing views the praxis of nursing as being based on concepts of empathy and care. Implicit in this belief is that nurses see all people as the same. The corollary is that racism does not affect the type and quality of nursing care provided. Morgan (1984), however, refutes this view finding that while Euro-American nursing students perceived black patients more favorably than black people, they perceived Euro-American patients more favorably than any other group. These obvious contradictions between caring; a deeply cherished principle in the identity of nursing and racism, make it difficult for nurses to acknowledge racial prejudice and

discrimination within the profession. I am convinced that racism is deep seated, embedded and pernicious within nursing.

Nurses are members and representative of Australian society and Australia is a race-centered society in which people are socialized into 'race-laden' vocabulary, cultural images, and attitudes. As Harris (1991) states in a reference to America, which is no less relevant to Australia, "….how is it possible to speak against racisms ... [when] language ... is encoded with attributing worth to peoples according to colours ... and types? ... How is it possible to do so when geographical regions have already been associated with types of persons... and stereotyped character traits of persons from those regions?"

In nursing, as in other areas and professions in Australian society, it is easy for the notions of cultural diversity, sensitivity, congruence, and safety to all become present-day proxies for cultural racism. The aforementioned euphemisms do not, "…..prevent racialised discourse or practice." (Johnstone et al., 2088b) "The ability to socially construct race is the foundation of the substitution process and becomes a form of race-making. Briefly and simplistically, biological characteristics (e.g., skin tone, hair texture), and their hierarchically valued social meanings are ascribed and used to distinguish groups. The combination of group characteristics and social meanings is attributed to individuals. This combination (characteristics and meanings) is assigned to cultures and in this way are used to discriminate among cultural experiences." (Porter, 1994, p.103). Hence, for Indigenous Australians their skin colour is the obvious biological characteristic for historical cultural inferiority (i.e., cultural racism).

Skin colour and cultural inferiority; medically defining Aboriginality

Historically Australia's health professionals as a collective have constructed and communicated popular preconceptions of Aboriginality. Commencing in the colonial era, Aboriginal peoples' susceptibility to introduced diseases set the tone for racial relations. Traditional owners' lack of resistance to illness was equated to a lack of resistance to colonisation (Bashford, 2000). From the 1850s to the 1930s, Aboriginal people were viewed as a 'doomed race' inexhaustibly rushing towards extinction. This view was further reinforced by the 'science' of the day; evolution. Simply stated, Aboriginal people as primitive hunters and gatherers were viewed as being unable to adapt to the 'modern' world. Obviously in retrospect, this view conveniently ignored the devastating impact of colonialism and settlement (McGregor, 1997). "Disparate rates of disease, particularly introduced STDs, were also used to create and reinforce ideas of racial difference" (Saethre et al., 2009, p.775). The high prevalence among the Aboriginal population led these diseases to be labeled as the 'black pox' or 'native pox' (O'Brien, 1998). Contemporary cultural standards and views of that time meant, "…Aboriginal people were considered to lack morality, restraint and other important and 'civilising' social skills." (Saethre et al., 2009, p.775).

Nurses have unconsciously ingested into their psyche the distorted, sanitized and conveniently forgotten history of colonization and therefore, when they complain,

for example, about Aboriginal peoples behaviour towards issues of health they, "…continue to reflect many earlier ideas that link Aboriginality, ill health and a lack of 'civilising' values" (Saethre et al., 2009, p.775). Humphery (2006) notes that non-Aboriginal nursing staff tend to largely ignore social determinant factors such as poverty, the continuing effects of colonialism, and the bureaucracy of medical service provision, whilst making generalised, 'statements of Aboriginality', which stress the inability of Aboriginal people to act in a timely fashion and prioritise health regimens. This language largely enacted by nurses continues to cast Aboriginal people as socially and culturally lacking. Saethre (et al., 2009) states that nurses often ascribe Aboriginal peoples' noncompliance and late presentation to irresponsibility, laziness and indifference, with this behaviour linked and compared to the notion of a, 'respectable citizen'. The respectful citizen of course represents a privileged 'white' norm (Hill, 1997; Kincheloe, 1998; Myser, 2003).

Mainstream Australian society is represented by 97% non-Indigenous peoples and hence, 'whiteness' assumes it is at the 'centre.' (Lipsitz, 1998) Pervasive social comparisons of culture and identity are described from this privileged white centre, which is referable and embedded into the local, conveniently sanitised and cosmopolitan history of colonization (Sandoval, 1997; Lamont, 1999) . "Cultural differences need to be understood as constructed over time within relations of domination" (Allen, 2006, p.67). Indigenous Australians are marginalized, disempowered and disenfranchised, and have been ever since colonisation. Their presence in today's society is the result of struggle with their cultural identity and is partly defined by that struggle (Okihiro, 1994; Flores & Benmayor, 1997). When the nurses in the story were employing 'whiteness' and "non whiteness" as a signifier, social histories were being mobilised (Jacobson, 1998). The nurse's unintended employment of, and ignorant racist vocabulary, simply linked skin colour with their socially valued expectations (Allen et al., 2006).

Maintaining racism in nursing

Barbee (1993) asserts to have found and categorized three types of racism relevant to nursing; denial, the color-blind (perspective), and aversive racism. In nursing, racism is denied by simply not using the term or addressing the issue in practice (except for some notable exceptions). Historically, it was argued that nurses, because of the very nature of their work , are not racist. As recently as the mid-1980s, Carnegie and Osborne (1985) state, "maybe it is because nurses, who know facts of human physical uniformity, who know that disease knows no colour [sic] line and who have pledged themselves to relieve suffering humanity regardless of race, creed or colour, cannot in all consciousness condone any form of discrimination" (p.148). This position presumes a magnanimous commonality in the term nurse; one in which nurses transcend racism (Barbee et al., 1993). Such a position is clearly superficial and not the case in reality.

A colour-blind perspective exemplifies prejudicial attitudes expressed in subtle and apparently nonracial forms, which avoid traditional racist discourse. It is a new racial ideology which articulates a non Indigenous defense of the racial order in a subtle,

apparently nonracial way. Being 'colour blind' provides tools to talk about race without appearing to be 'racist'—a critical element, given the normative climate that has crystallized in Australia since the 1960s when society commenced to disapprove of open expressions of racist views. People engaging in colourblind racism consider racial and ethnic group membership totally irrelevant to the way individuals (clients) are or should be treated (Rist, 1974). As Schofield (1986) points out the major assumption of this perspective is that interpersonal relations are not greatly influenced by group membership. Race is an invisible characteristic of the client; race is a social category that has no relevance to an individual's behaviour. Hence the nurse, according to this perspective does not notice the client's racial group membership. Nursing interactions with Indigenous clients are simply interpersonal. With regard to the prevalence of this form of racism, Malone (1993) sarcastically noted, "[t]here is a distinct problem with eyesight. Colour blindness is of epidemic proportion. Nurses are reporting they see no differences………. They are rewarded for this disability and, therefore, others become infected with the need to appear colour-blind" (p.23). In other words there is a self reinforcing circulatory in this racist perspective through the very act of denial.

Aversive racism is rooted in ambivalence; that is, feelings and beliefs camouflaged by an egalitarian value system in clear conflict with unacknowledged negative feelings and beliefs concerning Indigenous people (clients). According to this perspective such nurses are superficially egalitarian, non-prejudiced, and non-discriminating but nevertheless discriminate in subtle, rationalisable ways (Gaertner & Dovidio, 1986). Hence from an aversive-racism perspective, many nurses who explicitly support egalitarian principles and believe themselves to be non-prejudicial also, unconsciously, harbor negative feelings and beliefs about Indigenous clients. "Aversive racists thus experience ambivalence between their egalitarian beliefs and their negative feelings toward blacks" (Dovidio & Gaertner, 2000, p.315).

Negative consequences of aversive racism are not easily recognised by oneself, or others, while traditional techniques for eliminating racism through emphasizing its immorality and expressing disapproval are not effective. "Aversive racists recognize prejudice is bad, but they do not recognize that they are prejudiced . . . . Like a virus that has mutated, racism has also evolved into different forms that are more difficult not only to recognize but also to combat" (Dovidio & Gaertner, 1998, p.25). The nurses in the article expressed racial bias in indirect ways, which do not threaten their aversive racist, non-prejudiced self-image. Accordingly, any nurse who is defined as an aversive racist *consciously* recognises and endorses egalitarian values, and accordingly does not discriminate in situations in which they recognise that their acts of discrimination will be obvious to others (clients) and themselves—in the story I believe these nurses don`t fall within this definition – they may be attuned to racism but it would appear, *prima facie*, they did not even recognise their language as being unconsciously and impliedly discriminatory, and even if confronted, would objectively endeavour to rationalise the conversation as being based on factors other than on race (Johnstone & Kanitsaki et al., 2008).

I have a strong belief that the nurses in this story are colour blind to their racist remarks. In Australian one of the perpetuating societal fantasies is the, 'Indigenous look.' I am sure that the words employed by them highlights their unconscious stereotypical image of what an Indigenous person (client)   should look like; dark skin and with relatively few European features (Paradies et al., 2006a). After all skin colour and physicality are, "exceptionally important in the recognition and validation of Aboriginal identity" (Boladeras, 2002, p.142). As a result of non-Indigenous comments and   questioning of fair skinned Indigenous peoples, it challenges and questions their own identity and self worth, which in turn is a form of, "racism, scorn and disbelief." (Paradies, et al., 2000, p.359; Foley, 2000; Purdie, 2000) "This intense questioning of authenticity,……….is due to the profound disruption that white-skinned Indigenes represent for the Black-White racial dichotomy, so fervently clung to in Australia (Paradies et al., 2000a, p.359).

Addressing racism

If nursing covets being a redoubtable profession it must take the issue of racism out of the closet and apply the curative nature of sunlight. I believe the key to the issue or at the very least, a starting point, is the way in which we educate and train nurses so that they are able to recognise what racism is, and when it occurs, irrespective of its form, setting or structure. From this starting point, it is only then that the profession can plan and strategise to stamp out this scourge and advocate, from a position of moral sanctity, for the wider health services to commit to the same. It is not until professional introspection has been achieved, both at an individual and professional level, that wider issues involving institutional and organizational racism, can be confronted and addressed. Unless a systematic approach to addressing racism is undertaken, the nursing profession will not have the moral authority to be advocates and genuine agents for change in the wider healthcare system. Nurses will be fettered and hence undermined in their endeavour for having not addressed their own problems, before embarking on wider issues of cultural racism. In other words, the profession must believe that the prominence of the human right not to be subjected to racism is the almost-inevitable conclusion of a long process of moral development and action starting from within.

Conclusion

Racism uses biological differences to explain and justify "birth ascribed" social inequalities (O`Brien et al., 2006) and has been described as a means of keeping certain groups in communities and their capabilities exploitable (Vaughan, 1997). Racism is a disease that consists of attitude, ideation and behaviour based on the assumption of the superiority of white skin colour, enabling 'whites' to denigrate, abuse, dehumanise, ignore and exploit 'non-whites' (Pierce, 1970).

All nursing interactions are influenced and framed by both the client and the nurse's attitudes and understandings (Dudgeon & Pickett, 2000). Racism is cancerous to the same. Despite denials and silence by the nursing profession *(writ large)* concerning

racism, the concept and/or issue, in whatever form, continues unabated and unaddressed.

The turpitude of racism sits uncomfortably with the ideals of nursing as a profession. Each and every nurse, no matter where individually employed, has to take personal responsibility to practice in a culturally safe manner, which in turn, collectively manifests and morphs into a profession of leadership and sensitivity. The starting point in addressing racism is for the nursing profession and individual nurses to take responsibility for the lack of change to date and make sure that educational process begins at pace. To continue the historical path of denial and/or ambivalence concerning this topic/issue declines the responsibility of creating an honest, racist free profession. Anything less equates to dishonesty.

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